

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 20, 1983
Washington Hilton Hotel
Farragut Room
9:00am - 1:00pm

A G E N D A

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| V. | Report of the AAMC Officers' Retreat | Executive Council
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Hospital Services Provided to Medicare
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| VII. | Report of the Committee on Future
Directions for the American Hospital
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| VIII. | Career Preparation for Leadership in
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| X. | A Proposed Sliding Scale of Grant
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Assessment | Executive Council
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| XIV. | ACCME Protocol for Recognizing State
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XV. Information Item: Development of a Data Base
and a Classification System for Independent
Teaching Hospitals

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XVI. Other Business

XVII. Adjournment

Association of American Medical Colleges
COTH Administrative Board Meeting
November 8, 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
Earl J. Frederick
Irwin Goldberg
Sheldon S. King
John A. Reinertsen
John V. Sheehan

ABSENT

Robert E. Frank
Haynes Rice
William T. Robinson

STAFF

James D. Bentley, PhD
Joseph C. Isaacs
Richard M. Knapp, PhD
Nancy E. Seline
Melissa H. Wubbold

I. Call to Order

Dr. Rabkin called the meeting to order at 7:30am in the Chevy Chase Room of the Washington Hilton Hotel. He indicated he would do his best to move the meeting along interspersed with breakfast culinary delights served by the Washington Hilton staff. Dr. Dalston introduced as his guest Mr. Peter Roberts who is an Administrative Fellow at the University of Michigan Hospital.

II. Consideration of the Minutes

ACTION: It was moved, seconded and carried to approve the minutes of the September 9, 1982 Administrative Board Meeting without amendment.

III. Nominating Committee Report

Mr. Marylander indicated that fellow members of the Nominating Committee were Mitchell Rabkin, MD and James (Jim) Ensign. He stated that he would not report the nominations for the AAMC Assembly unless requested at this time. The Administrative Board and AAMC Executive Council nominations are as follows:

- o Three nominations for three-year terms on the COTH Administrative Board, expiring 1985
 1. Glenn R. Mitchell, Medical Center Hospitals, Norfolk, Virginia
 2. David A. Reed, Samaritan Health Services, Phoenix, Arizona
 3. C. Thomas Smith, Yale-New Haven Hospital, New Haven, Connecticut
- o Two-year AAMC Executive Council appointment, expiring 1984

Robert E. Frank, Barnes Hospital, St. Louis, Missouri
- o Immediate Past Chairman

Mitchell T. Rabkin, MD, Beth Israel Hospital, Boston, Massachusetts
- o COTH Chairman

Mark S. Levitan, Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania

o COTH Chairman-Elect

Earl J. Frederick, Children's Memorial Hospital,
Chicago, Illinois

These nominations accompanied by those for positions on the AAMC Assembly will be presented to the COTH membership at its Business Meeting shortly after lunch on Monday, November 8.

IV. Membership Application

Dr. Bentley reviewed the membership application. Based on staff recommendation and Board discussion, the following action was taken:

ACTION: It was moved, seconded and carried to approve the St. Mary's Hospital, Milwaukee, Wisconsin for CORRESPONDING MEMBERSHIP.

V. "Health Care: What Happens to People When Government Cuts Back"

Mr. Reinertsen, who as a member of the American Hospital Association Committee, described the history and development of the report which was prepared by the Special Committee on Federal Funding of Meantl Health and Other Health Services. He urged the group to at least read the letter of transmittal from David Kinzer and the Summary on pages xii-xiv. Mr. Marylander made specific reference to the section on page 31 entitled, "On the Need for a Fair Share Approach to Charitable Care". He asked how those on the Committee expected this fare share to be financed when there was already such a strong negative reaction to the cost-shifting issue. Following further discussion of this and other matters, it was agreed that it would not be appropriate for the COTH Administrative Board to make any recommendation on the AHA report which as yet had not been acted upon by the American Hospital Association.

VI. Adapting to Per Case Payment Systems

Jim Bentley described the activities of a number of associations (American Hospital Association, Health Care Financial Management Association, state hospital associations) and accounting firms (Ernst & Whinney, Coopers & Lybrand, and Arthur Young & Company) as they have been developing educational programs directed at the significantly changed Medicare payments to hospitals using "target rates" and expanded Section 223 limits, both of which are computed and applied on a cost per case basis.

A review of the programs presently being developed show that they share several characteristics. They are oriented primarily toward understanding the conceptual rationale for the two limits, properly computing the limits, determining the financial impacts of the limits, and discussing the managerial implications of per

case limits. The least well-developed aspects of these programs are directed at the managerial implications of per case limits.

In addition, while per case limits appear to offer the opportunity to integrate administrative and clinical decisions, the educational programs presently being offered are directed primarily toward administrative executives only. This appears to be a serious shortcoming which the AAMC could address by drawing together the various constituencies, including deans, faculty and hospital directors. The following points were made in the discussion of the matter.:

- o There was discussion of whether the same educational program could serve all types of AAMC hospital constituents, including the range from university-owned hospitals to community hospitals with teaching programs without fulltime chiefs of service;
- o The role of the housestaff in such activities was discussed;
- o The role of nursing and medical records is also a matter that needs discussing;
- o The unique feature of an AAMC contribution could be the group of individuals brought together to discuss the issues and therefore two or three key clinical chairman should be included in the audience as representatives from each institution;
- o Since such a large audience should be interested perhaps a slide presentation could be developed for use at local institutions;
- o The level of discussion needs to be carefully planned since there are various levels of knowledge to which a program would need to be addressed. It is possible that a subcontract with one of the big eight accounting firms could be arranged to develop such a series of conferences.

Dr. Knapp suggested that it was important to identify those matters that were unique and special for purposes of understanding the implications of per admission limits on teaching hospitals. There was not complete agreement with this statement. While some members of the Board expressed a sense of urgency, there were others who believed that the possibility exists that the quality of a program in this area might be much higher if a good deal of planning, thought, thought, effort and experience were put into. Such an effort would take some time. It was agreed that the staff would further discuss all these matters and bring the issue before the Administrative Board again in January.

VII. Adjournment

The meeting was adjourned at 8:45am. 3

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COH Administrative Board Meeting
September 9, 1982

PRESENT

Mitchell T. Rabkin, MD, Chairman
Mark S. Levitan, Chairman-Elect
Stuart J. Marylander, Immediate Past Chairman
James W. Bartlett, MD, Secretary
Jeptha W. Dalston, PhD
Robert E. Frank
Earl J. Frederick
Irwin Goldberg
Sheldon S. King
John A. Reinertsen
Haynes Rice

ABSENT

Fred J. Cowell
Spencer Foreman, MD
William T. Robinson
John V. Sheehan

GUESTS

Manson Meads, MD
Nancie Noie
Thomas K. Oliver, Jr., MD
Richard S. Wilbur, MD

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Melinda Hatton
Joseph C. Isaacs
Richard M. Knapp, PhD
Anne Scanley
Nancy E. Seline
Melissa H. Wubbold

I. Call to Order

Dr. Rabkin called the meeting to order at 9:00am in the Chevy Chase Room of the Washington Hilton Hotel. He introduced Manson Meads, MD, Vice President for Health affairs at Wake Forest University Medical Center which is comprised of Bowman Gray School of Medicine and North Carolina Baptist Hospital in Winston-Salem. Dr. Meads is a Distinguished Service Member representative to the AAMC Executive Council and joined the COTH Administrative Board for its discussion today. Before moving directly to the Agenda, Dr. Rabkin noted that Dr. Knapp wished to report on two matters of interest.

Dr. Knapp reported that a Management Advancement Program is being planned for September 30-October 5, 1983 to be held at the Far Horizons Hotel on Long Boat Key in Sarasota, Florida. All COTH Chief Executives who have not attended a session in the past will be invited on a first come, first serve basis and the attendance will be cut off between 45-50 individuals. Special arrangements will be made with the Veterans Administration to select those VA Chief Executives who wish to attend.

Dr. Knapp also reported that the staff is planning to expand the University-Owned and Operated Survey to include all major affiliated hospitals. He indicated that there was an awareness of the difficulty in identifying the list but that staff would be working with a variety of criteria in order to compile the list of those hospitals that should be included.

II. Consideration of the Minutes

Dr. Dalston called attention to the section of the minutes describing COTH sponsorship of a capital purchasing program and indicated that much of this discussion as expressed in the minutes carried a negative tone. He felt that a number of positive points were made in the discussion. While no change was made in the minutes, there was a consensus that all those present were aware of the positive points raised, but that the four questions with the negative tone had served well to identify issues for the Committee that was appointed to study the matter.

ACTION: It was moved, seconded and carried to approve the minutes of the June 24, 1982 Administrative Board Meeting without amendment.

III. Membership Applications

Dr. Bentley reviewed the membership application. Based on staff recommendation and Board discussion, the following action was taken:

ACTION: It was moved, seconded and carried to approve Memorial Hospital in Chattanooga, Tennessee for CORRESPONDING MEMBERSHIP.

IV. Statement on Status of Minority Students in Medical Education

Dr. Cooper indicated that despite major efforts which successfully increased black first year enrollment to a peak of 7.5% in 1974-75, the proportion of total enrollment for the under-represented minorities (blacks, American Indians, Mexican Americans and mainland Puerto Ricans) has formed a plateau at about 8%. The size of the applicant pool represented by these minority groups has remained relatively stable over a five year period. Although the percentage for blacks increased by about one percentage point from 1977-78 to 1978-79, it has remained at about that level for the following years. The proportions for American Indians and Mexican Americans and mainland Puerto Ricans showed little change over the five year period. Also for this period, the percentage of under-represented medical school graduates remained at approximately seven percent. In light of the current trend in minority application and enrollment activity and the anxiety over the current financial assistance situation, Dr. Cooper recommended that the Board approve the statement as set forth on page 53 of the AAMC Executive Council Agenda.

ACTION: It was moved, seconded and carried to approve the statement as set forth on page 53 of the AAMC Executive Council Agenda book.

V. Report of the Ad Hoc Committee on Joint Major Equipment Purchasing

Dr. Bartlett, who chaired the ad hoc Committee, described the meeting which was held on the previous day. He explained that the Committee recognized that as part of their research, patient care and education missions, AAMC constituents are high technology users for whom group purchasing could offer significant savings and market position benefits. These constituents include not only teaching hospitals, but also medical schools which often utilize high technology equipment (e.g.; nuclear magnetic tape resonators) that is not yet reimbursable for use by hospitals in patient care.

Dr. Bartlett stated that the Committee expressed some fear of being "aced out" of opportunities by other purchasing groups and determined that the AAMC should explore the major equipment

needs of its constituency and the alternative group purchasing arrangements available to them. He noted that representatives of two major equipment purchasing groups, Voluntary Hospitals of America (VHA) and the Metropolitan Associations Purchasing Service (MAPS), attended the Committee meeting. He reported that the Committee discussed the broader question of the roles of COTH and the AAMC in relation to advocacy and representation versus a service orientation. Also addressed by the Committee were the unique problems of state university hospitals which have limited purchasing flexibility and the critical concerns regarding capital formation and the difficulties in acquiring capital. Dr. Bartlett felt it was particularly interesting to note that the Committee's discussion focused almost exclusively on radiology, which apparently consumes the largest portion of most hospitals' capital equipment budgets.

Dr. Cooper emphasized that placing the AAMC in the role of an operator would be a substantial departure from its traditional role and would be a proposal that would need to be discussed more broadly among all the Councils and approved by the Executive Council. Dr. Rabkin expressed appreciation to Dr. Bartlett and Mr. Frank for their work on the ad hoc Committee and agreed with the Committee's recommendation to pursue more information on constituent needs and available alternatives prior to committing the Association on any significant new course. Both Dr. Dalston and Mr. Reinertsen were concerned that the need for urgent AAMC action on this issue was not being adequately sensed. Dr. Knapp responded that the need to do something, particularly for the Appalachian Teaching Hospital group that originally approached the Association for assistance, is fully recognized. Dr. Bartlett stated that the Committee concurred with this view, but recognized the need to first assess the situation.

Although no official action was taken by the Board, there was the consensus that the following ad hoc Committee recommendations should be presented to the AAMC Executive Council:

"In light of the rapidly changing structure of the hospital field and market, the AAMC should examine what group services are needed by teaching hospitals and medical schools, and how such services might be effectively provided to preserve and strengthen both the individual institution and the influence of teaching hospitals and medical schools as groups of institutions.

"With respect to group purchasing, the AAMC staff should be requested to assess the access of AAMC constituents (teaching hospitals and medical schools) to currently

operating group purchasing activities for major capital equipment and ascertain if the need for improved and broader access to such services is a specified need of AAMC constituents."

The COTH Board requested that a written report be prepared of the Committee's deliberations and AAMC staff findings, which would be available for review and discussion at the January Administrative Board and Executive Council meetings. Further, the AAMC should consider this matter as a possible item for discussion at the AAMC Officers' Retreat in December.

VI. Payment for Services of Provider Based Physicians

Dr. Knapp distributed background material on this issue which is attached as Appendix A to these minutes. He described Section 108 of the Tax Equity and Fiscal Responsibility Act of 1982 which is addressed to the issue of payment for services of provider based physicians. He indicated that under the terms of Section 108, the DHHS Secretary is to prescribe regulations which will distinguish between (1) professional medical services which are personally rendered to an individual patient which contribute to the patient's diagnosis and treatment and are reimbursable only under Part B on a charge basis; and (2) professional services which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Since to a large degree such an action will be directed at physician reimbursement in the clinical laboratory, Dr. Knapp reviewed the January 24, 1980 Executive Council Action with respect to Medicare reimbursement for pathology services (also included in Appendix A to these minutes).

Following discussion it was agreed that the COTH Administrative Board recommend to the AAMC Executive Council that the current AAMC position is appropriate to deal with this issue. It was further recommended that the staff review the position taken by the College of American Pathologists and work with that organization in resolving this set of problems.

VII. Election of Distinguished Service Members

Dr. Rabkin explained the criteria for nomination to Distinguished Service membership in the AAMC which are set forth on page 24 of the AAMC Executive Council Agenda book. He indicated that the staff had reviewed the situation and recommended that Chuck Womer be recommended by the COTH Administrative Board for Distinguished Service membership.

ACTION: It was moved, seconded and unanimously carried that Mr. Charles Womer be recommended for Distinguished Service membership in the AAMC.

VIII. Relationships with the JCAH

Dr. Rabkin reported that Dr. John Affeldt, JCAH President, is very interested in hearing more on teaching hospital concerns about the Joint Commission and discussing their current and future relationships. Dr. Affeldt will be joining the Administrative Board at its January meeting. Therefore, Dr. Rabkin requested that the Board members identify issues which Dr. Affeldt could be asked to address. The following suggestions were made:

- o the current status of the appeals process -- Mr. Rice;
- o the definition of "professional staff organization" -- Mr. Rice;
- o privilege delineations for physicians who admit few patients -- Mr. King;
- o quality and attitude of surveyors and status of specialized teams for teaching hospitals -- Mr. King, Dr. Dalston and Mr. Levitan;
- o status of joint surveys (e.g.; with state licensure reviews) -- Mr. Goldberg;
- o equivalency standards that would enable teaching hospitals to demonstrate how they assure quality of care -- Mr. Goldberg;
- o teaching hospital ability to meet medical records requirements -- Mr. King; and
- o the challenges generally facing the JCAH now and in the future.

Dr. Knapp was requested to write to Dr. Affeldt and review the outcome of the Board's discussion on this agenda item.

IX. AAMC Study of Teaching Hospital Characteristics

As agreed at the June Board meeting, the original draft report on the characteristics of teaching hospitals had been revised into two reports and mailed to the Board in August. Dr. Bentley briefly reviewed each report in terms of its intended purpose, audience and tone. Board members were generally pleased with the outcome of the revision and each of the separate reports was viewed as more appropriate for its purpose than the original had been. Several members offered suggestions for re-wordings and editorial changes. The

discussion concluded with Board members agreeing to submit comments on the drafts within two weeks. Upon receipt of the comments, staff will review both reports and distribute them to the appropriate audiences.

X. Preparation for Leadership in the Teaching Hospital/ Academic Medical Center

Dr. Dalston opened his presentation on this agenda item by asking the following question; "Given the present high demand for leadership and administrative performance in teaching hospitals and the rapid intensification of the leadership requirements for teaching hospitals, how can the field enhance preparation of new careerists and ultimately increase effectiveness in office?" He defined "the field" as hospital administration, academic medicine, medical administration and medical school administration. He noted that numerous actors are already on the scene dealing with leadership preparation -- graduate programs in hospital/health administration, MBA graduate programs, schools of public health, business schools, clinical department chairmen and clinical practitioners (administrative residencies, internships, externships, fellowships, etc.).

Dr. Dalston then explained some of the major issues which he wished the Board to consider:

- o Can teaching hospital management/leadership be taught academically?
- o Is it within the purview of COTH to become involved in career preparation of these persons?
- o Should COTH become involved in career preparation or continuing education for leadership in teaching hospitals?
- o Should COTH expand its Executive Development (MAP) program?
- o Should COTH get involved in post-master's clinical practitioner training?
- o Should any effort be put forth to reduce the sea of confusion relative to administrative residencies, fellowships, internships, externships and management development programs?

He noted that the AUPHA, general education accreditation bodies, individual institutions and health care corporations and systems, the ACHA, individual universities and programs,

hospital trustees and university vice presidents and officers are among those who have expressed concern about this issue of hospital management development and are seeking problem resolution. In response to the question; "Should COTH get involved?", Dr. Dalston believed the answer to be yes and that COTH /AAMC should wish to exert an influence, though not necessarily as a primary player. He suggested that he would develop a background paper if the Board expressed interest in the subject.

After further discussion by the Board, there was a consensus that the issue needed more discussion. Dr. Dalston was asked to elaborate on his presentation with additional pertinent information for further Board consideration.

XI. AAMC Response to the Enactment of the Small Business Innovation Act

Anne Scanley of the AAMC's Department of Planning and Policy Development informed the Board of some of the ramifications of the recently adopted Small Business Innovation Act that set aside portions of the government research funds to go to small businesses. According to Ms. Scanley, institutions that had been considering establishing spin-off organizations to act as small businesses should be aware that the law precludes these spin-off organizations from being eligible for these set-aside funds. However, individual faculty members and physician staff can organize small businesses to apply for these funds. Such activities can detract from the physician's commitment to the institution. Possibilities for COTH members to obtain some of these funds include signing consulting, leasing or subcontract agreements with eligible small businesses.

ACTION: The Board recommended that the Association staff wait until the proposed regulations implementing this legislation are published before notifying members of the significance of the act.

XII. Graduate Medical Education Positions

A brief discussion was held in which the Board members agreed that their comments regarding the potential shortage of graduate medical education positions had been made during the previous evening's joint Board meeting with the Council of Deans and the Organization of Student Representatives. Board members had expressed concern about the ability of teaching hospitals to maintain the number of residency positions given the imposition of Medicare and other reimbursement constraints and about the desire of some groups of specialists to add years to the present length of the residency program in their specialty.

The Board agreed no action was necessary

XIII. AHA Prospective Payment Plan

As a result of the COTH Administrative Board recommendation in June that the AAMC should support the American Hospital Association's prospective payment proposal in principle, the proposal's outline was included in the Executive Council Agenda. This item required no action by the Board; however, Dr. Bentley requested Board guidance on a discussion paper of design principles prepared by the AHA for the proposal. Principle 1 stated, "Over the long term, payment for hospital services under the Medicare program should move to locally determined, market-oriented pricing systems." Dr. Bentley's question concerned the Board view of the principle's endorsement of the phrase "involving bidding and negotiations." Without formal vote, the Board instructed Dr. Bentley to seek the removal of this phrase from the draft principle.

XIV. Information Item: Hospitals Having Terminated COTH Membership, 1980-82

Dr. Knapp reported that he wished the Board to be aware of those 18 institutions that had terminated membership in the Council of Teaching Hospitals since 1980. He indicated that repeated efforts both by Mark Levitan and himself to reactivate the membership of Children's Hospital of Philadelphia had not met with success. Stuart Marylander volunteered to discuss the matter with the chief executives of Rancho Los Amigos Hospital in Downey, California and Martin Luther King, Jr. General Hospital in Los Angeles. John Reinertsen indicated he would discuss the matter with the administrator of the Veterans Administration Medical Center in Salt Lake City.

XV. Adjournment

The meeting was adjourned at 12:30pm.

Senate Conference Report

PAYMENT FOR SERVICES OF PROVIDER BASED PHYSICIANS

(Section 108 of the Bill)

Present law.—Hospitals and skilled nursing facilities retain or employ various kinds of physicians, such as radiologists, anesthesiologists and pathologists, who provide numerous services for the institution itself in addition to direct patient care services. The services that these hospital-based physicians perform for the institution may include supervision of professional or technical personnel in certain hospital departments (e.g., laboratory or X-ray departments), research, teaching or administration. These practitioners negotiate a variety of financial agreements with hospitals and skilled nursing facilities regarding the services rendered by them in the provider setting.

Under current law and regulations, services furnished by a physician to hospital inpatients are reimbursed on the basis of reasonable charges

under part B only if such services are identifiable professional services to patients that require performance by physicians in person and which contribute to the diagnosis or treatment of individual patients. All other services performed for the hospital (or for a skilled nursing facility) by provider-based specialists (e.g., radiologists, anesthesiologists, pathologists) are to be reimbursed as provider services on the basis of reasonable costs.

Committee amendment.—While the above policy has been established by the law and by regulation since the inception of the medicare program, it has never been uniformly implemented. As a result the amounts that the program has paid to some hospital based physicians are related to the amount of work performed by hospital employees rather than by the physician himself.

The committee amendment directs the Secretary of Health and Human Services to prescribe regulations, effective no later than October 1, 1982, which will distinguish between (1) professional medical services which require performance of the physician in person and which are personally rendered to individual patients and which contribute to the patients' diagnosis and treatment and are reimbursable only under part B and (2) the professional medical services of practitioners which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. The Secretary would be expected to prescribe specific conditions, appropriate to each of the physician specialties, to establish when a practitioner's involvement in a patient care service is adequate to justify treating it as a physician service which is reimbursable on a reasonable charge basis under the part B program.

Medicare reimbursement for the services that would be covered under the respective parts of the program would be subject to appropriate tests of reasonableness.

As in the case of other physicians, services that are reimbursable on a reasonable charge basis will be subject to the customary-and-prevailing charge limits established under Part B of medicare. Similarly the compensation for supervision, teaching, administration and other professional services that would be reimbursable on a reasonable cost basis would be evaluated in terms of time that the physician expends, compensation comparability, and such other factors as the Secretary may prescribe.

The committee directs the Secretary to monitor changes in arrangements, patterns of service and hospital physician relationships as a result of this proposal.

Effective date.—October 1, 1982.

Estimated savings.—

Fiscal years:	Millions
1933.....	\$63
1934.....	73
1985.....	84

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REIMBURSEMENT OF PROVIDER-BASED PHYSICIANS

SEC. 108. (a) Title XVIII of the Social Security Act is amended by adding after section 1886 of the Social Security Act (as added by section 101(a)(1) of this subtitle) the following new section:

"PAYMENT OF PROVIDER-BASED PHYSICIANS

"SEC. 1887. (a)(1) The Secretary shall by regulation determine criteria for distinguishing those services (including inpatient and outpatient services) rendered in hospitals or skilled nursing facilities—

"(A) which constitute professional medical services, which are personally rendered for an individual patient by a physician and which contribute to the diagnosis or treatment of an individual patient, and which may be reimbursed as physicians' services under part B, and

"(B) which constitute professional services which are rendered for the general benefit to patients in a hospital or skilled nursing facility and which may be reimbursed only on a reasonable cost basis.

"(2)(A) For purposes of cost reimbursement, the Secretary shall recognize as a reasonable cost of a hospital or skilled nursing facility only that portion of the costs attributable to services rendered by a physician in such hospital or facility which are services described in paragraph (1)(B), apportioned on the basis of the amount of time actually spent by such physician rendering such services.

"(B) In determining the amount of the payments which may be made with respect to services described in paragraph (1)(B), after apportioning costs as required by subparagraph (A), the Secretary may not recognize as reasonable (in the efficient delivery of health services) such portion of the provider's costs for such services to the extent that such costs exceed the reasonable compensation equivalent for such services. The reasonable compensation equivalent for any service shall be established by the Secretary in regulations.

"(C) The Secretary may, upon a showing by a hospital or facility that it is unable to recruit or maintain an adequate number of physicians for the hospital or facility on account of the reimbursement limits established under this subsection, grant exceptions to such reimbursement limits as may be necessary to allow such provider to provide a compensation level sufficient to provide adequate physician services in such hospital or facility."

(2) Section 1861(v)(7) of such Act, as amended by section 101(d) of this subtitle, is further amended by adding at the end the following new subparagraph:

"(C) For provisions restricting payment for provider-based physicians' services, see section 1887."

(c) The Secretary of Health and Human Services shall first promulgate regulations to carry out section 1887(a) of the Social Security Act not later than October 1, 1982. Such regulations shall become effective on October 1, 1982, and shall be effective with respect to cost reporting periods ending after September 30, 1982, but in the case of any cost reporting period beginning before October 1, 1982, any reduction in payments under title XVIII of the Social Security Act to a hospital or skilled nursing facility resulting from the such regulations shall be imposed only in proportion to the part of the period which occurs after September 30, 1982.

Conference agreement

The conference agreement includes the Senate amendment with minor modifications. The agreement directs the Secretary to prescribe regulations which will distinguish between (1) professional medical services which are personally rendered to an individual patient, which contribute to the patient's diagnosis or treatment, and are reimbursable only under part B on a charge basis; and (2) professional services which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Reasonable cost reimbursement for provider-based services could not exceed a reasonable compensation equivalent established by the Secretary in regulations. The conference agreement directs that regulations implementing this provision be published and effective by October 1, 1982. The conferees understand that such regulations are already under preparation by HHS. The publication and timely implementation of these regulations would reflect the intent of the conferees.

EXECUTIVE COUNCIL ACTION
January 24, 1980

Medicare Reimbursement for Pathology Services

In promulgating reimbursement policies for Medicare, HEW and Congressional policy-makers have proposed various methods to separate Part A and Part B services provided by physicians. These proposals have been of serious concern to a number of medical disciplines, particularly pathology. The Association's Executive Council policy approved in March 1977 supported reimbursement policies which recognized crucial professional services in pathology and furthered the development of the discipline and opposed payment limitations which inhibited development of the discipline. A copy of a recent draft revision of HCFA regulations was objectionable to pathologists because it required the pathologist to be personally involved in the performance of each clinical pathology service in order to receive fee-for-service payment. The Association's ad hoc Committee on Section 227 considered this issue at its October 17 meeting, and recommended a revision in the Association's current policy to make it consistent with Senate Finance Committee language supporting percentage arrangements based on a relative value scale for compensation of pathologists. It was reported that such a policy was supported by pathologists. The proposed new policy statement:

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline. The Association, notes, however, that Senate Report 96-471 would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on an approved relative value scale "...which takes into consideration such physicians' time and effort consistent with the inherent complexity of procedures and services." The Association supports such a proposal.

The Council of Deans reported some discomfort with supporting percentage contract arrangements, but recognizing the difficulty in changing funding for any department within a short period of time, by a split vote agreed that the statement should be supported as a temporary device. CAS approved the statement, citing its concern that the development of the discipline might otherwise be inhibited. COTH recommended that the statement be

EXECUTIVE COUNCIL ACTION

January 24, 1980

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amended to clarify that the percentage contract arrangement was being supported as only one option of compensation, and on that basis had approved the statement.

ACTION: On motion, seconded, and carried, the Executive Council agreed to amend the proposed policy statement to add the phrase "as one option of compensation for pathology."

ACTION: On motion, seconded, and carried, with one dissenting vote, the Executive Council approved the following policy statement on payments for pathologists services:

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline. The Association noted, however, that Senate Report 96-471 would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on approved relative value scale "...which takes into consideration such physician's time and effort consistent with the inherent complexity of procedures and services." The Association supports such a proposal as one option of compensation for pathology.



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. VINCENT HOSPITAL AND HEALTH CARE CENTER
Hospital Address: (Street) P.O. BOX 40970, 2001 West 86th Street
(City) INDIANAPOLIS (State) INDIANA (Zip) 46260
(Area Code)/Telephone Number: (317) 871-2345
Name of Hospital's Chief Executive Officer: SISTER THERESA PECK
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):	<u>605</u>	Admissions:	<u>26,213</u>
Average Daily Census:	<u>93.3%</u>	Visits: Emergency Room:	<u>28,471</u>
Total Live Births:	<u>3,255</u>	Visits: Outpatient or Clinic:	<u>78,458</u>

B. Financial Data

Total Operating Expenses: \$ 85,389,318

Total Payroll Expenses: \$ 48,224,232

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: \$ 1,569,543

Supervising Faculty: \$ 650,224

C. Staffing Data

Number of Personnel: Full-Time: 2,247 (122) (Stress Center)
 Part-Time: 709 (34)

Number of Physicians: (Active/Assoc. 344)

(Courtesy 232)

Appointed to the Hospital's Active Medical Staff: 744 (All other 168)

With Medical School Faculty Appointments: 347 (1981)

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

Internal Medicine Ob-Gyn Surgery (part-time)
Family Practice Medical Director Pediatrics (part-time)

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	<u>10</u>	<u>194</u>	<u>Elective</u>
Surgery	<u>9</u>	<u>32</u>	<u>8 Elective</u> <u>1 Required</u>
Ob-Gyn	<u>3</u>	<u>14</u>	<u>2 Elective</u> <u>1 Required</u>
Pediatrics	<u>1</u>	<u>12</u>	<u>Elective</u>
Family Practice	<u>1</u>	<u>16</u>	<u>Elective</u>
Psychiatry	<u>0</u>	<u>0</u>	<u>0</u>
Other: Allergy	<u>1</u>	<u>6</u>	<u>Elective</u>
Emergency	<u>1</u>	<u>18</u>	<u>Elective</u>
Anesthesiology	<u>1</u>	<u>13</u>	<u>Elective</u>
Neurology	<u>1</u>	<u>4</u>	<u>Elective</u>
Radiology	<u>3</u>	<u>25</u>	<u>Elective</u>
Pathology	<u>1</u>	<u>2</u>	<u>Elective</u>

B. Graduate Medical Education

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

<u>Type of Residency</u> ¹	<u>Positions Offered</u>	<u>Positions Filled by U.S. & Canadian Grads</u>	<u>Positions Filled by Foreign Medical Graduates</u>	<u>Date of Initial Accreditation of the Program</u> ²
First Year Flexible	8	8	0	1982
Medicine	30	26	1	?
Surgery				
Ob-Gyn	12	12	0	?
Pediatrics				
Family Practice	18	18	0	1970
Psychiatry	2	2	0	N/A
Other: Anesthesiology	4	4	0	N/A
Orthopedics	4	4	0	N/A
Urology	1	1	0	N/A
Otolaryngology	1	1	0	N/A

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

Name of Affiliated Medical School: Indiana University School of Medicine

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

Information Submitted by: (Name) PAUL F. MULLER, M.D.

(Title) Medical Director

Signature of Hospital's Chief Executive Officer:

Sister Theresa Park (Date) 12/16/82



INDIANA UNIVERSITY

SCHOOL OF MEDICINE

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

December 29, 1982

Dr. Richard Knapp
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle
Washington, D.C. 20036

Dear Doctor Knapp:

It is a genuine pleasure to support the application of the St. Vincent Hospital and Health Care Center for membership in the Council of Teaching Hospitals. The Indiana University School of Medicine considers the St. Vincent Hospital one of our major affiliates. As has been accurately described by Dr. Muller in the application, St. Vincent provides educational programs at all levels in the continuum. Our affiliation which began many years ago with shared continuing medical education programs has matured to include offerings in each year of the medical curriculum as well as shared residency programs in five major disciplines.

The Hospital employs a cadre of full-time specialists who head the various disciplines and hold faculty rank. The program is coordinated by Dr. Paul Muller, Clinical Associate Professor of Obstetrics and Gynecology and Assistant Dean.

I am therefore pleased to recommend the St. Vincent Hospital to you and urge positive action by the COTH and the Executive Council of the AAMC.

Sincerely yours,

A handwritten signature in cursive script that reads "Steven C. Beering".

Steven C. Beering, M.D.
Dean

SCB:mjs

IV. SUPPLEMENTARY INFORMATION

St. Vincent Hospital and Health Care Center maintains fully-accredited free-standing residency training programs in Obstetrics-Gynecology, Internal Medicine, Family Practice and Pathology. In addition, residents from Indiana University School of Medicine serve rotations at St. Vincent in the areas of Anesthesiology, Orthopedic Surgery, Genito-Urinary Surgery, General Surgery and Psychiatry. Undergraduate programs are maintained for Indiana University students in all four years, beginning with the Freshmen Introduction to Medicine, a Sophomore Physical Diagnosis, Junior Clerkships in Ob-Gyn and Surgery, and thirty-two Senior Electives enjoy a highly filled rate. Over four hundred medical students per year pass through St. Vincent Hospital. Educational conferences are provided by all departments for house staff and medical students varying from daily to weekly and Medical Grand Rounds are held each Wednesday morning at eight o'clock for both attending and house staff. Two named symposia are held yearly in cardiology and surgery and in addition, nationally recognized educational programs in orthopedics, dermatology, hand surgery and gynecology are offered yearly.

Research activity is supervised by a full-time Research department with staff and secretarial support and working with a Research committee and an Institutional Review Board. The activities at the present time consist mainly of drug protocol programs in both oncology and cardiac arrhythmia, and a more basic program in providing epithelial coating for artificial vascular grafts.

In summary, St. Vincent Hospital serves as a closely affiliated teaching institution for the Indiana University School of Medicine and as a high quality provider of health care for the northwest side of Indianapolis, as well as provider of tertiary services for the State of Indiana and neighboring states in certain areas such as cardiology, cardiovascular surgery, oncology and hand surgery.



840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6000
Cable Address AMHOSP

To call writer, telephone 312.280.

November 30, 1982

TO: Regional Advisory Boards

SUBJECT: Discussion Draft--Report of the Committee on Future Directions of the American Hospital Association

Attached is the Discussion Draft--Report of the Committee on Future Directions of the American Hospital Association.

Origin of Document

In 1981 and 1982 the Board of Trustees, acting as a Committee on Future Directions of the American Hospital Association, studied the emerging hospital environment in order to assess whether changes in the Association would be necessary to meet the future needs of hospitals. A steering committee and three working parties were established to examine issues concerning AHA membership, dues, and structure. The attached discussion draft reflects the preliminary conclusions of the full committee.

Issues Involved

The Board undertook this project because it recognized that important trends in the field and in the political environment were having and would have a major impact on the Association and hospitals. Most pressing for the Association was the trend toward increasingly larger systems of hospitals, which was already having a direct effect on the Association's dues revenues. Because the merging of major systems and the tremendous growth in the size of individual systems were not anticipated when maximum dues were established for type IX multihospital systems, the Association would experience major reductions in total institutional dues revenues if the dues structure were left unchanged.

A second major issue for AHA was the increasingly intense competitive environment for hospitals, caused, in great part, by pressures from reduced funding for health care services and cost containment. This competition was viewed as potentially disruptive to the Association and the field, and pointed to a need for an overall umbrella organization to represent the interests of the field as a whole. It also suggested a need for AHA to pay more attention to the various segments of its hospital membership to assure a "voice" for all groups of hospitals in the Association. These factors led to consensus that the structure and membership of the Association needed a thorough examination.

The growing need for strengthened relationships within hospitals among executive management, trustees, and medical staff emphasized a third issue for AHA--assuring that Association programming, policy, and governance are responsive to the individual and collective needs of all three partners in hospital governance and management. Hospitals' success in coping with new payment systems and funding restrictions will depend largely on the understanding and cooperation between their administrators, trustees, and medical staffs. There was agreement that AHA should examine mechanisms to help strengthen this hospital team's role in the Association and in the field.

Approval Process

The Board of Trustees is seeking extensive discussion of this document by the RABs, the councils, the General Council, and other membership groups, and welcomes comments and recommendations for revision. The RABs will have three opportunities to review and comment on this document prior to final Board consideration in July. The report and any bylaws revisions required by its recommendations will be submitted to the House of Delegates at the 1983 annual convention.

Recommended Disposition

This document is presented for review and comment. Because the Regional Advisory Boards will have three opportunities to review this document, the Board of Trustees requests that at the winter round the RABs concentrate on reviewing the mission statement and the 16 general recommendations in the report. The Board agrees with these general recommendations, but is seeking reactions to and comments on them from the RABs. There is less consensus on the operational recommendations, and the Board will seek suggestions and comments on them at the spring round of RAB meetings so they can be revised as needed and considered again in July.

E. E. Gilbertson
Chairman
Committee on Future Directions
of the American Hospital Association



840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6000
Cable Address AMHOSP

To call writer, telephone 312.280.

DISCUSSION DRAFT

REPORT OF THE COMMITTEE ON FUTURE DIRECTIONS
OF THE AMERICAN HOSPITAL ASSOCIATION

Prepared by the Special Committee of the Board
and referred to the membership
bodies of the Association
November 17, 1982

11/30/82

DISCUSSION DRAFT

REPORT OF THE COMMITTEE ON FUTURE DIRECTIONS OF THE AMERICAN HOSPITAL ASSOCIATION

INTRODUCTION

1 A cardinal tenet of any organizational entity that proposes to grow and
2 progress over a prolonged period is that it must periodically assess its
3 future purpose, functions, and usefulness. This type of assessment normally
4 requires four steps: 1) understanding where the organization is and why;
5 2) looking ahead to future trends that will affect the organization; 3) de-
6 termining where the organization should be in the future; and 4) deciding
7 what steps must be taken to reach that point. The assessment of future
8 purpose and goals is the mark of a dynamic, flexible, and enduring
9 organization.

10 Failure to undertake this assessment process inevitably leads to deterioration
11 of the organization, and can create such anomalies as producing gas guzzling
12 autos at a time when gasoline prices are shooting up, building the better
13 typewriter when the world wants word processors, and investing in slide-rules
14 in the electronic computer age. For the American Hospital Association, it
15 could lead to giving recognition in policy development to traditional
16 interests when new interests warrant attention and attempting to serve all
17 member needs when other organizations may be specifically designed or better
18 designed to serve some of them. These ultimately translate into declining
19 membership, a smaller revenue base, and strong competition from other
20 organizations.

1 Planning for the future and to adapt to future needs can ensure that when
2 hospitals meet the future, AHA will be ready to help them. It can assure
3 that AHA will continue to be relevant to its members and to sustain and
4 increase their support.

AHA's Future Directions Project

5 For the past eighteen months, the Board of Trustees of the American Hospital
6 Association, acting as a Committee on Future Directions of the American
7 Hospital Association, has been assessing its future purpose and functions as
8 part of a planning process. The timing of this assessment and
9 implementation of its recommendations is opportune; the signs of the future
10 are visible, but their effects, for the most part, have not yet begun to be
11 felt.

12 The Future Directions Project began at the Board of Trustees' retreat in
13 1981. The retreat focused on the changing hospital environment. After
14 reviewing an environmental assessment and hearing presentations about trends
15 in the 1980s and strategic planning, the Board met in small discussion
16 groups to discuss the major forces that would shape the hospital of the
17 future and to consider the implications of these forces for hospital
18 associations. Key trends were seen as diversification by hospitals,
19 changing public opinion and expectations, emphasis on cost containment, and
20 competition. It became increasingly apparent to the Board members that the
21 implications for the AHA were far from peripheral. Discussion ranged from
22 the notion that AHA should consider becoming an association of associations
23 to the possible need for AHA to broaden its membership base to the

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1 recognition of the AHA's emerging leadership role in coordinating other
2 associations. Some of the most significant questions asked were:

3 "What should be the Association's mission?"

4 "Who will make up AHA's membership?"

5 "How will AHA be able to finance its mission, and what is the role of
6 service activities in financing it?"

7 "How can we structure the policy development process to relate to diverse
8 and often competing constituencies?"

9 The Board continued to discuss the issues arising from this retreat at its
10 May and August meetings. By November, it had become clear that the Board
11 wanted to devote intensive attention to them within the strategic planning
12 context. At its November meeting the Board voted to form itself into the
13 Committee on Future Directions of the American Hospital Association. Board
14 members were assigned to a steering committee and to one of three working
15 parties on membership, dues and structure (Appendix A).

Approach to the Future Directions Project

16 The three working parties met in conjunction with Board meetings, and the
17 1982 Board retreat was devoted to their activities, with special speakers
18 supplementing their discussions. The task confronting the committee and its
19 component working parties was to determine where AHA currently is and how
20 AHA reached this point, examine future trends that will affect the industry
21 and the Association, determine what AHA's mission should be to meet the
22 needs of the future, and finally develop recommendations to enable AHA to
23 fulfill the mission.

1 The Working Party on Membership was concerned with the impact on AHA's
2 membership base of the growth of multi-hospital systems and the expanding
3 and altering scope of hospital services. Its charge was to identify the AHA
4 institutional membership base--who AHA members are and what they do--and to
5 assess prospects for future membership. In addition, the working party was
6 to determine the roles and prospects for regular and society personal
7 members.

8 The Working Party on Dues' charge was to consider what institutional and
9 personal dues should cover, how dues should be allocated between independent
10 and multimembers, and what dues levels are acceptable to various members.

11 The Working Party on Structure had to assess the Association's
12 organizational structure in view of the conclusions of the other two working
13 parties. Its charge was to examine the effectiveness of AHA's membership
14 organization in program planning, policy development, policy approval, and
15 governance and to assess important changes likely to affect the future of
16 the Association, as well as to evaluate implications for organizational
17 structure of the recommendations of the other working parties.

18 Inherent in the charges to all three working parties was the mandate to
19 develop recommendations to serve as a blueprint for the Association's future
20 growth.

1 The activities of each of the working parties tended to build on the
2 conclusions and recommendations of the others. Recommendations on dues
3 could not be made without the recommendations on who should comprise the AHA
4 membership, and recommendations on structure could not be made without an
5 understanding of the conclusions on the membership and dues issues. All
6 three working parties presented their reports to the Steering Committee,
7 which then submitted an interim report to the full committee in August 1982
8 and finally presented this discussion draft report and recommendations to
9 the full committee in November 1982. This report and recommendations of the
10 Committee on Future Directions of the AHA is based on the work and views of
11 the full committee.

ASSESSMENT ISSUES

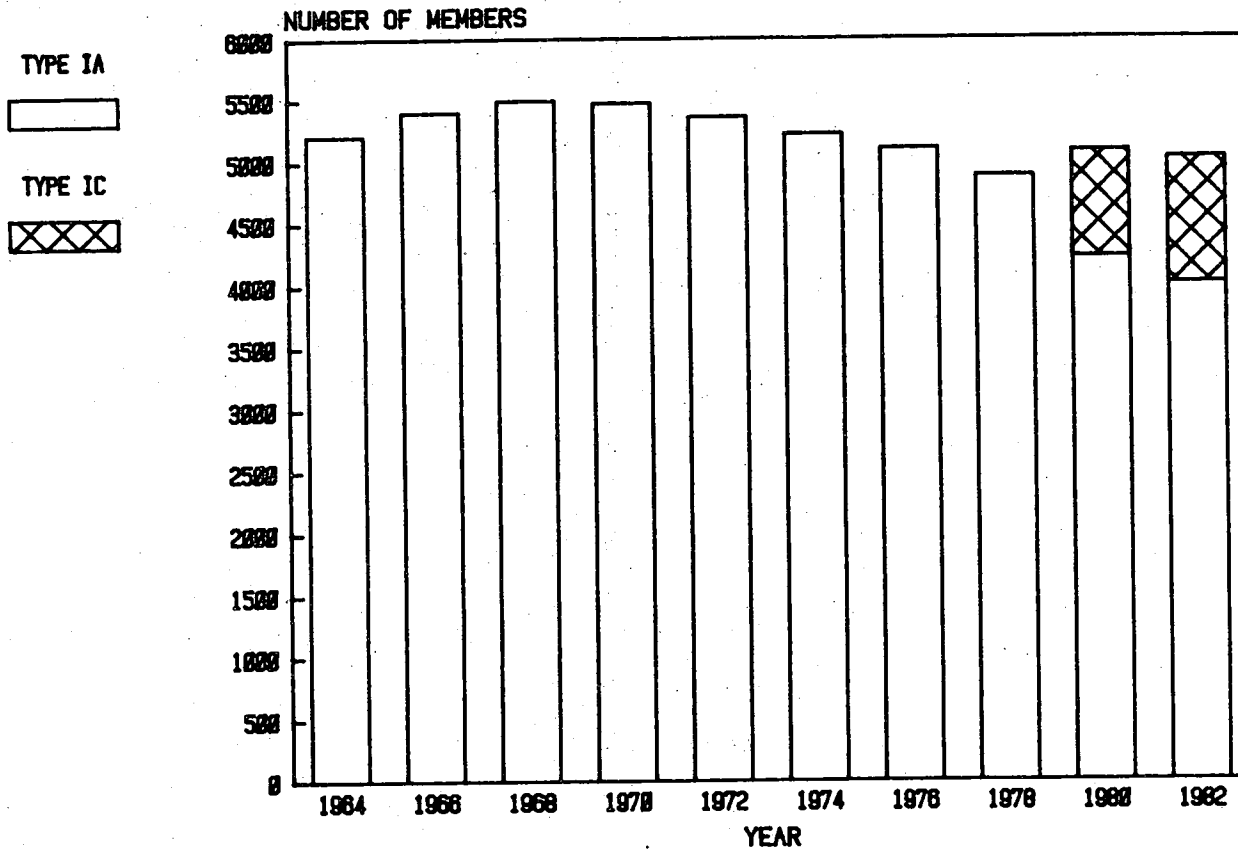
AHA's Current Position

12 To assess the Association's current position, the Committee on Future
13 Directions did extensive analysis of AHA membership trends and the results
14 of the 1981 membership survey. The membership data gave an indication of
15 how many hospitals support the Association, and the survey information gave
16 insight as to why and how the hospitals were making membership decisions.

17 The membership data revealed that institutional membership in the
18 Association peaked in the late 1960s, as government started to play a more
19 direct financing role in health care via Medicare and Medicaid and the need
20 for strong hospital representation and advocacy programs became apparent.

1 Membership then fell off in the early 1970s and increased again with the
22 establishment of type IX membership in the late seventies.

AHA INSTITUTIONAL MEMBERSHIP SHORT TERM US HOSPITALS 1964-82



- 1 AHA's membership includes 82 percent of short-term, non-federal hospitals.
- 2 This represents 91 percent of the short-term beds and 92 percent of the
- 3 short-term admissions in the United States, but for some types of hospitals,
- 4 membership is much lower and appears to be eroding. Only 62 percent of
- 5 small hospitals, particularly those under 50 beds, are members in AHA.
- 6 About 61 percent of investor-owned hospitals and about 75 percent of state
- 7 and local hospitals are members of AHA. Long-term non-federal hospitals
- 8 have a 73 percent membership rate, but unlike short-term hospitals, the
- 9 larger the long-term hospital, the less likely it is to be an AHA member.

1 The results of the membership survey confirm and, in some cases, explain the
2 changes in membership. A significant finding related to who at the hospital
3 actually makes the decision to join an association. Board approval is
4 required for trade association membership in 38 percent of member
5 institutions and 50 percent of non-member institutions. The committee
6 believed this should have ramifications for future AHA services and
7 commitment to trustees.

8 The other results, in general, confirmed beliefs already guiding AHA
9 programming and services. The survey identified the most important factors
10 influencing decisions to join an association. AHA's membership agreed that
11 representation and advocacy is the most important factor influencing the
12 decision to join a hospital association. AHA was perceived as doing a
13 superior job in national representation by members and non-members, although
14 AHA was not viewed as particularly knowledgeable about the local needs of its
15 members, which are served by state and metropolitan hospital associations.
16 Educational programming was the second most important factor influencing the
17 decision to join a hospital association and was also seen as one of the more
18 competitive areas for AHA. Publications and data collection and analysis
19 were both ranked third as factors influencing decisions to join. In
20 publications, AHA was regarded as doing well on governance and hospital
21 management but not as well on technical issues. In data, AHA and state
22 associations were ranked comparably on providing the data collection and
23 analysis services. Technical assistance in hospital operations was the
24 least important issue influencing institutions to join an association.

1 Attitudes about AHA reflected a perception that AHA may overemphasize large,
2 tertiary institutions, and that AHA seems distant from member institutions
3 on some issues.

4 Personal membership has grown steadily from 16,000 in 1970 to almost 35,000
5 in 1981. During this period, four new personal membership societies have
6 been formed, but growth has occurred in all of the original 11 societies as
7 well. The membership survey showed that personal members show more interest
8 in educational programs and information and resource services than do
9 institutional members.

10 The committee concluded from this examination that the membership is
11 basically sound, but that some elements needed to be further considered and,
12 perhaps, modified.

Trends Shaping the Field

13 The Committee on Future Directions also considered a number of inter-related
14 trends that are reshaping the field and concluded that the emerging hospital
15 industry might be quite different than the one AHA was designed to serve.
16 The emphasis on cost containment by public and private third-party payers,
17 the increasing competition among providers and the emergence of new types of
18 providers, the increasing diversification and corporate restructuring of
19 hospitals, and the growth of multi-hospital systems are all having major
20 effects on the nation's hospital system and on AHA.

1 From a representation standpoint, these developments bring up critical
2 issues for AHA. As government dollars become tighter for health care, AHA
3 advocacy on reimbursement issues becomes increasingly important, and yet the
4 diversity and competition in the field could put AHA in the position of
5 attempting to represent and serve interests that are sometimes not wholly
6 consistent: investor-owned hospitals versus not-for-profit hospitals;
7 free-standing services versus hospital-based services; the interests of
8 specialty hospitals versus those of the general hospitals; western hospitals
9 versus northeastern hospitals. In addition, the increasing concern about
10 what the government will do has prompted formation of more specialized
11 national hospital groups, and questions arise as to how AHA should relate to
12 them -- as allies or as competitive forces?

13 In terms of services, it will become increasingly difficult even to
14 determine what part of the institution is the AHA member and how AHA should
15 relate to the various hospital subsidiaries and non-health care programs.
16 In a multi-hospital system are the headquarters or the hospitals or both the
17 members of AHA -- and can AHA adequately serve both their needs? As
18 hospitals restructure, will the AHA dues system be adequate for ensuring
19 equitable dues from different hospitals? Is the ratio between benefits and
20 dues geared to stay in balance with these changes? Can and should the
21 policy development process at AHA take into account these new emerging
22 interests?

23 These are types of issues and questions that led the Committee on Future
24 Directions of the AHA to reassess the Association mission and to plan for
25 AHA to meet the needs of the future hospital industry.

AHA MISSION

Where Do We Want To Be

1 The Committee on Future Directions of the American Hospital Association
2 agreed that in order to begin finding answers to the challenges created by
3 the changing environment, consensus on an appropriate AHA mission for the
4 future was essential. A mission statement would help to identify
5 appropriate directions for AHA.

6 Following the initial meetings of the working parties, the steering
7 committee and then the full committee met to determine what the Association
8 mission should be. With the initial analysis of the Working Party on
9 Membership serving as a basis, the committee concluded that the AHA's
10 mission is to be the national leadership organization for all hospitals*
11 providing representation and membership services to enable them to better
12 serve the needs of the public.

13 Inherent in the mission are four elements: 1) that AHA's interest is
14 confined to hospitals; 2) that AHA's primary goal is representation; 3)
15 that AHA's interest is all hospitals; and 4) that other organizations to
16 serve smaller segments of the hospital field are likely to continue to exist
17 and to proliferate. Representation relates to institutional interests and
18 includes advocacy and lobbying programs along with the policy development
19 and analysis, and research and data collections, which supports them. The
20 committee viewed membership services as relating to individuals within the
21 institution. AHA institutional services should be targeted to the needs of

*"All hospitals" are limited to those meeting AHA's requirements for registration. See AHA Guide to the Health Care Field.

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1 hospital executive management, governance, and medical staff leadership.
2 Services to other hospital managers and professionals should be provided
3 through personal membership programming.

4 In recommending adoption of this mission, the committee recognized the need
5 for broad representation of the hospital industry and the need for an
6 organization that can convene all important viewpoints. It viewed AHA as
7 the national umbrella organization for all hospitals, with the realization
8 that dealing with the diversity in the field within the framework of AHA was
9 more beneficial than dealing with it outside of AHA. In looking at the
10 differences between groups of hospitals such as not-for-profit and
11 investor-owned, the committee agreed with an observation made at the Board's
12 1982 retreat; the differences among hospitals within these groups are
13 probably as great or greater than those between the groups. When viewing
14 the growth of special interest hospital groups, the committee recognized
15 that AHA's informal role as coordinator and leader of hospital associations,
16 particularly in representation and advocacy, will continue to be important.
17 All indicators pointed to a need for a national organization for all
18 hospitals.

FINDINGS AND RECOMMENDATIONS

19 Although the working parties were each looking at distinct areas --
20 membership, dues, or structure -- their work was interrelated, with the
21 findings of the membership working party guiding the directions of the other
22 two groups. General recommendations of the membership working party were

1 often supplemented by operational recommendations of the structure or dues
2 working parties. This report of findings and recommendations discusses the
3 general recommendations and the operational recommendations in the context
4 of each other, rather than in the context of the individual working party
5 reports. Each recommendation is classified as either a general
6 recommendation -- that is, a broad proposed principle to guide AHA -- or an
7 operational recommendation -- that is, one specific action that could be
8 taken to implement the general recommendations of the Association. The
9 operational recommendations present one scenario of how the general
10 recommendations could be implemented. The committee recognizes that a
11 variety of alternative approaches might be appropriate for consideration by
12 the membership. Pending further discussion by various membership groups,
13 the Committee believes the operational recommendations in this report
14 provide one possible appropriate approach. Appendix B provides descriptions
15 of how the Association might change if all the general and operational
16 recommendations were accepted.

Membership

17 There were two central membership issues: who should be members of AHA and
18 how should AHA relate to other organizations that serve or represent
19 hospitals.

20 Given AHA's mission of representing all hospitals, what group should
21 constitute the membership? Two alternatives were given close attention --
22 state hospital associations, and individual hospitals. A case could have

1 also been made that the membership should be multi-hospital systems. Those
2 favoring a federation structure composed of the state hospital associations
3 viewed the states as the vital link in AHA's representation and advocacy
4 programs. The argument favoring a membership composed of multi-hospital
5 systems viewed the encompassing of all independent hospitals into one type
6 of arrangement or another as inevitable and believed that systems,
7 therefore, would be the unit of membership most appropriate for fulfilling
8 the mission. Those favoring continuation of individual hospital membership
9 believed that the grass roots, direct support and interaction between AHA
10 and hospitals was essential.

11 The second issue of how AHA should relate to other organizations
12 representing hospitals was heavily influenced by the mission emphasis on AHA
13 acting as a national umbrella organization. Implicit is the recognition of
14 the legitimate role of other organizations that represent or serve
15 hospitals. This issue includes the state hospital associations and the
16 multi-hospital systems, as well as multi-state alliances and other
17 organizations representing hospitals.

18 Other issues included treatment of non-hospital health care institutions
19 which are currently members, identification of the appropriate hospital
20 focus for AHA efforts, and consideration of personal memberships.

General Recommendations:

- 21 1) AHA should remain an association of operating hospitals.

1 The committee believed that there is a distinct need for individual
2 hospitals to have a stake in and a commitment to the field as a whole
3 through AHA, and that AHA needs the grass-roots strength hospitals and
4 their communities can provide. The committee supported closer AHA ties
5 with the state hospital associations, but did not think that a
6 federation-approach to membership was warranted by the make-up of the
7 industry. It also agreed that multi-hospital systems should have a role
8 in AHA.

- 9 2) Other types of providers and groups organizationally separate from
10 hospitals should be associate members of AHA to obtain its programmatic,
11 not representational, services.

12 The committee did not believe that AHA could continue to serve as full
13 members nonhospital institutional providers, which may have very
14 different representational needs.

- 15 3) AHA services to members should be based on a definition of "hospital
16 services" that includes all direct and indirect hospital-based patient
17 care activities without regard to the hospital corporate organization.

18 The impact of diversification and change in the corporate structure of
19 hospitals should not detract from the hospital "patient care" mission,

1 which AHA seeks to serve. Hospital subsidiaries which offer nonpatient
2 care related services should not be the focus of AHA programming
3 initiatives.

- 4 4) AHA should actively recruit personal members of the AHA, particularly
5 persons entering the hospital field.

6 The committee concluded that personal memberships are a vital element of
7 the Association and provide an important vehicle for meeting the
8 professional needs of hospital managers. In addition, the committee
9 believed that increasing the number of hospital professionals who are
10 members of AHA would strengthen the ties between the institution and AHA.

Operational Recommendations:

- 11 1) AHA membership types II through VIII* should become a new category of
12 "associate member," which would receive information from and might
13 participate in programming of AHA. Associate membership should be
14 offered to those organizations currently in membership types II through
15 VIII*.
- 16 2) Multi-state alliances and other groups representing hospitals should be
17 offered affiliated status, similar to the affiliation arrangements
18 currently made with the state hospital associations.

*AHA membership types II through VIII consist of nursing care institutions, ambulatory care centers, Blue Cross Plans, HMOs, shared service organizations, planning agencies, vital schools of nursing.

Dues and Benefits

1 The issues surrounding dues and benefits related to what activities are
2 appropriate for fulfilling the mission and how they might be financed
3 equitably.

4 Determining a dues base that would ensure that dues assessments would be
5 equitable, despite corporate restructuring, was given close attention.
6 AHA's dues methodology was compared with those of state and metropolitan
7 hospital associations and with those of other types of organizations. The
8 committee sought to analyze the advantages and problems presented by basing
9 dues on factors other than expenses. In particular, an admissions basis and
10 a net patient revenues basis were studied closely.

11 The issue of the cost-benefits of AHA membership for hospitals as a whole
12 and for particular types of hospitals was examined in view of concern that
13 the current structure may not adequately reflect different levels of
14 benefits received by different types of institutions. Attention was also
15 given to the need to simplify AHA dues arrangements, which have become
16 increasingly complex as they have been adapted to accommodate different
17 types of organizations. The historic arrangement with the states under
18 which the state associations collect dues for AHA and receive a grant from
19 AHA was also examined.

20 The committee examined the evolution of the AHA dues structure, noting the
21 establishment of institutional membership in 1918, followed rapidly by the
22 initiation of a shared dues arrangement with state hospital associations in

1 1920. In 1969, the dues formula was put on a sliding expense scale, and in
2 1980 dues brackets were indexed to inflation. The other major event in dues
3 history was the recent addition of type IX memberships for multi-hospital
4 systems, which included a maximum dues for a single system not to exceed ten
5 times the maximum dues paid by a type I-A member. The maximum dues' effects
6 and potential effects on AHA revenues as the hospital chains grow larger and
7 merge received considerable attention.

General Recommendations:

8 1) Dues should cover representation and advocacy, basic membership
9 services, convening of members for policy development and governance
10 activity, and furthering unity in the field.

11 Institutional dues should be used primarily to finance activities to
12 fulfill the AHA mission. These include activities such as data
13 collection, research, and policy analysis and development, which
14 support the representation and advocacy programs of the Association.
15 Association services to benefit particular institutions or persons
16 should be organized and financed separately.

17 2) AHA should offer only services that are consistent with the interests
18 of hospitals or the whole hospital industry.

19 AHA's mission calls for AHA to represent the entire hospital field,
serving as an umbrella organization. Attempting to be "all things" to

1 "all hospitals" does not further progress toward this mission and
2 wastes resources. AHA's role is a broader industry role and its
3 activities must reflect this.

4 3) Membership services should be directed at hospital institutional
5 leadership -- executive management, trustees, and medical staff
6 leadership.

7 This will ensure that AHA serves the interests of the hospital as a
8 whole, consistent with its mission. At the same time, it targets
9 services to those who are in the position to make decisions on AHA
10 membership -- trustees and executive management.

11 4) There is a basic value of membership in the Association, which must be
12 recognized in the dues schedule and in recruitment and retention
13 efforts.

14 The committee believed that there is a basic value of membership for
15 all hospitals, which must be assessed and used as the basis for dues
16 determinations. It also believed that the current dues schedule is
17 generally satisfactory, with the addition of minimum dues and the
18 elimination of maximum dues for multi-hospital systems.

19 5) Dues should reflect the patients served by the hospital and should be
20 sensitive to the economic circumstances of hospitals.

1 The committee believed that action was necessary to ensure that AHA
2 dues could be more equitably allocated. There was some concern that
3 the current expense-based formula did not provide a consistent means of
4 assessing dues and was not easily measured across restructured
5 corporate lines. The committee believed that the formula should
6 recognize the economic constraints of hospitals serving high numbers of
7 charity and public aid patients.

Operational Recommendations:

- 8 1) There should be a minimum dues for institutions.
- 9 2) There should be no maximum dues for multi-hospital systems.
- 10 3) Dues should be based on net patient revenues based on consolidated
11 statements of institutions, which will provide a more equitable and
12 consistent means of assessing dues.
- 13 4) Dues categories should be simplified.
- 14 5) Exceptions in the dues process should be granted, if appropriate, to
15 groups of hospitals such as federal hospitals and long-term hospitals
16 that receive different services as compared with non-federal short-term
17 hospitals.
- 18 6) AHA should be accountable to the membership for use of dues revenues.
- 19 7) Dues for associate members should be uniform.
- 20 8) Personal membership benefits should not be such that personal
21 membership is seen as an alternative to institutional membership.
- 22 There should be higher dues differentials for employees of nonmember
23 institutions than currently exist, especially for CEOs of nonmember
24 institutions.

1 9) The state retention formula for type I membership should be continued,
2 and if possible, incentives to the allied associations to encourage AHA
3 membership should be added.

Structure

4 The primary structure question was, "Given the mission to serve all
5 hospitals, how should the policy development and approval processes be
6 modified to ensure appropriate representation of all interests in the AHA?"
7 Given the membership principle that operating hospitals should remain the
8 membership unit within the Association, little doubt was expressed that
9 hospitals should have the dominant voice in the processes, but much
10 attention was given to increasing the effectiveness of that voice so that it
11 represents all parts of the institutional membership. In addition,
12 consideration was given to the importance of recognizing other organizations
13 to which hospitals belong and which already represent the interests of
14 hospitals, particularly the state hospital associations and the multi-
15 hospital systems -- both of which currently have a significant role in the
16 governance process.

17 The committee also looked at the policy development structures to determine
18 if changes should be made to increase the quality or the quantity of their
19 deliberations. Increasing the opportunities for participation at the
20 various stages of policy development and approval was seen as vital to
21 fulfill the role of an umbrella organization for the hospital field.

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1 Considerable attention was given to the way the RABs, the councils, and the
2 House of Delegates function. The predominant view expressed was that the
3 RABs were functioning well, and that the delegates found the RABs to be a
4 rewarding and beneficial activity. The councils were viewed as functioning
5 efficiently, but areas of improvement were considered. For example, there
6 was recognition that some of the councils represent constituent interests
7 while others are set up on the basis of hospital functions, and still others
8 seem to relate to defined activities of the Association. The impact of
9 these varying orientations on the policy development process was discussed
10 and evaluated. The activities of the House of Delegates were discussed in
11 terms of the joint House/RAB structure, which was viewed as an effective
12 system. The predominant concerns voiced related directly to the meetings of
13 the House of Delegates, which have been characterized by an absence of
14 debate or discussion. In discussions of these structural aspects of the
15 governance and policy process, efforts were made to distinguish between
16 problems resulting from actual prescribed functions of these bodies and
17 problems resulting from the way in which some of the functions are carried
18 out.

19 In addition, the issue of personal member participation in the policy
20 process was also closely considered. The Association has attempted to
21 provide mechanisms for participation by the affiliated societies through the
22 council structure; evidence suggested that a different type of mechanism,
23 which would allow societies to emphasize governance issues, rather than
24 policy development in general, would be more appropriate. There was also
25 great concern and interest in increasing the involvement of personal

1 membership groups, particularly trustees, who have indicated increasing
2 satisfaction with the AHA approach of encouraging greater trustee
3 self-direction in matters of program planning and representation and policy
4 development. The committee also recognized that there exists a broad
5 cross-section of hospital professionals who have limited access to AHA in
6 programming and policy development, and that hospitals and AHA could benefit
7 from their participation. The committee spent considerable time discussing
8 the appropriate participation mechanisms for each of the different groups.

General Recommendations:

- 9 1) Major groups of individual hospitals should be represented in the
10 Association's policy approval and governance structure, as well as in
11 recommending program activities and services.

12 . The committee recognized that within the institutional membership are
13 groups of hospitals with common interests and concerns, and that the
14 Association and the field could gain from these groups having an
15 opportunity to have a collective voice in the policy process.

16 . The committee believed that to the extent that groups of hospitals
17 with common interests already exist, they should be able to act
18 collectively and plan programs, when appropriate, within the
19 Association structure. Not only would this increase the democratic
20 elements in AHA's structure, but in some cases it might obviate the
21 need or perceived need of these groups to go out and establish a new
22 organization.

- 1 2) The Association's structure should recognize other health care related
2 organizations to which individual hospitals belong.

3 The committee agreed that continued recognition of the allied hospital
4 associations and the multi-hospital systems was important and also that
5 some type of recognition of the growing multi-state alliances for
6 hospitals is necessary if AHA is to fulfill the mission of representing
7 all hospitals. As these groups already represent important segments of
8 hospitals, their participation in AHA would help assure an adequate
9 voice for the institutions they represent.

- 10 3) AHA should ensure maximum effective membership participation in policy
11 development.

12 Maximum effective membership participation by institutional and
13 personal members was viewed as enhancing the quality of the policy
14 process.

- 15 4) Individual hospitals should have the dominant role in the policy
16 processes.

17 This is consistent with the mission and membership principle.

- 18 5) There should be no change in function of the major policy bodies -- the
19 House of Delegates, Board of Trustees, the Regional Advisory Boards,
20 the General Council, or the councils.

1 Although the committee recommends changes in composition and, in the
2 case of the councils, some changes in how the functions are carried out,
3 it viewed the structure as basically sound.

- 4 6) Strategic planning should be incorporated into the regular activities of
5 the Board of Trustees.

6 The Committee on Future Directions' experience as a strategic planning
7 body convinced the committee of the importance of a continued interest
8 in the elements of planning for the future of the Association.

Operational Recommendations:

Institutional Membership

House of Delegates

- 9 1. The House of Delegates should consist only of designated representatives
10 of individual member hospitals, hospital governing boards and medical
11 staffs and qualified multi-hospital systems.

12 . Hospital representatives selected by affiliated state hospital
13 associations and Puerto Rico, the District of Columbia, and Canada
14 should continue to have 100 delegates to the House.

15 . Hospital constituency sections should be established. A constituency
16 section is a category of institutional membership for hospitals
17 sharing common interests, functions, or concerns such as small and
18 rural, community, public-general, federal, or teaching hospitals.

1 Individual hospitals would select membership in one constituency
 2 section, based on criteria or qualifications established for membership
 3 in the section. On a quadrennial basis, criteria for sections would be
 4 reevaluated, hospitals would have the option to select membership in a
 5 different section, and the number of section delegates would be
 6 reapportioned on the basis of section membership. Constituency sections
 7 would elect governing councils which would nominate delegates to the
 8 House through the Committee on Nominations. Constituency sections would
 9 have a total of 50 seats in the House.

- 10 . Multi-hospital systems should continue to be allotted up to 15
- 11 delegates.
- 12 . Regional physician and trustee delegates should be allotted 18 seats
- 13 in the House, with one physician and one trustee from each of the
- 14 nine regions selected respectively by the Assembly of Hospital
- 15 Medical Staffs and the Assembly of Hospital Governing Boards. (see
- 16 page 28)

Chart I

House of Delegates

Delegates of constituency sections (50)	Delegates of state hospital associations (100)	Delegates of qualified multi-hospital systems (up to 15 currently 12)
Regional Physician Delegates (9)	Board of Trustees: 12 elected at large 9 elected by Regional Advisory Boards (RABs) 4 officers (25)	Regional Trustee Delegates (9)

Board of Trustees

- 1 1. A Board Strategic Planning Committee with membership following the
2 Finance Committee model (four Board members with one from each class)
3 but chaired by the Speaker of the House, should be established.

- 4 2. Members of the Board should be assigned as "Board representatives" to
5 the regions and RABs in order to enhance the role of Board members and
6 to decrease time demands on the officers.

Regional Advisory Boards

- 7 1. With the addition of the constituency section delegates, one of the
8 functions of the nominating committee will be to ensure that RAB
9 membership mirrors distribution of members in the specific regions and
10 to even out geographic imbalances.

General Council

- 11 1. General Council membership should include the chairman officers, the
12 executive vice-president, the two assembly chairmen, and the council
13 chairmen.

Councils

- 14 1. There should be nine councils, seven related functionally to subjects
15 involving individual hospital or AHA policy problems, one for
16 volunteers, and one for allied associations.

Chart II
Proposed Council and Sample Committee Structure

Council on Allied
Hospital Associations

Committees on:

Association Development
Association Relations
(Ad Hoc)

Council on
External Relations

Committees on:

Government Relations
Community Relations
(Ad Hoc)

Council on Finance

Committees on:

Institutional Payment
Financial Management
and Accounting
(Ad Hoc)

Council on
Human Resources

Committees on:

Health Manpower
Development
Health Manpower
Management
(Ad Hoc)

Council on Management

Committees on:

Hospital Planning
Hospital Operations
(Ad Hoc)

Council on Nursing

Committees on:

Nursing Education
Nursing Practice
(Ad Hoc)

Council on
Professional Services

Committees on:

Medical Education
Patient Services
(Ad Hoc)

Council on Research
and Development

Committees on:

Hospital Research
Hospital Research and
Educational Trust
Advisory and
Environment
(Ad Hoc)

Council on Volunteers

Committees on:

Volunteer Policy
and Programming
Community Policy
and Programming
(Ad Hoc)

- 1 2. Each council should include two standing committees with the potential
2 for additional ad hoc committees to carry out specific functions of a
3 limited duration.
- 4 3. Councils may initiate consideration of policy issues or may consider
5 items referred to them.
- 6 4. To expand participation, referrals to the councils may be made by
7 personal membership societies, hospital constituency groups, and other
8 hospital organizations through either the General Council or the
9 Secretariat staff.

Personal Membership

- 10 1. The importance and interest of governing board members and medical staff
11 leaders in AHA activities should be recognized through establishment of
12 Assemblies, which would select the trustee and physician representatives
13 in the House and would participate in the General Council, as well as
14 conduct programming.
- 15 2. The key roles played in the hospitals by those who manage special
16 hospital lines of business, such as ambulatory care, comprehensive
17 health care delivery organizations, and extended care, should be
18 recognized through establishment of Program Centers, which would
19 function in a manner similar to the professional societies.

- 1 3. Attorneys and other categories of learned professionals who work for
2 hospitals but are not generally employed by them, should be eligible for
3 membership in Academies.
- 4 4. The professional societies should continue as currently structured.
- 5 5. A new "Personal Member Operations Committee," consisting of one
6 representative from each society, academy, and program center serving
7 for three-year staggered terms with annual elections of a chairman,
8 should be established to consider management and governance issues
9 concerning these personal membership groups and to organize any joint
10 educational activities.

CONCLUSION

11 Observing that the hospital field is in a period of transition would be a
12 major understatement. The way in which hospitals view themselves and their
13 missions and the way they are viewed by others are undergoing fundamental
14 change.

15 Expansion in the industry, which has traditionally meant more beds and more
16 acute care hospitals, is beginning to refer to diversification outside of
17 the acute inpatient care setting, and preventive, primary, and chronic types
18 of care are becoming increasingly important. The organizational structure
19 of the hospital industry is changing. The multi-hospital system phenomenon
20 and the trend toward restructuring are significantly changing the

1 traditional organizational picture of the field. The emphasis on health
2 care cost containment and the very tight restrictions on reimbursement for
3 hospital care are changing the way hospitals do business and how they view
4 themselves in relation to other institutions. Competition and divisiveness
5 among hospitals are apparent and increasing.

6 Essentially the hospital industry in this nation ten years from now promises
7 to be radically different from the one in 1982. If the American Hospital
8 Association is to serve the emerging hospital industry, it too must change.
9 The Board, through the Committee on Future Directions, has devoted a year
10 and a half to determining how AHA should change. The recommendations of the
11 Committee on Future Directions of the American Hospital Association are
12 designed to ensure that AHA can continue to serve the field through
13 leadership in representation and through membership services. The
14 recommended changes will strengthen the democratic processes in the
15 Association and will focus AHA on the demands of the future.

Final Note

16 The Committee on Future Directions of the American Hospital Association has
17 developed this report and recommendations over the course of 18 months. It
18 reflects the results of many hours of discussion and debate. In submitting
19 this report and recommendations to the membership, the committee wishes to
20 open these important future directions ideas and proposals to general
21 discussion with the goal of strengthening the final Future Directions
22 recommendations.

1 Following initial comments from the Regional Advisory Boards, the councils,
2 the General Council, the sections and assemblies, the societies, and other
3 membership groups, the Board will reexamine the recommendations, revise them
4 as necessary, and develop a proposed operational plan, all of which will be
5 reviewed by the Regional Advisory Boards. The Board will then write a final
6 report, which will be reviewed in the summer round of the Regional Advisory
7 Boards and will be revised by the Board just prior to the meeting of the
8 House of Delegates in Houston in early August. Necessary adjustments in the
9 bylaws to implement the Future Directions project will be considered by the
10 House of Delegates at that time.

COMMITTEE ON THE FUTURE DIRECTIONS OF THE
AMERICAN HOSPITAL ASSOCIATION

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J. Alexander McMahon
Stanley R. Nelson
Richard L. Sejnost
Janet Skadan
Eugene L. Staples
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David G. Williamson Jr.
Senior Management:
J. Alexander McMahon
Secretary: Kevin F. Hickey

*Through November 18, 1982.

AHA FUTURE DIRECTIONS: WHAT CHANGES FOR WHOM

Hospitals

1 PROPOSED: The individual hospital would be the unit of institutional
2 membership in the AHA.

3 CURRENT: Hospitals are type I members of AHA, multi-hospital systems are
4 type IX members, and nonhospitals (such as ambulatory care
5 centers, Blue Cross Plans, HMOs, shared service organizations,
6 planning agencies, nursing care institutions and hospital
7 schools of nursing) may be type II through VIII members.

8 PROPOSED: AHA dues for individual institutions will be calculated on the
9 basis of net patient revenues.

10 CURRENT: AHA dues for individual institutions are calculated on the basis
11 of expenses.

12 PROPOSED: There would be a minimum dues level for individual institutions.

13 CURRENT: There is no minimum dues level for individual institutions.

1 PROPOSED: There would be no maximum dues level for multi-institutional
2 systems.

3 CURRENT: There is a maximum dues level for systems.

Representation in the House of Delegates

4 PROPOSED: Hospitals would be represented by delegates selected by their
5 state hospital associations, by delegates nominated by
6 constituency section governing councils, and by delegates of
7 multi-hospital systems.

8 CURRENT: Hospitals are represented by delegates selected by their state
9 hospital associations. Multi-hospital systems are allotted up to
10 15 delegates, based on the percentage of individual hospitals
11 belonging to qualified systems.

12 PROPOSED: An AHA-formed Assembly for Hospital Governing Boards and Assembly
13 for Hospital Medical Staffs will select their respective regional
14 delegates in the House.

15 CURRENT: Regional Advisory Boards select regional trustee and physician
16 delegates to the House.

Nonhospital Health Care Organizations

1 PROPOSED: Membership types II through VIII would be discontinued.
2 Nonhospital organizations and institutions formerly in those
3 types would be encouraged to be associate members.

4 CURRENT: Nonhospital health care organizations and institutions can be
5 type II through VIII members of AHA.

AHA Councils

6 PROPOSED: AHA would have nine councils, seven directly related to functions
7 involving individual hospital or AHA policy problems and two for
8 allied associations and volunteers, as well as two assembly
9 groups representing medical staff and governing board. Each
10 council would have two standing committees, with the provision
11 for ad hoc committees.

12 CURRENT: AHA has 12 councils: six related to hospital functions, three
13 representing constituent groups (Governance, Physicians,
14 Volunteers), and three with internal AHA programmatic or
15 governance responsibilities (Affiliated Societies, Allied
16 Hospital Associations, and Federal Relations). Only one council
has a standing committee.

General Council

1 PROPOSED: The General Council would consist of each of the nine council
2 chairmen, plus the chairmen of the two assemblies (governing
3 boards and medical staff), the three chairman officers, and the
4 executive vice-president.

5 CURRENT: The General Council consists of the 12 council chairmen, the
6 three chairman officers, and the executive vice-president.

Personal Membership

7 PROPOSED: Individuals involved with hospitals may join the Association
8 through regular memberships; societies for hospital professionals
9 (food service, social work, etc.); program centers for managers
10 of hospital lines of business (ambulatory care, health promotion,
11 etc.); assemblies for trustees and medical staff; and an academy
12 for hospital attorneys.

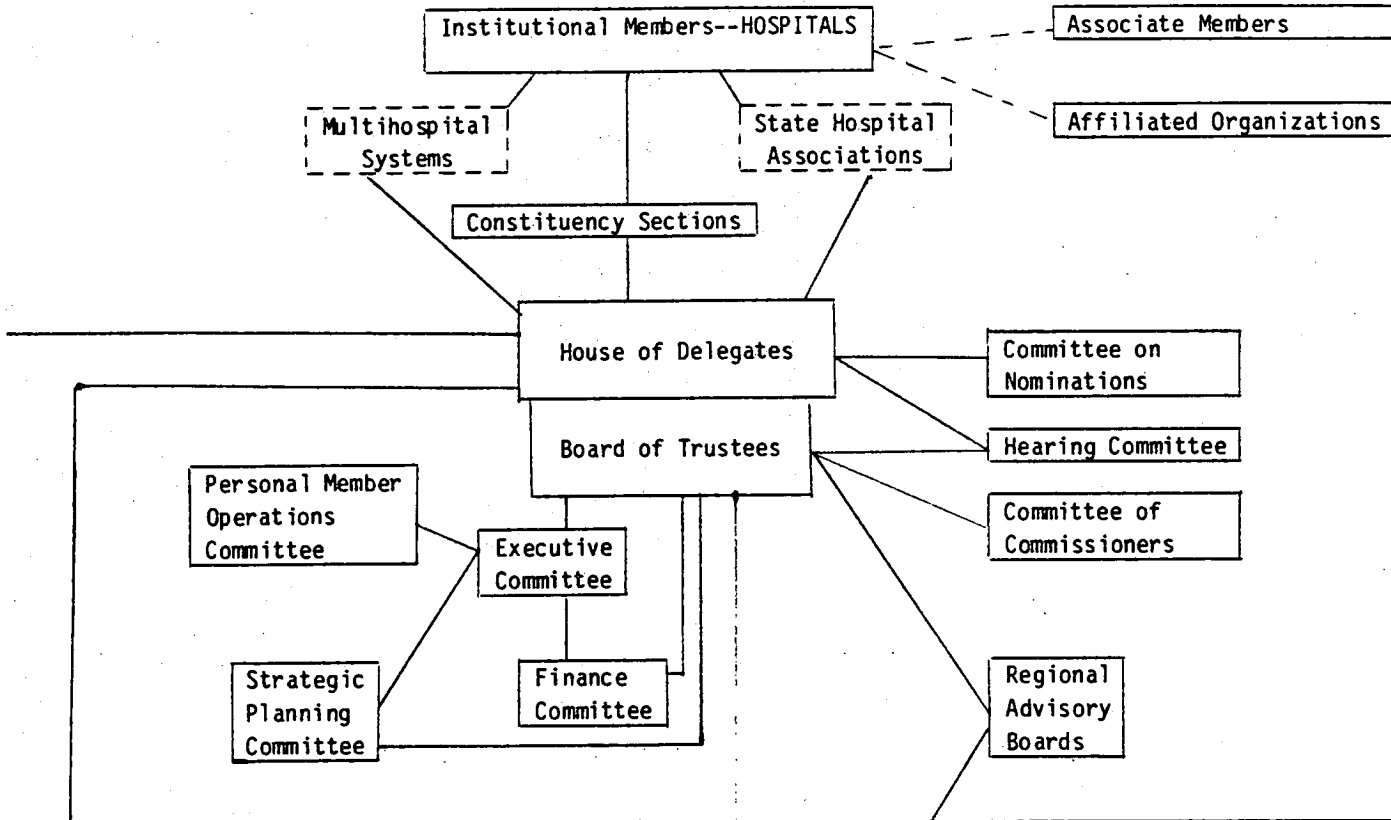
13 CURRENT: Individuals involved with hospitals may join the Association
14 through regular memberships and societies for hospital
15 professionals.

1 PROPOSED: All personal membership bodies would have representation on a
2 Personal Member Operations Committee, which would consider
2 management and governance issues concerning these groups.

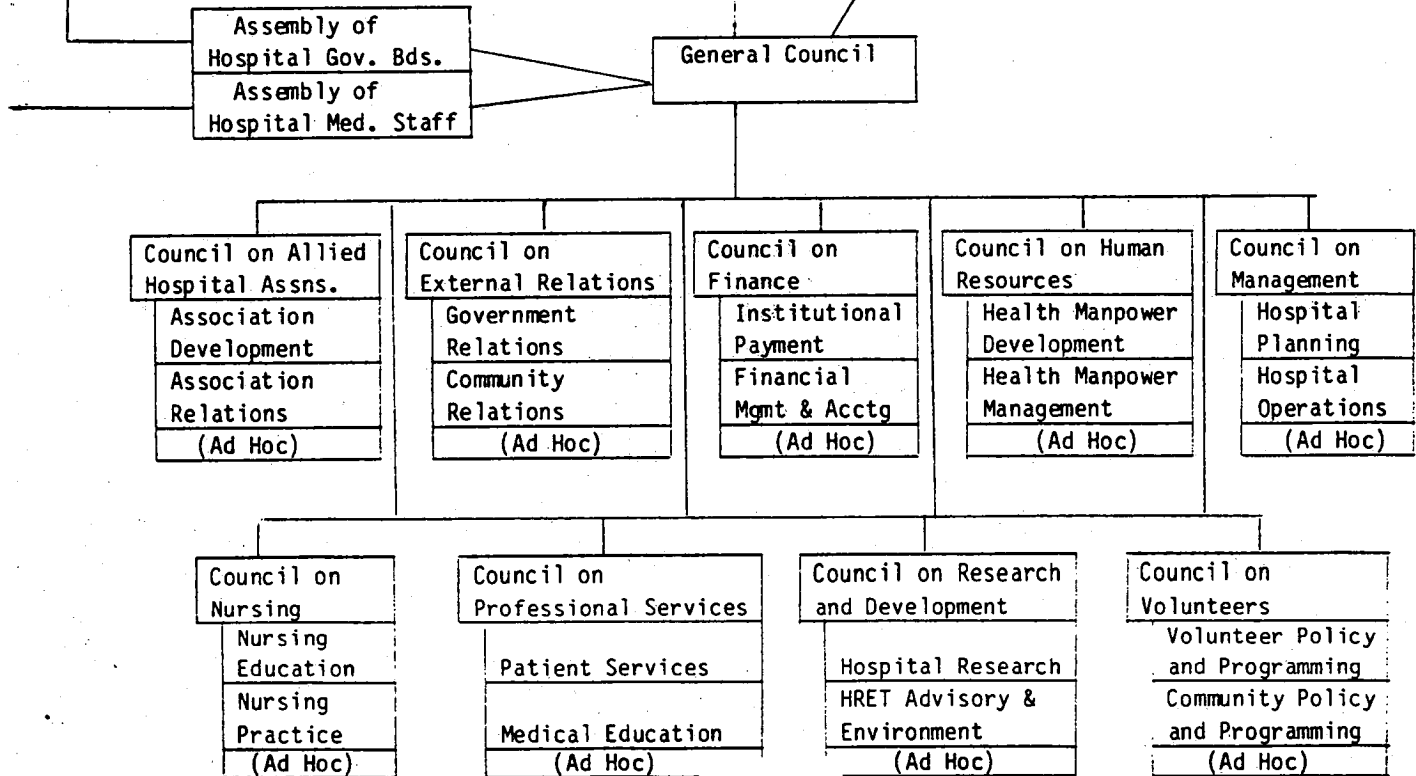
4 CURRENT: Societies nominate members for appointment to the Council on
5 Affiliated Societies.

PROPOSED STRUCTURE
 AMERICAN HOSPITAL ASSOCIATION
 (Policy Approval and Development)

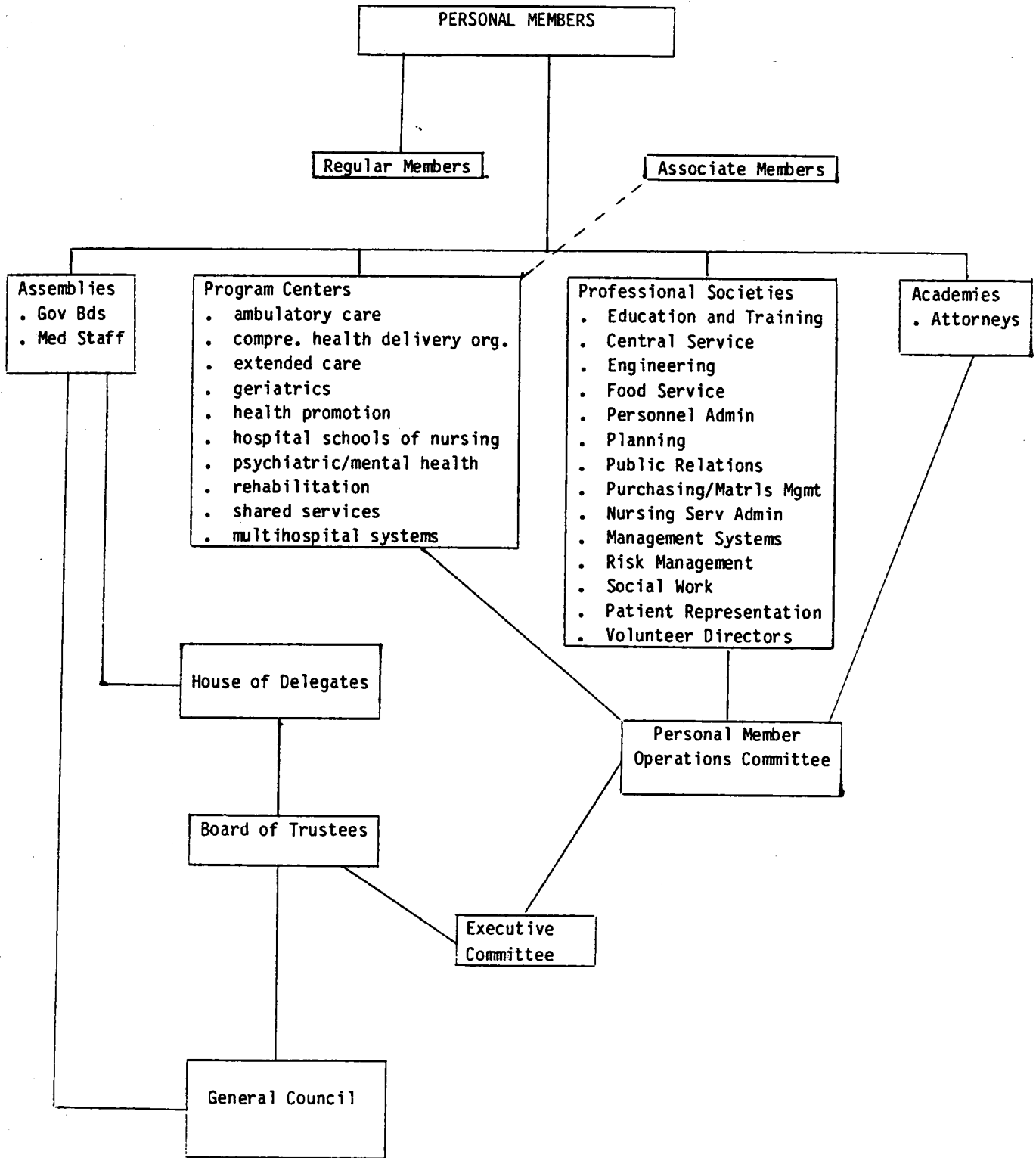
POLICY APPROVAL



POLICY DEVELOPMENT



PROPOSED PERSONAL MEMBERSHIP STRUCTURE
 AMERICAN HOSPITAL ASSOCIATION



University of Michigan Hospitals
DISCUSSION PAPER FOR COTH PRESENTATION
J. W. Dalston/P. W. Roberts
December 31, 1982

DISCUSSION PAPER
ON
CAREER PREPARATION FOR LEADERSHIP
IN
TEACHING HOSPITAL ADMINISTRATION

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Prepared For:

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January 19, 1983

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Appendix A - Conceptual Illustration: A Matrix of Contemporary Requirements (Skills & Knowledge) for Teaching Hospital Administration

Appendix B - Major Conclusions Arising From Exploratory Seminar on Post Master's Clinical Practicums - April 26, 1981

Appendix C - Career Development Model for Health Services Administration

EXECUTIVE SUMMARY

This paper examines teaching hospital leadership in light of present and future performance requirements. Major societal forces are rapidly increasing the complexity and growing inter-institutional involvement of teaching hospitals and academic medical centers. The demand for high performance of leaders of these institutions will continue to increase in scope and intensity over the coming years.

Diverse and comprehensive knowledge and skills are required for effective performance in today's teaching hospitals. These job requirements range all the way from a solid grasp of medical education to business and computer acumen. Such job requirements are continually evolving, changing, and expanding through time. This rapid evolution of teaching hospitals also works to shorten the time period of educational obsolescence. These factors call into question the manner and efficacy of career preparation for these demanding positions.

Recently, a number of organizations and individuals have acknowledged the need for deliberate preparation of people for leadership posts in teaching hospitals. In an attempt to move toward more complete preparation for teaching hospital/academic medical center leadership, some institutions have begun to explore ways to enhance career preparation by tailoring both didactic and clinical educational programs.

In the course of this work and the accompanying dialogue, a number of key questions arise: (1) Can leadership in teaching hospitals/academic medical centers be learned other than "on the job"?; (2) What are the current pathways to these leadership posts?; (3) Which is more relevant and by what means - early career preparation, mid-career preparation, or advanced career preparation?; (4) In this process of career preparation, what role should be played by teaching hospitals? academic medical centers? academic programs? professional organizations such as ACHA, AMA, etc.?; (5) What role, if any should be played by COTH?; and other related questions.

The paper reaches the conclusion that the AAMC, in general, and the COTH, in particular, should become involved in career development for leadership posts in teaching hospitals. The rationale for this conclusion rests upon two points: (1) As an organization publicly accountable for the quality of services provided by its members, the AAMC has major responsibility for concern in this arena; and (2) The AAMC and its members constitute the most knowledgeable party to the subject and should exert appropriate influence on all other parties toward enhancement of teaching hospital leadership performance.

The paper concludes with three specific recommendations growing out of the conclusions just cited.

I. INTRODUCTION

Circa February/March, 1982, Jephtha Dalston suggested to Mitch Rabkin (Mitchell T. Rabkin, M.D., CEO of Beth Israel Hospital, Boston, Massachusetts, and the immediate past-chairman of the COTH Board), and Dick Knapp (Richard M. Knapp, Ph.D., Director, Department of Teaching Hospitals, COTH), that an agenda item on the subject of career preparation for leadership in teaching hospitals be scheduled for a future COTH Board Meeting.

Subsequently, Dick Knapp contacted Jeph Dalston to coordinate placement of this topic on the COTH Board agenda for the September Meeting. Dalston agreed, with the understanding that the context of the item be one of exploration, brevity, and verbal presentation. The purposes of this session were to describe the topic, to identify some of the major issues, to discuss the topic briefly, and to determine the level of interest and relevance of the topic to the COTH Board.

This presentation and discussion did occur on September 11, 1982, and the decision of the COTH Board at that point was to schedule the topic for a later meeting with more thorough preparation, including a more comprehensive paper on the subject. This paper is that more comprehensive piece, designed to serve as a discussion stimulant for an agenda item at the January COTH Board Meeting.

The paper opens with an outline of the context and objectives of the piece. The next section turns to environmental factors, describing teaching hospitals as rapidly evolving, complex institutions which are being bombarded by a growing diversity of societal forces with increasing intensity and swiftness. In Chapter IV, the diverse "field" of teaching hospital leadership is briefly outlined, focusing upon the various posts being addressed. The results of a brief, informal survey of the backgrounds of COTH Administrative Board members and other leaders in teaching hospital administration are set forth in order to develop a conceptual framework for understanding the career paths of individuals who have moved to such positions (Chapter V). Then, Chapter VI examines the base of knowledge and skills required of teaching hospital leaders in the mid-1980's and 1990's.

The paper then analyzes the issues and factors in both advanced career development as well as early career preparation for these leadership posts in teaching hospitals. Chapter VII examines the factors, issues, and principal questions related to persons at mid- and late career who move to such posts. Illustrative examples are given regarding the several models or typologies by which present incumbents have come to these positions. Chapter VIII then examines the academic and clinical preparation of young, entry-level careerists for such

leadership positions in teaching hospitals and academic medical centers. Again, illustrative examples are put forward with some description of a so-called national "movement" by some educators and practitioners.

Chapter IX sets forth a summary of emerging issues related to the subject and a set of tentative conclusions. Each of the issues is quite debatable and the conclusions reached constitute the judgment of the authors of this paper. Although the tentative conclusions are strongly held for reasons stated in the paper, it is readily conceded that the issues are quite debatable and the principal purpose of these conclusions is not so much to persuade as to stimulate discussion among members of the COTH Board. The paper closes with a set of recommendations for action.

II. CONTEXT/OBJECTIVES

The context/objectives of the following paper are:

1. To provide a cursory analysis of the relationship between the current condition of teaching hospitals and the leadership requirements for these hospitals.
2. To provide a base of information to COTH Board members as to present activities and the body of knowledge relative to career paths, career preparation, and continuing career development for leadership in teaching hospital administration.
3. To raise questions with COTH Board members which relate to career preparation for leadership in teaching hospital administration.
4. To stimulate discussion of possible influence by and/or involvement of COTH in the preparation/development of appropriate individuals and, ultimately, to contribute to a continuing increase in the quality of teaching hospital leadership.

III. THE TURBULENT ENVIRONMENT

The health care industry, as a whole, is in the midst of a provider reformulation in terms of competition, organizational structure, financial underpinnings, and mature market behavior. This broad-scale restructuring has arisen as some strong, assertive health care organizations boldly advance while others, more traditional and conservative, struggle to maintain their viability in the face of both threatening and propelling societal forces.

The impact on teaching hospitals and medical education has been even more dramatic than on the field, generally. Increasing demands for accountability, severe environmental pressures, and the growing interdependence of academic medical centers, have all led to changing roles and expectations of teaching hospital leadership. Academic faculty and practitioners alike are emphasizing the development of sophisticated, specific and functional skills by health care managers. Medical school deans are becoming increasingly concerned with organizational issues and finances as compared with the more traditional concerns of curriculum and student affairs. Teaching hospital leaders are expected to be very active as health statesmen in external affairs as well as super-ordinate managers of internal operations.

Moreover, teaching hospitals are experiencing unprecedented demands for accountability from various external constituencies with regard to the high cost of medical care and the provision of comprehensive health services. In addition, other units within the academic medical center are increasing their demands for accountability of hospital management and of teaching hospitals as a member of the "university family." Teaching hospitals, encumbered with high educational and technology costs, are facing increased competition from large, aggressive, multi-hospital corporations and group medical practices.

As a result of the turbulent, changing environment, the practice of teaching hospital leadership is under a complex set of pressures and, consequently, is advancing on multiple fronts and within numerous disciplines to meet performance requirements. The diverse complexity of the leadership role in the teaching hospitals has brought about a similar diversity in educational backgrounds and career preparation by the people who come to these posts. What is the field of "Teaching Hospital Administration/Leadership, anyhow?"

IV. THE FIELD

The field of leadership in teaching hospital administration includes a wide-ranging set of individuals from a number of disciplines functioning in a variety of leadership posts. For example, the discipline of hospital administration, medical group practice, medical

school administration, higher education administration, academic medicine, public policy analysis, and others. A very brief delineation of these disciplines follows for purposes of clarity.

Academic medicine relates closely to teaching hospital leadership and furnishes a number of its practitioners. Medical administration is concerned with the management of medical practice. Medical school administration, on the other hand, is primarily involved with the wide range of faculty affairs, including academic medicine, biomedical research, and faculty practice plans. Aggregations and consolidations within medical practice have given rise to an increasing emphasis on group medical practice administration.

The field of higher education administration has become increasingly involved in medical affairs with the growing interdependence of units within the university as a whole. University administration often finds itself devoting large amounts of time to hospital/medical education matters.

In recent years, a number of universities have turned to the creation of an Academic Health Center Chief Administrative Officer (AHC-CAO) to help meet the challenge of providing effective leadership within AHC's. The AHC-CAO serves a broad range of needs and represents a spectrum of vested interests. Overall, the CAO is perceived as a resource allocator, an external health statesman, and a mediator.

Within hospital administration, the increasing complexity of operations has led to separation and specialization of many functional

areas with a concomitant need for overall coordination and planning. Closely related is the explosion of knowledge and career preparation in the field of business wherein studies in computer science, industrial engineering, operations research, and related industrial/corporate fields are offered.

Separate from the practice of leadership within institutions, the theoretical field of public policy analysis has matured and become integral to the internal and external functioning of teaching hospitals. Leaders in public policy analysis include the disciplines of political science, economics, and public administration, among others.

V. CAREER PATHS

Having identified the several disciplines comprising the "Teaching Hospital Field", we now turn to the pathways by which present teaching hospital officials come to these posts. An informal survey of the backgrounds of Council of Teaching Hospital Board Members and selected leaders in teaching hospitals revealed a number of career routes. For purposes of analysis, these various pathways may be logically put into three somewhat distinct typologies. The typologies are not intended to be exhaustive or conclusive, but represent an attempt at a conceptual framework which appears useful for discussion purposes.

Medical School Administration Model:

Academic preparation consists of completion of medical school with optional postgraduate education. Academic preparation is followed by a medical residency, internship, or clerkship. Faculty appointment in the medical school is followed by progression through assistant, associate, and full professorial posts. Prominent faculty members become elected to key medical committees and appointed to leadership positions. Appointment to the Dean's staff is followed by progression through assistant dean, associate dean, and medical school deanship status. It is noteworthy that, in the career path within the field of medical school administration, there is an absence of didactic preparation and clinical experience in general management skills and health care administration.

Business Model:

Academic preparation consists of a graduate degree in business administration. New graduates of MBA programs enter a highly competitive interview process for entry-level positions. Career preparation activities, beyond didactic training, consist of a small number of individually-sponsored executive development programs which are reserved for individuals of proven worth. The business model is often characterized as a "sink or swim" approach whereby recent

graduates are forced to rely upon their individual skills and abilities during competitive transition and on-the-job training periods. After the entry-level position, individuals progress through a series of administrative posts leading to a chief executive officer position. It is noteworthy that there is an absence of preparation regarding medical education processes and health care administration in the career path of business administration.

Health Services Administration Model:

Academic preparation consists of a graduate degree in hospital administration, health services administration, public health, etc. Career preparation activities, following the didactic phase, consist of clinical practicum experience within the structure of an administrative fellowship, residency, or management development program. The purpose of the clinical practicum is to provide a rich learning experience during the transition from academia to practice. Individuals follow their clinical practicum experiences with entry-level employment followed by progression through a series of administrative posts leading to a chief executive officer position. It is noteworthy that there is an absence of preparation regarding understanding of, and sensitivity to, political processes and medical education/practice in the career path of health services administration.

VI. THE BASE OF KNOWLEDGE AND SKILL

Before going forward in this analysis, we must consider what qualifications, in a basic sense, are necessary for successful teaching hospital administrative practice. Given the turbulence of the setting, the diversity of the field, and the variety of career pathways, it is not surprising that the conventional construct of qualifications is similarly quite diverse. Teaching hospital leadership requires a wide variety of specific/functional and general/conceptual skills and knowledge bases from a variety of disciplines.

Increasingly, financial skills and business acumen are required of all leaders in teaching hospital administration. In addition to finance, specific skills in information systems, data processing, financial development, organizational management, public relations, and others, have become essential. Knowledge and understanding of the medical education process is equally important to effective leadership in teaching hospitals. Skill and knowledge in medical practice is also quite relevant. As teaching hospitals function more inter-dependently with other units on the medical center campus, and the environment becomes increasingly turbulent and uncertain, teaching hospital leaders require a sensitivity to, and understanding of, political processes. (Appendix A contains a conceptual illustration devised by the authors to relate the essential skills and knowledge base for teaching hospital leaders with the areas of programmatic emphasis for the three career path typologies noted in Section V.)

Educational preparation for physicians is strong in knowledge of medical practice, medical education, and the hospital/health care setting, but generally incomplete in the areas of financial/treasury skills, general management skills, understanding of political processes, knowledge of information systems, and an understanding of university affairs. Where graduates of business administration programs receive preparatory emphasis in financial/treasury skills, general management skills, and information systems, they generally lack emphasis in knowledge of medical practice, the medical education process and the hospital/health care setting, and an understanding of political processes and university affairs. While graduates of programs in health services administration, public health, and public administration receive preparatory emphasis in general management skills, knowledge of the hospital/health care setting, and information systems, they generally lack comprehensive preparation in an understanding of the medical education process, medical practice, university affairs, financial/treasury skills, and political processes.

The conceptual illustration indicates that there are gaps between the essential base of knowledge and skills required for effective leadership in teaching hospital administration and the areas of programmatic emphasis for the various programs. The "perceptual lag" effect also becomes prominent as some academic programs continue to prepare people with a knowledge base which has lost some of its

relevance in the rapidly evolving world of practice. In short, there is currently no integrated academic program which prepares an aspiring teaching hospital leader with the base of knowledge and skills outlined here. In the next two sections, there are described the various means by which parties to the matter strike accommodation and other means for sharing the absence of a single, preparatory program. These means are discussed in two categories: Mid-to-Late Career Development and Early Career Development.

VII. MID-TO-LATE CAREER DEVELOPMENT

"On-the-job" learning may be the only way, but a number of mechanisms, educational initiatives, short courses, etc., have been developed by individuals and organizations to fully prepare mid-to-late careerists for movement to teaching hospital administrative posts. For purposes of analysis, the following illustrative examples are set forth:

A. Illustrative Examples:

A look at activities related to continuing education programs, management development programs, and executive sabbaticals will help to illustrate the present state of affairs. The following is not intended to be an exhaustive inventory, but instead, illustrative of the total.

A wide variety of professional development education or training programs have been introduced recently in the health care industry. The most commonly utilized include: (1) Individual hospital- sponsored in-house programs The range of these programs currently available encompasses a variety of seminars, institutes, workshops, and conferences which are shorter, with knowledge and skill orientations; (2) State hospital association programs; (3) American Hospital Association's continuing education programs; and (4) American College of Hospital Administrators professional development programs. The sponsorship of formal training indicates a heavy reliance on professional association programming (which takes a broad-based versus teaching hospital focus) and minimal involvement with academic institutions. It is important to note that the American College of Hospital Administrators requires continuing education as a part of the advancement process from Nominee, to Member, to Fellow.

The ACHA has also developed a generic Health Executive Self-Assessment tool which allows executives to assess their broad range of knowledge and skills as a baseline from which to design individual development programs. Somewhat related, the AHA has developed its Program for Institutional Effectiveness Review (PIER), designed to audit and improve hospital operating performance.

Harvard Business School and the Wharton School of Business also offer both continuing education and intensive management development programs for health care executives. In addition, the American Management Association conducts extensive management development programs.

The Association of American Medical Colleges is in the process of revitalizing and expanding its Management Advancement Program to better meet the needs of its constituency.

The American Medical Association and various medical societies are offering increasing numbers of continuing education programs in management development for physicians.

Following in the tradition of the academic world, the health care industry is beginning to explore the concept of corporate sabbaticals. The Western Network for Education in Health Administration and the Association of Western Hospitals (an "umbrella" organization affiliated with a number of professional associations as well as universities operating in thirteen states to develop and deliver educational programs to a variety of health care organizations and practitioners) co-sponsor the National Center for Executive Sabbaticals. The Center designs and coordinates individualized sabbaticals for health care managers. Primary benefits accrue to both the organization providing the sabbatical and the manager taking the sabbatical. Since sabbaticals are only now emerging in the health care industry, there are very few hard data to draw upon for either exposition or evaluation.

B. Present State of Affairs:

Continuing education opportunities are scattered rather unsystematically across the country and the health care field.

Despite the existence of some very excellent and comprehensive programs, there appear to be areas of health care management, such as teaching hospital leadership, wherein few resources are available to professionals seeking to strengthen their professional skills. In addition, despite the almost unanimous recognition of the need for continuing education and the already existing mandatory requirements for some professions in some states, there is little agreement on how to effectively evaluate and pursue continuing education.

One of the first attempts to bring order to the process has been the publication by the Radcliffe Program in Health Care of a two-volume work entitled "Resources for Continuing Education in Health Care."¹ The Radcliffe study (1975) identified 254 separate continuing education courses in health care. This indicated the wide variety of continuing education programs available at that time. More recently, Wesbury, Mosher, and Sachs developed a taxonomy of continuing education learning modalities, identifying

¹ Radcliffe Programs in Health Care Resources for Continuing Education in Health Care, Radcliffe Institute, Radcliffe College, 1977.

both formal and informal activities within which health care managers pursued continuing education.²

Whether any real effort will be made to coordinate and register continuing education programs in the health field for purposes of quality and convenience remains to be seen. At present, there is little sharing of information, great overlap and duplication, and no quality control. It is a highly competitive business and, in some instances, it can be a most profitable endeavor.

It is likely that continuing education for health care policy planning and administration will exhibit even greater need, demand, proliferation and competition in the decade ahead.

VIII. EARLY CAREER PREPARATION

A look at some of the career preparation activities which exist within health services administration, along with a look at the "state

². Stuart A. Wesbury, Jr., Ph.D., John E. Mosher, and Michael A. Sachs, "A Continuing Education: An Approach Toward Structure and a Call for Help," Hospital and Health Services Administration, Summer, 1978.

of the movement", chronologically, will help to illustrate the present state of affairs.

A. Illustrative Examples:

The early post-master's fellowship programs in health services administration began in the late 1960's, primarily in major universities and Academic Medical Centers, and have continued to grow in number and diversity. A survey conducted by the University of Michigan Hospitals (1980) revealed approximately twenty-five programs. Major teaching institutions that offer post-master's clinical practicums include:

- Johns Hopkins Hospital management development program.
- Massachusetts General Hospital fellowship program.
- Rush-Presbyterian-St. Luke's Medical Center fellowship program.
- University of Minnesota fellowship program.
- University of Michigan Hospitals/Medical School fellowship program.
- St. Thomas' Health District (London, England) fellowship program.
- University of Toronto Medical Center fellowship program.

In addition to teaching institutions, major national organizations and foundations, such as the Kellogg Foundation, the Robert Wood Johnson Foundation, and the American Hospital Association/Blue Cross-Blue Shield Association, have developed and maintained health policy fellowships.

These various programs range in duration from one to two years, differentially offer line or staff experience, place the individual in various levels of the management hierarchy, and are generally institution-specific. There exists a difference of opinion among leaders associated with post-graduate fellowships as to whether or not the experience ought to be specifically tailored to preparation for teaching hospital leadership and whether or not a common set of standards ought to be established for such programs.

B. Chronology of Events:

Becoming aware of the growing confusion and lack of direction nationally, in clinical education and health services administration, a number of practitioners and academicians highly interested in the subject began to pool information. As early as 1977, there was some growing awareness of the difficulties and efforts to understand the forces affecting change and what would be a proper course for the field as a whole. For example, in 1977, there was a Preceptors' Conference at Ohio State University which set out to present and clarify the various issues and aspects

(common and divergent) of several fellowship programs in health care administration. Westerman,³ Dalston,⁴ and Bander⁵ provided descriptions of their respective fellowship programs, along with responsibilities which they felt must be met by health care institutions and administrators.

In 1980, at the Minnesota Preceptors' Conference, there was extensive consideration given to the matters by Edward Connors and others. Connors delivered a keynote address wherein he suggested "centers of excellence" in post-master's training or clinical practicums in the context of a multi-year, multi-institutional

3. John H. Westerman, "The University of Minnesota Hospitals and Clinics Post Graduate Fellowship in Health Services Administration." Presented at Ohio State Annual Preceptors' Conference, May 27, 1977, Columbus Ohio. Also presented at Exploratory Seminar on Post Master's Clinical Practicums on April 26, 1981. Washington, D.C.
4. Jephtha W. Dalston, "Fellowship in Health Care Administration." Ann Arbor, Michigan. Presented at the Ohio State Annual Preceptors' Conference, May 27, 1977. Columbus Ohio. (Updated March 31, 1981 for presentation at Exploratory Seminar on Post Master's Clinical Practicums. April 26, 1981. Washington, D.C.
5. Kay W. Bander and Delanson Y. Hopkins, "Massachusetts General Hospital Administrative Fellowship Program." Presented at the Ohio State Annual Preceptors' Conference. May 27, 1977. Paper also presented at Exploratory Seminar on Post Master's Clinical Practicums. April 26, 1981. Washington, D.C.

framework. He also noted that health care institutions must be viewed as centers for executive development, demonstrating a commitment to clinical education beyond the master's degree.⁶

Subsequently, discussion took place among a number of leaders in the field as to whether or not a national symposium on the subject would be proper and desirable. These discussions continued through the fall of 1980 and the outgrowth of that deliberation was a consensus that there should be, not a large-scale symposium, but a national, yet highly-targeted and exploratory seminar. There was not enough known on the subject to make a large-scale symposium productive. It was decided, rather, to conduct a smaller-scale seminar of some five to six dozen persons who seemed most interested in the subject.

It was strongly felt that this initial seminar should be anchored in the academic community. Therefore, it was decided to have this initial conference conducted in conjunction with the annual meeting of the Association of University Programs in Health Administration. At the same time, discussion occurred on the growing interest in the subject by the American College of Hospital Administrators. The exploratory seminar did take place, papers were presented, and the subject was carefully examined. The

6. Edward Connors, Keynote comments made at Minnesota Preceptors' Conference (1980) and Exploratory Seminar on Post Master's Clinical Practicums, April 26, 1981. Washington, D.C.

proceedings of that conference were compiled and published in the AUPHA Staff Report (May, 1981).⁷ A number of conclusions arose from the seminar itself and the post-seminar data which was gathered from the participants. Appendix B contains a delineation of the major conclusions of the Exploratory Seminar.

Following the Exploratory Seminar, high interest was expressed by the Association of University Programs in Health Administration (AUPHA) and the American College of Hospital Administrators (ACHA) to move forward. The ACHA is presently addressing the issue of early career preparation through a Task Force on Beginning and Early Career Development. This task force is looking at the Broad spectrum of hospitals in a generic sense and will be making recommendations to the ACHA in approximately one year as to how the ACHA might influence the linkage of academic programs and practitioners. Appendix C contains a working conceptual model of career development in health services administration taken from the Task Force deliberations. The AUPHA has been integrally involved in supporting work being done in the area of early career development, both by individuals and organizations such as the ACHA.

7. AUPHA Staff Report, May, 1981, p. 1

With regard to medical education, both the National Academy of Sciences (Institute of Medicine's Comprehensive Review of Medical Education in the United States) and the Association of American Medical Colleges (AAMC Project on General Professional Education of the Physician and College Preparation for Medicine) are presently conducting major studies of the medical education process. One early finding from the studies of medical education is the growing number of physicians becoming interested in hospital management and pursuing administrative posts.

Overall, the present activities by individuals and organizations alike are diverse and sporadic. In addition, no coordinated effort presently exists to address the need for leadership in teaching hospital administration.

IX. EMERGING QUESTIONS/TENTATIVE CONCLUSIONS

Growing out of the analysis presented in this paper are a number of questions which are germane to the topic. Some of the most relevant are set forth below in three categories for the sake of clarity. Tentative conclusions have been provided under each question to focus discussion of the issue.

3. Does a potential relationship exist between the AAMC Project on General Professional Education of the Physician and the topic of career preparation for leadership in teaching hospitals?

- a. Yes, concomitant with any work done in the area of career preparation, is the need for an assessment of the educational process and coordination of these two efforts.

4. From what types of educational programs will the leadership for teaching hospitals emerge?

- a. It appears that the leadership for teaching hospitals will emerge from a wide variety of programs, given the diversity of leadership posts which exist and the skills essential for individuals filling these posts.

5. What is the extent of "transferability" of administrative skills among teaching hospital administration, medical school administration, university administration, etc.?

- a. It appears that generic management skills and knowledge of specific functional areas (e.g., finance, information systems) can be applied in a variety of leadership positions with respect to teaching hospitals. However, differences of opinion exist with respect to the "transferability" phenomenon.

A. General:

1. What are the necessary and essential skills and knowledge base for a leader in teaching hospital administration? Has a current assessment of such been made for teaching hospital administration as practiced in the 1990's?
 - a. The reader is referred to Appendix A for a cursory look at the necessary and essential skills and knowledge base with the caveat that such an assessment has not been made for practice in the 1990's.

2. At what point in the career of individuals, either preparing for or presently working in teaching hospital administration, will an intervening career development/enhancement effort have the greatest potential impact and cost/benefit relationship?
 - a. Given that individuals seem to remain in the institutional settings in which they receive their early exposure and training, and given the fact that academic preparation is largely theoretical as opposed to the programmatic world of practice, it would appear highly beneficial for teaching hospitals to sponsor early career clinical practicum experiences, thus ensuring a larger pool of well-prepared individuals.

6. Can teaching hospital management/leadership be taught academically/didactically?
 - a. General management skills, organizational behavior, and selected functional skills (e.g., finance, management information systems) coupled with a knowledge of teaching hospitals, themselves, can be taught in an academic setting.

B. Mid-to-Late Career Development:

1. Has any assessment been made of the relevant skills and knowledge bases in which leaders in teaching hospital administration need continuing education?
 - a. No, continuing education programs generally arise "ad hoc" from "conventional wisdom" or a sudden shift in the environmental forces (e.g., Medicaid/Medicare legislative changes).
2. Should there be such an assessment for teaching hospital administration?
 - a. Private industry believes such an assessment is important and, consequently, engages in very sophisticated, organized assessments on a regular basis. Hospitals, in general, have endorsed and utilize the general ACHA Executive Self-Assessment tool. Recently, the

for-profit, multi-unit systems have begun an organized assessment of managerial skills for administrators of their institutions.

3. Should continuing education programs be differentially targeted at various phases in an individual's career?
 - a. Given that the responsibilities undertaken by individuals differ as they develop in their careers, it would appear that the continuing education needs of individuals change in parallel fashion.
4. What organized career pathways presently exist for medical school leadership?
 - a. In a recent study of career cycles of deans, Petersdorf and Wilson failed to discover any clearly-defined career pathways, but instead, found a potpourri of career patterns which were often influenced to a great extent by the political nature of the institution.⁸
5. What should the role of AAMC, in general, and COTH, in particular, be with respect to executive continuing education/executive sabbatical programs?
 - a. COTH is in a unique position to be able to provide guidance to the AAMC, in general, as to the focus for a revitalized and expanded AAMC Management Advancement Program.

8. Robert G. Petersdorf, M.D. and Marjorie P. Wilson, M.D., "The Four Horsemen of the Apocalypse," Journal of American Medical Association, Vol. 247, No. 8, 1153-1160.

C. Early Career Preparation:

1. Should any effort be put forth to reduce the sea of confusion relative to administrative residencies, fellowships, internships, externships, and management programs?
 - a. Yes, providing direction and guidance for programs aimed at preparing individuals for leadership posts in teaching hospitals will provide impetus to the continuing effort to upgrade teaching hospital leadership.
2. What career preparation opportunities presently exist for medical school leadership?
 - a. According to Petersdorf and Wilson, there seems to be a lack of adequate career preparation opportunities for individuals heading towards medical school leadership positions.⁹
3. Should any strengthened career preparation effort for teaching hospitals focus on administrative generalist or administrative specialist skills? Or both?
 - a. While private industry focuses on administrative specialist skills and hospitals seem to focus upon administrative generalist skills, teaching hospital career preparation activities will probably focus on both specialist and generalist skills.

9. Robert G. Petersdorf, M.D. and Marjorie P. Wilson, M.D., "The Four Horsemen of the Apocalypse," Journal of American Medical Association, Vol. 247, No. 8, 1153-1160.

4. Should COTH attempt to influence/become involved in early career preparation for leadership in teaching hospitals? In continuing education for leadership in teaching hospitals?
 - a. The increasing requirement for performance by teaching hospital leaders indicates that some organized attention be given to the enhancement of both early career preparation and advanced career development of individuals. Presently, no organized effort in this direction exists. COTH, as well as other organizations, are likely candidates for this effort.

X. RECOMMENDATIONS FOR ACTION

Given the previously-expressed interest of the COTH Board and the analysis presented in this paper, the authors recommend that the COTH Board give consideration to the following:

1. That COTH Support and Influence the AAMC Management Advancement Program:
 - a. Revitalized and expanded effort with some focus on teaching hospital leadership.
 - b. Targeted to specific needs and interests of diverse practitioners from a variety of disciplines and means of career preparation.
 - c. Development of a teaching hospital skill assessment tool.

- d. Conduct an assessment of the essential and necessary skills/knowledge base for teaching hospital leaders of the future.
 - e. Sponsor an executive sabbatical program for leaders in teaching hospital administration.
2. That COTH Support and Influence the ACHA Task Force on Beginning and Early Career Development.
- a. Sponsor clinical practicum experiences as preparation for teaching hospital leadership posts.
 - b. Provide guidance to the Task Force on the needs of teaching hospitals for qualified leaders.
 - c. Influence the development of guidelines for clinical practicum experiences in teaching hospital leadership.
3. That COTH Convey to Academic Organizations, Units, and Programs, the Need for Enhanced Preparation of Individuals for Leadership Posts in Teaching Hospitals.
- a. Assist in the development of preparatory academic activities focused upon leadership in teaching hospitals.
 - b. Encourage COTH members to provide practical clinical experiences for students in academic programs.
 - c. Support and influence the efforts of individual universities, medical schools, schools of public health, schools of business administration, AUPHA, AAMC, and the American Council on Education to advance the academic preparation of individuals for leadership posts in teaching hospitals.

APPENDIX A

CONCEPTUAL ILLUSTRATION

A MATRIX OF CONTEMPORARY REQUIREMENTS (SKILLS & KNOWLEDGE) FOR TEACHING HOSPITAL ADMINISTRATION

The following conceptual illustration has been designed by the authors to provide a construct for discussion purposes. It is not intended to be of an absolute or conclusive nature. The marked "cells" indicate areas of programmatic emphasis within the various career paths as they relate to the essential skills and knowledge base for leaders in teaching hospital administration.

CONCEPTUAL ILLUSTRATION

A MATRIX OF CONTEMPORARY REQUIREMENTS
 (SKILLS AND KNOWLEDGE)
 FOR TEACHING HOSPITAL ADMINISTRATION

ESSENTIAL SKILLS AND KNOWLEDGE BASES

CAREER PATHS	Financial/ Treasury	General Management	Medical Practice	Medical Education	Political Processes	Health Care Setting	Information Systems	University Affairs
Medical Model			X	X		X		
Business Model	X	X					X	
Health Services Administration Model		X				X	X	

KEY: An "X" in a cell indicates academic and/or clinical preparatory emphasis/presence.

A blank cell indicates a lack of preparatory emphasis/presence.

APPENDIX B

MAJOR CONCLUSIONS
ARISING FROM

Exploratory Seminar
on
Post Master's Clinical Practicums

Conducted in Conjunction with the Faculty Institute
and Annual Meeting of the Association of University Programs in
Health Administration

April 26, 1981

Washington, D.C.

The following list of conclusions was prepared by Seminar participants from the University of Michigan Hospitals. They were developed from the Seminar Proceedings and post-Seminar data gathered from all the participants.

MAJOR CONCLUSIONS
FROM
EXPLORATORY SEMINAR
ON
POST MASTER'S CLINICAL PRACTICUMS

As a result of the discussions which took place during and after the Seminar, a number of conclusions became apparent. Many participants felt that the conclusions were the most important aspect of the exploratory seminar. These conclusions are listed below as follows:

1. That the subject had barely been touched; that the surface had only been scratched; that much more study needed to be done; and that there should be an organized effort to bring about systematic and orderly study and examination of the subject.
2. That there needs to be greater distinction/definition among the three main models of administrative practicums, the residency, the executive development approach, the fellowship, and the several variations of these models.
3. That the promulgation and imposition of standards is undesirable; that the strength of the field lies in its diversity and its traditional pluralism, so rigid standards should not be adopted; but that, clearly, there need to be guidelines to guide and assist all parties who are conscientiously trying to make the transition from the classroom to practice and to infuse greater quality into post-master's clinical education.
4. That students are very confused; that it is virtually impossible for them to make intelligent, informed career choices; and that planning their career patterns is very difficult.
5. That the question should be posed in a way to address the field as a whole even though there are very important, more narrow considerations here. For example, the interest and needs of the academic health centers and the fellowships that have been spawned therein could be a desirable and productive focus of study. The leadership and thinking of these practitioners and academicians in the academic health centers are very important, but the question should not be posed in any way to focus upon them. The overall effort should avoid any notion of elitism, but should address the need for post-master's clinical education for the field as a whole in all of its components.

6. That there is a growing problem with the timing of recruitment of post master's fellows and residents. This recruitment has almost reached the point of the earlier experiences of the NCAA college recruitment of high school "blue chippers", where the college coaches were recruiting earlier and earlier to the point of serious interference with both scholastic and athletic activities in high schools. The analogy is that we are finding the post-master's sponsors of administrative fellowships beginning to recruit second-year MHA students earlier and earlier in the year. First, it was April, then February, and now it is well into the fall of the year. This is now interfering seriously with the second-year academic work of the students. It is diverting their attention at inappropriate times, as well as that of faculty members. There needs to be some understanding or some guidelines as to when this recruitment season will open.
7. That there should be, at some point, a national symposium as originally conceived in order to further this work.
8. That the basic need for direction and definition is upon us.

There is yet one larger, more global issue which was extensively discussed at the exploratory seminar. It also surfaced and was explored at the 1981 Preceptors' Conference of the Washington University Graduate Program in Health Services Administration.

This more global issue is embodied in these additional questions:

- Shall the field of health services administration continue in a systematic way to provide clinical education in health services administration in the traditional fashion linked in with academic programs through preceptorship and the implicit intent and practice of a preceptor/mentor relationship with proteges and aspiring careerists in the field who are given preferential opportunities and guided through their careers?
- Shall the traditional pattern be reinforced and simply recast/reshaped to accommodate to the changes which have occurred in didactic education in the field through the 1970's so as to provide transition and post-master's clinical education?
- Or, shall we move to the mode generally practiced by industry, business, and commerce, whereby the MHA graduates come forward, pursuing their own interests at their own initiative without organized faculty and program effort to place the new graduates without preceptorial influence or preceptorial systems in place, and relating, principally, to individual organizations, rather than to the field as a whole?

The main argument, here, is that, given the growing competition, the pressures for cost containment, etc., in the 1980's, each organization will seek out its own young management talent, bring them into an intra-corporation executive development program, and provide them with opportunities and training that prepare them for managerial posts within that organization. The whole post-master's effort would be tailored and directed toward practice in that organization, particularly. Following this approach, entering careerists would not be prepared for general practice anywhere. Rather, they would be prepared specifically for the specialized needs of the sponsoring organization. By this means, the investment made by the organization would be an investment for itself. The traditional notion that each hospital residency site had a general obligation to prepare people broadly for the field and for practice elsewhere would dissolve as, indeed, some would argue, it is already in the process of doing. Others argue that the business/industry model of executive development cannot apply to the health care field because of basic differences between the two fields. For example, the relative size of industrial corporations vis-a-vis hospitals constitutes a major distinction. Corporations such as General Motors, General Electric, and Procter & Gamble possess sufficient scale to justify major programs in executive development. Hospitals across the country are simply not large enough, goes the argument, to operate such programs efficaciously over time. In any event, the questions above are facing us in the field, to be recognized and addressed, requiring well-conceived responses for action or to be accepted as a sign of the times.

APPENDIX C

CAREER DEVELOPMENT MODEL
FOR
HEALTH SERVICES ADMINISTRATION

Working Paper From the

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS
TASK FORCE ON BEGINNING AND EARLY CAREER DEVELOPMENT

The following conceptual model was developed during the deliberations of the ACHA Task Force on Beginning and Early Career Development. It is intended to be a working document utilized for the sake of discussion and not a final, polished piece. Its inclusion in this paper is designed to stimulate and focus discussion of career development for leaders in teaching hospital administration.

**CAREER DEVELOPMENT MODEL
FOR
HEALTH SERVICES ADMINISTRATION**

PROFESSIONAL ROLE/ASPIRATION/REQUIREMENT

HOSPITAL	GROUP MED PRACT	HEALTH POLICY ANALYSIS	MULTI-HOSPITAL SYSTEMS
VOL N-F-P	PUBLIC TEACHING	MPH	AGENCY/HEALTH PLANNING
			ACADEMIC MEDICAL CENTERS

**STAGE I
UNIVERSITY
GRADUATE
EDUCATION**

PURPOSE - GENERIC/FOUNDATION EDUCATION FOR LEADERSHIP/ADMINISTRATIVE PRACTICE IN VARIETY OF WAYS IN HEALTH CARE FIELD.

TWO-YEAR DIDACTIC/ACADEMIC COURSE WORK (UNIV) UNDER FULL-TIME FACULTY LEADING TO MHA. GRAD PROGRAMS ARE PLURALISTIC LOCATED IN VARIETY OF ACADEMIC BASES: SPH'S, MEDICAL SCHOOLS, "B" SCHOOLS, ETC. PROGRAMS MAY SPECIALIZE OR DEVELOP TRACKS OF EMPHASIS.

FACTORS/CHARACTERISTICS OF HOSPITAL EXPOSURE:

FIRST YEAR		A. HOSPITAL/CLINICS ENVIRONMENTAL EXPOSURE IS NOT A RESIDENCY
---	---	B. COURSE WORK: (1) HOSPITAL ORIENTATION; (2) PROBLEM SOLVING; (3) MAJOR MASTER'S PAPER - THESIS
		- MANAGEMENT PROBLEM
---	---	C. OVERSIGHT BY FACULTY - NOT PRECEPTOR
SECOND YEAR		D. NO PRECEPTOR/MENTOR/PROTEGE RELATIONSHIP
---	---	E. CALL "CLERKSHIP" OR OTHER CLEAR TERM
---	---	F. HOSPITAL IS ESSENTIALLY A LABORATORY
---	---	G. PLURALISTIC AND FLEXIBLE

**STAGE II
POST
GRADUATE
TRAINING**

PURPOSE - STRUCTURED/TAILORED CLINICAL PRACTICUMS (MAYBE SPECIALIZED/PROBABLY SPECIALIZED) TO EFFECTIVELY BRIDGE TRANSITION FROM ACADEMIA TO PRACTICE AND TO PROVIDE OPPORTUNITY FOR ACQUISITION OF SPECIFIC KNOWLEDGE, INFORMATION, SKILLS, AND ENVIRONMENTAL INSTINCTS.

NOT-LESS-THAN FACTORS/CHARACTERISTICS OF CLIN EXPERIENCE

A. POST-MASTER'S ADMIN RESIDENCY	12 MOS	A. MINIMUM TRAINING/LEARNING RESOURCES
B. POST-MASTER'S ADMIN FELLOWSHIP	1-3 YRS	B. "MONITORING" OR "SINK-OR-SWIM"
C. POST-MASTER'S MGMT DEVELOPMENT	1-5 YRS	C. PLURALISTIC AND FLEXIBLE
		D. ACHA STRONG INFLUENCE IN QUALITY
		E. CREDENTIALLING
		F. EMBRACES MD'S, MBA'S, MPH'S, MHA'S, ETC.

**STAGE III
CONTINUING
CAREER
TRAINING/
EDUCATION**

PURPOSE - PROVIDE MEANS FOR UPDATING ORIGINAL CAREER PREPARATION AND ACQUISITION OF NEW KNOWLEDGE/SKILLS DURING COURSE OF ONE'S CAREER.

FACTORS/CHARACTERISTICS OF CONTINUING TRAINING/EDUCATION

A. EARLY CAREER		A. STRONG ACHA INFLUENCE OR QUALITY
---	---	B. CREDENTIALLING
B. MID-CAREER		C. PLURALISTIC AND FLEXIBLE
(BEYOND SCOPE OF T/F		D. ACHA SERVES AS CORE RESOURCE/CREDIBLE CONSULTANT
- GENERAL COMMENT ONLY)		E. CME CONCEPT (?)
C. ADVANCED CAREER		F. UNIVERSITIES/AMA/BANFT INSTITUTE/VA SYSTEM/ BUGLEY/ETC.
(BEYOND SCOPE OF T/F		G. SELF-ASSESSMENT
- GENERAL COMMENT ONLY)		

NATIONAL FUND FOR MEDICAL EDUCATION

NFME # _____

999 Asylum Avenue, Hartford, CT 06105

(203) 278-5070

Application for Innovative Grant

NAME OF INSTITUTION/ORGANIZATION Methodist Hospital of Indiana, Inc.
1604 North Capitol Avenue
Indianapolis, Indiana 46202

TITLE OF PROJECT DEVELOPMENT OF A DATA BASE AND A CLASSIFICATION SYSTEM
FOR INDEPENDENT TEACHING HOSPITALS

AMOUNT REQUESTED \$55,000 **TERM OF YEARS** One

ATTACH PAGES CONTAINING THE FOLLOWING:

- 1) Goal(s) of project
- 2) Need: a) Brief survey of literature to demonstrate that the project is innovative and needed
b) Impact outside of applicant institution
- 3) Design for achieving goal(s)
- 4) Completion schedule for project sub-tasks
- 5) Evaluation plan to assess program development and achievement of objectives
- 6) Evidence of institutional commitment (money, materials, facilities and/or personnel)
- 7) Prospects for continuation and dissemination if project succeeds
- 8) Detailed budget and justification
- 9) Brief curriculum vitae of major project personnel
- 10) Summary of the proposal (USE ONLY SHEETS PROVIDED) which describes items 1, 3, 5, and 8 in sufficient detail that a reader **without expert knowledge** could grasp the significance of the proposal
- 11) Self-addressed label for acknowledging receipt of application

PROPOSALS SHOULD BE LIMITED TO 25 PAGES (NOT INCLUDING CURRICULUM VITAE) DOUBLE-SPACED; BRIEFER PROPOSALS ARE ENCOURAGED (SEE POLICY PAMPHLET).

PLEASE SUBMIT ORIGINAL AND 14 COPIES. ATTACH ALL SUPPORTING DOCUMENTS AND LETTERS TO THE BACKS OF THE APPLICATIONS.

PROPOSER

James G. Anderson, Ph.D.
James G. Anderson, Ph.D.*

Stephen J. Jay, M.D.
Stephen J. Jay, M.D.

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APPROVED BY CHIEF EXECUTIVE OFFICER:

(Note: applications will not be
accepted without this endorsement)

Frank P. Lloyd, M.D.
signature

Frank P. Lloyd, M.D., President
name and title (please type)

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**NAME AND ADDRESS OF PERSON TO WHOM
GRANT CHECKS SHOULD BE SENT:**

Wayne Edwards, Assistant Vice President
for Fiscal Services

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Indianapolis, Indiana 46202

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INSTITUTION/ORGANIZATION Methodist Hospital of Indiana, Inc.

Indianapolis, Indiana 46202

TITLE OF PROJECT DEVELOPMENT OF A DATA BASE AND A CLASSIFICATION SYSTEM FOR
INDEPENDENT TEACHING HOSPITALS

SUMMARY OF PROPOSAL

(Do not exceed 1½ pages provided)

At the present little is known about the distinguishing characteristics of the 1,349 independent teaching hospitals that provide the operating environment for much of medical education in the U.S. Many of these hospitals do not fit the traditional model of a teaching hospital. This diversity and lack of data makes it difficult for these hospitals to collectively or individually respond to proposed public policies that would affect reimbursement, regulation, and financing of medical education and research.

In this project, a questionnaire will be developed to supplement existing sources of data and will be administered to independent teaching hospitals. A data base will be constructed that can be used:

- (1) To provide quantitative descriptions of the size, scope, and organization of medical education and research at independent teaching hospitals.
- (2) To classify those hospitals into relatively homogeneous groups on the basis of teaching and research.
- (3) To examine the relationship between levels of teaching and research, and hospital and patient characteristics.

Thirteen hospitals that are members of the Consortium of Independent Teaching Hospitals have agreed to participate in the design and evaluation of this project. Moreover, all participating hospitals will be provided with and asked to evaluate a group profile that describes the facilities and services; size, scope, and organization of

SUMMARY (Continued)

medical education and research; and the operating characteristics of the hospitals that comprise the group. If the evaluation of the project results is positive, a proposal will be made to initiate an annual survey of independent teaching hospitals under the sponsorship of the Consortium of Independent Teaching Hospitals.

NFME USE ONLY

(Do not write in this space)

GOALS OF THE PROJECT

Increasingly, independent hospitals are engaged in graduate and undergraduate medical education as well as in allied health education. Independent teaching hospitals are hospitals involved in training medical students and/or house staff that are not owned or controlled by university medical schools. The responsibility for hospital administration, medical staff and teaching faculty appointments, and direction of most education programs is left with the hospital. Unless there are substantial reductions in first-year medical school enrollments in the next few years the demand for clerkships and residency training positions in these hospitals will increase significantly (Kindig and Dunham, 1982).

Many of these hospitals do not fit the traditional model of a teaching hospital. What is more, wide variations among these institutions in the size, scope, organization, and financing of their medical education programs makes it difficult to identify those essential characteristics that critically affect the cost and quality of medical education. The current economic environment as well as legislative proposals that would differentially reimburse and regulate teaching hospitals suggest a need to develop quantitative descriptions of teaching hospitals in general and of independent teaching hospitals in particular.

A preliminary study indicated major limitations in the data available to describe the scope and magnitude of hospitals' teaching and research activities (Anderson, Jay, and Hackman, 1982). Consequently, the goals of this project are:

- (1) to design a survey of independent teaching hospitals

- (2) to collect data from these hospitals that describe the level of their involvement in undergraduate, graduate, continuing, and allied medical education; the extent of their research activities; and the nature of their affiliation with medical schools and other hospitals
- (3) to create a data base for independent teaching hospitals
- (4) to develop quantitative descriptions of the level of teaching and research in which these hospitals are engaged
- (5) to classify independent teaching hospitals into peer groups of relatively homogeneous hospitals based on levels of teaching and research
- (6) to examine the relationship between levels of teaching and research, and hospital and patient characteristics

NEED FOR THE PROJECT

Diversity Among Teaching Hospitals

A recent report by the Department of Teaching Hospitals of the AAMC (1981a) points out that traditionally teaching hospitals were owned and operated by medical schools. Their usual urban location resulted in the provision of highly specialized care and outpatient services for a large indigent population. During the past two decades, however, teaching hospitals have changed dramatically in response to new demands. The increase in medical schools and their enrollments coupled with an emphasis on primary care specialties and concern about the distribution of physicians led medical schools to affiliate with a larger number of hospitals in order to provide clerkships and residency positions. By 1981 there

were 67,868 interns and residents in almost 1,600 institutions and agencies in the U.S. The majority of these institutions (1,414) were hospitals, 95 percent of which were not university owned (AMA, 1981a).

While teaching hospitals are committed to the same major objectives, namely the provision of patient care, medical education, and clinical research, they vary significantly in terms of the relative emphasis they place on each of these goals. They also differ in terms of their corporate, administrative, medical staff, and financial structures (see Table 1). Teaching hospitals also have a myriad of affiliation arrangements or agreements with other institutions and hospitals. These affiliations remain poorly characterized and understood.

At present little is known about the general distinguishing characteristics of the institutions that produce the operating environment for undergraduate and graduate medical education in the U.S.; remarkably little information is available concerning the specific distinguishing features of independent teaching hospitals. Consequently, there is a need to identify the distinguishing characteristics of contemporary teaching hospitals and to develop quantifiable criteria for establishing involvement in the allocation of resources to medical education and research.

Lack of Data

Results of a preliminary study indicate major limitations in the secondary sources of data available to characterize the level of medical education and research conducted by independent teaching hospitals. Data on which to base quantifiable measures of the scope and magnitude of undergraduate and graduate medical education, allied health education, continuing medical education, research activities, faculty characteristics, quality, and associated costs of medical education are generally unavailable.

Table
SOME DISTINGUISHING CHARACTERISTICS OF TEACHING HOSPITALS

Distinguishing Characteristic	Involvement in Medical Education	
	Low	High
Graduate Medical Education	1 or 2 Primary Care Specialties	3 or 4 Primary Care Specialties plus Other Clinical Specialties
Undergraduate Medical Education	No Involvement	Required Clerkships
Continuing Medical Education	No Involvement	Division of Continuing Medical Education
Medical Research	No Clinical, Biomedical or Health Services Research	Sponsored Clinical, Biomedical and/or Health Services Research
Allied Health Education Programs	No other Training Programs	Residencies in Clinical Pharmacy; Nursing School; Allied Health Training Programs
Medical School Affiliation	Limited	Major
	No Joint Faculty Appointments	Teaching Staff of the Hospital hold Faculty Appointments in Academic Departments of Medical School
Composition of Medical Staff	Voluntary Chiefs of Services; Voluntary Teaching Staff	Full time, salaried Chiefs of Services; Teaching Staff Compensated
Cost and Financing of Medical Education ¹	Less than 1% of Expenses for Medical Education	6% or more of expenses for Medical Education
Facilities/Services (Complexity Index) ²	Basic Score: 1 - 5	Tertiary Score: 12 - 17
Case Mix and Complexity (Complexity Index) ³	Score: 0.90 - 1.10	Score: 1.20 - 1.40

¹AAMC, 1981a

²Klastorin and Watts, 1982.

³Horn and Schumacher, 1979.

Appendix I indicates sources of data for a preliminary list of variables that describe teaching hospitals.

For example, the Council of Teaching Hospitals of the AAMC conducts an annual Survey of University Owned Teaching Hospitals' Financial and General Operating Data. Data are collected only from the 65 university owned hospitals and the report is restricted to the institutions participating in the survey (AAMC, 1981d).

A second COTH study involves an annual Survey of Housestaff Stipends, Benefits, and Funding. While this survey includes 410 hospitals that are members of COTH, it excludes almost 1,000 other teaching hospitals in the U.S. that are not members. Also only aggregate statistics are published in the report and no data are available for individual hospitals (AAMC, 1981c).

Data are reported on the total number of filled residency positions by USMGs and FMGs in the COTH Directory of Educational Programs and Services (AAMC, 1982b). Again, however, only COTH members are included. A complete listing of residency programs and the number of positions offered is contained in the National Residency Training Program Directory published by the AMA (1982). However, a major limitation is the way that residencies are reported. In those instances where several hospitals share a program, it is impossible to allocate residencies to individual hospitals based on the published data. Other studies have traditionally allocated all of the positions to the unit that administers the program. This practice, however, may underestimate the role that many independent teaching hospitals play in training house staff. Also, this practice markedly impairs an accurate quantification of the costs of medical education.

Published data on most of the other variables such as the nature and funding of research activities, the size and scope of allied health education and continuing medical education programs are almost nonexistent. Moreover, while affiliated hospitals are of increasing significance in providing medical education at both the undergraduate and graduate level, limited data are available concerning the nature of interinstitutional relationships. Medical school affiliation is merely classified into three categories by the AAMC, namely graduate, major, or limited affiliation.

Only two studies have examined the nature of affiliation between medical schools and teaching hospitals (Sheps, 1965; Keyes et al., 1977). The AAMC study involved an in depth study of only six medical schools and their affiliated teaching hospitals. At present there is a need for a larger scale study of the factors that describe the extent and scope of affiliation between medical schools and independent teaching hospitals. Data are needed on the extent to which hospital teaching staff and university faculty serve on joint committees responsible for recruiting faculty, establishing curricula, etc. The financial implications of affiliation agreements also need to be defined.

Another important characteristic that differentiates teaching hospitals is the composition and structure of their medical staff. An AHA study revealed that the number of physicians on the medical staff of teaching hospitals is generally two and three times that of non-teaching hospitals (Kessler, 1976). The same study, however, revealed a great deal of variation among hospitals in the composition of the medical staff. Hospitals that place a high priority on research and medical education are likely to have full-time clinical service chiefs who are compensated by the hospital for their administrative duties. Other physicians may also receive part or all of their salaries from the hospital in order that they may devote time and effort to

clinical research and teaching. At the other extreme staff physicians at community hospitals with limited involvement in medical education may receive no compensation from the hospital or medical school even if they serve as attending physicians for house staff or medical students.

A second differentiating characteristic is the relationship that the hospital medical staff has with the faculty of the medical school with which the hospital is affiliated. At one extreme physicians on the medical staff of the hospital who teach may also have faculty appointments in academic departments of the medical school. At the other extreme the teaching staff of the hospitals may be composed entirely of practicing physicians who have no academic ties whatsoever. The medical staff of many teaching hospitals is comprised of both types of physicians.

Data on medical staff composition are not routinely collected and published. Consequently, there is a need to collect data on the number of staff physicians engaged in medical education and/or research; the nature of their teaching, research, and/or administrative responsibilities; how they are compensated; and their academic status.

Other Studies

The AAMC has initiated a study of teaching hospitals (Bentley and Butler, 1980). A sample of 33 COTH member hospitals were asked to submit their 1978 fiscal year patient discharge abstracts and bills, Medicare costs reports, audited financial statements, annual reports, and patient origin studies. Three questionnaires were also used to obtain data on educational programs, hospital staffing, and patient services. While this is a comprehensive study, it is limited to two percent of the teaching hospitals in the U.S., and only to members of COTH.

In a second effort to examine the financing of graduate medical education, the U.S. Department of Health and Human Services (1982) has contracted with Arthur Young and Company for a four year study of the production and financing of graduate medical education. Based on a typology developed during the first year of the project 45 hospitals will be selected for study. Data will be collected in order to answer the following questions:

- (1) To what extent do interns and residents substitute for physicians and/or other hospital staff?
- (2) To what extent do alternative reimbursement structures in teaching hospitals affect the quality of patient care, the quality of medical education, and total reimbursement?
- (3) How does teaching status affect the variation in total expenditures (physicians and hospital) from hospital to hospital?
- (4) How well do conventional case mix indices measure the types of cases and costs being treated at teaching hospitals?
- (5) What criteria should be used to measure teaching status?
- (6) To what extent do fees paid for physicians' professional services finance medical education in the hospital and medical school?

This study is also comprehensive but is based on only 45 of the 1,414 teaching hospitals. Moreover, the typology used to select hospitals for inclusion in the study (Worthington, 1981) has serious limitations. First, published data were used to construct the classification system. The limitations of the existing data discussed earlier resulted in dummy variables being used to indicate the affiliation status of the hospital and the presence or absence of clinical clerkships for medical students. Also joint residency positions were totally allocated to the hospital administering the program.

Second, since all U.S. teaching hospitals, university owned and independent, were included in a single analysis, there is considerable variation among hospitals that make up each group despite their apparent similarities. Consequently, important differences among these hospitals related to their teaching and research programs may be masked. For example, two major underlying dimensions that appear to differentiate the 20 hospitals included in a preliminary study conducted by the authors are the proportion of independent residency programs that are offered and the nature of the hospital's affiliation with a medical school (Anderson, Jay, and Hackman, 1982). These dimensions appear to be obscured in the DHHS classification system. This suggests that it may be important to develop separate typologies for classifying university owned and independent teaching hospitals.

A third study of 20 independent teaching hospitals was performed by Anderson, Jay, and Hackman (1982). This pilot study was designed to test the methodology to be used in this project. Hospitals were clustered on the basis of the residency programs they offered. Three groups of hospitals were identified that differed significantly in terms of the way they organized their graduate medical education programs. Also a cluster analysis of clinical specialties indicated a well-defined hierarchy. This finding suggests that teaching hospitals add residency programs in new clinical specialties in a definite sequence. Detailed findings from this pilot study will be used to illustrate the research design for this project in the next section.

Impact of the Project

The development of definitive, quantifiable criteria for identifying teaching hospitals and establishing levels of teaching and research are particularly important due to recent developments (AAMC, 1981a, 1981b; Butler et al., 1980; Heysell, 1981) such as:

- (1) cost containment legislation that would differentially reimburse teaching hospitals considered to be "primary affiliates" of medical schools
- (2) "consumer choice" programs that would require separate identification and subsidization of teaching and research costs
- (3) health planning efforts that would provide preferential treatment to certificate of need applications from certain teaching hospitals designated as primary providers of tertiary care
- (4) increased emphasis on competition in the health care field resulting in corporate restructuring of hospitals and the development of multi-institutional arrangements among hospitals and other health service institutions.

This study has been designed to gather data that can be used to develop quantitative descriptions of independent teaching hospitals. In addition, because of the diversity among these hospitals in size, scope, organization, and financing of medical education and research, a method of classification will be used to group together teaching hospitals that are, as far as possible, similar with respect to their educational and research programs. Such a classification system can be used by regulators, financial intermediaries, planners, researchers, and hospital managers, and educators.

For example, group evaluation based on guidelines, norms, and standards derived from a group of similar institutions is widely used by Blue Cross plans for the purpose of setting rates. These classification systems, in general, are rather crude, classifying hospitals by size and/or region. Since the success of group evaluation depends upon the similarity of the institutions that constitute the reference group, it is important to take levels of teaching and research into consideration in establishing reference groups for the purpose of setting rates.

A homogeneous classification system is also important to hospital managers. Traditionally programs such as the Professional Activity Study (PAS), Hospital Administrative Services (HAS), and the Health Services Data System provide managers with group statistics to which they can compare their own hospital. The value of these programs could be enhanced for teaching hospitals by developing reference groups that reflect similarities among hospitals in terms of their teaching and research efforts.

A classification system that identifies clusters of similar teaching hospitals is also useful in research and evaluation. Experimental and control groups could be formed by random assignment of hospitals belonging to the same group. The clusters also can be used as fairly homogeneous strata in a stratified random sample of hospitals. Such a sample can be used for surveys such as the National Hospital Panel Survey conducted monthly by the AHA as well as for other surveys by governmental agencies, research organizations, and planning agencies.

RESEARCH DESIGN

Design of Study

The first phase of the project will involve the identification of important characteristics that differentiate among hospitals engaged in medical education. Generally, the characteristics believed to be important in differentiating among teaching hospitals fall into the following categories (adapted from the AAMC, 1981a):

- (1) the size, scope, and quality of the hospital's undergraduates, residency, and fellowship programs
- (2) the size, scope, and quality of the hospital's continuing medical education program
- (3) the nature and extent of medical research activities

- (4) the presence of and the size, scope, and quality of allied health education programs
- (5) the nature of affiliation with medical schools
- (6) characteristics of the medical staff and teaching faculty
- (7) cost and financing of medical and allied health education and research
- (8) general hospital characteristics
 - (a) size, scope, and quality of services
 - (b) general financial summary indicators
 - (c) corporate structure
 - (d) patient case mix and complexity

These characteristics provide a framework for systematically examining variations among teaching hospitals. Three important questions need to be addressed. The first is what measures should be used to quantify a hospital's teaching status? The second is what data are available or needed on which to base these measures? A preliminary list of potential variables and the availability of data are contained in Appendix I. A third empirical question is whether these measures of the amount and type of medical education and research produced by hospitals can be used as the basis for classifying teaching hospitals into a number of homogeneous groups?

Where data exist and are available, arrangements will be made to acquire these data. An example is the AHA Annual Survey of Hospitals. At the same time, a questionnaire will be developed to collect data on educational and research programs, faculty composition, affiliation with medical schools and other hospitals, and other hospital characteristics deemed to be important. Criteria will also be developed to be used to select hospitals for inclusion in this study.

Thirteen hospitals involved in the formation of the Consortium of Independent Teaching Hospitals have agreed to participate in this research effort. These institutions will assist in the development and preliminary testing of the questionnaire.

Data Collection

Arrangements will be made with agencies such as the AHA and the AAMC to transfer available data on the teaching hospitals included in this study. Also these hospitals will be contacted and asked to complete the questionnaire.

Construction of a Data Base

Data will be coded and a computerized data file will be created. This file will contain a detailed description of independent teaching hospitals in terms of selected financial characteristics, facilities and services, patient characteristics, educational programs (graduate, undergraduate, continuing, and allied health), research and development characteristics, affiliation relationships, and faculty composition. This comprehensive data base can be used to address a number of important issues pertaining to teaching hospitals, such as cost and quality, as well as to develop a classification system.

Data Analysis

Following the construction of the data base, the data will be extensively analyzed using statistical techniques such as factor analysis and regression analysis in order:

- (1) to develop quantitative measures of teaching and research
- (2) to gain insight into the relationships between these measures and other hospital characteristics
- (3) to identify a set of variables that capture the range of teaching and research activities in which hospitals are engaged

- (4) to select those variables to be used to cluster hospitals into relatively homogeneous groups based on levels of teaching and research.

The characteristics that describe the scope of a hospital's medical education program will be used to determine whether it is possible to classify teaching hospitals into relatively homogeneous groups reflecting interhospital differences in teaching status. Such a typology would be of a great deal of value to researchers, planners, and policy makers.

For example, a preliminary typology was developed for independent teaching hospitals using published data from the '82-'83 Directory of Residency Training Programs. For each of the 20 hospitals involved in the formation of the Consortium of Independent Teaching Hospitals (CITH), a profile was created indicating the types of residency programs offered. Twenty different clinical specialties are offered by these hospitals. They are listed in Table 2. Types of programs were used instead of the number of residency positions in each specialty because the published data do not permit the allocation of positions among two or more hospitals with shared residency programs.

In order to investigate the possible existence of a typology representing distinct patterns of graduate medical education, a cluster analysis was performed on the residency program profiles using the CONCOR computer program (Schwartz, 1977). CONCOR is a hierarchical clustering algorithm based on iterative correlational analysis. It begins by forming a square intercorrelation matrix between the rows (representing hospitals) of the original data matrix where the columns represent the 20 clinical specialties. Hospitals are successively split into a larger number of smaller groups with similar correlation profiles. Each hospital in a group is more

Table 2

CLINICAL SPECIALTIES OFFERED BY THE 20 CITH HOSPITALS¹

PRIMARY CARE SPECIALTIES

Internal Medicine
Family Practice
Obstetrics/Gynecology
Pediatrics

SURGICAL SPECIALTIES

General Surgery
Orthopedic Surgery
Urology
Other surgical specialties: Colon and Rectal Surgery
Neurosurgery, Plastic
Surgery, Thoracic Surgery

HOSPITAL BASED SPECIALTIES

Anesthesiology
Nuclear Medicine
Radiology: Diagnostic Radiology, Nuclear Radiology,
Therapeutic Radiology
Pathology: Dermatopathology, Neuropathology, Pathology

MEDICAL SPECIALTIES

Neurology
Ophthalmology
Allergy/Immunology, Dermatology
Otolaryngology
Physical Medicine and Rehabilitation
Psychiatry

OTHER SPECIALTIES

Emergency Medicine
Flexible Program

¹Specialty groupings used in the U.S. DHHS (1982) study

similar to (i.e., more highly correlated with) every other hospital in its group than it is to any other hospital outside the group. The results are displayed by means of a dendrogram or tree in Table 3. This diagram indicates similarities among the 20 hospitals in terms of the types of residency programs they offer.

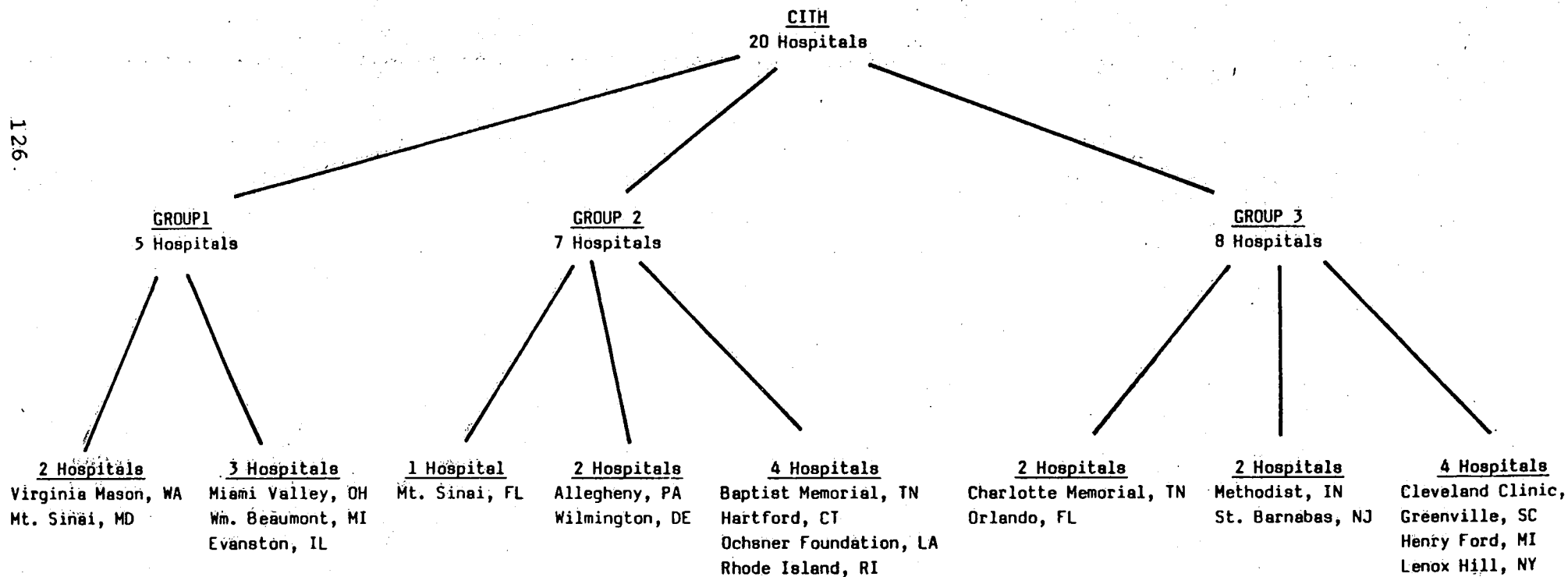
The dendrogram indicates the existence of three major groups of hospitals. Each of these groups in turn is composed of several subgroups. For example in Group 1, Evanston, Miami Valley, and William Beaumont Hospital are more alike than Sinai and Virginia Mason. All five of these hospitals are more similar to one another in terms of the types of residency programs they offer than they are to the other 15 hospitals that comprise Groups 2 and 3.

Data presented in Table 4 were used to interpret and evaluate the typology. A number of characteristics of each hospital are presented as are the group profiles. Group profiles are also presented in Figure 1. The three groups differ in several important respects. Group 1 in general consists of smaller hospitals (Av = 647 beds) with fewer residency programs and residents per bed. An important distinguishing feature of this group of hospitals is the nature of their affiliation with medical schools and other hospitals. Two out of the five hospitals have a limited affiliation with a medical school. Also about half of the residency programs are jointly offered with other hospitals.

Group 2 differs from Group 1 in that the hospitals are generally much larger (Av = 926 beds). They also offer more residency programs (Av = 13 specialties). As in Group 1, almost 40 percent of these hospitals have a limited affiliation with a medical school and about half of the residency programs offered are joint.

Table 3

DENDROGRAM FOR 20 CITH HOSPITALS



112
113
114
115
116
117
118
119
120

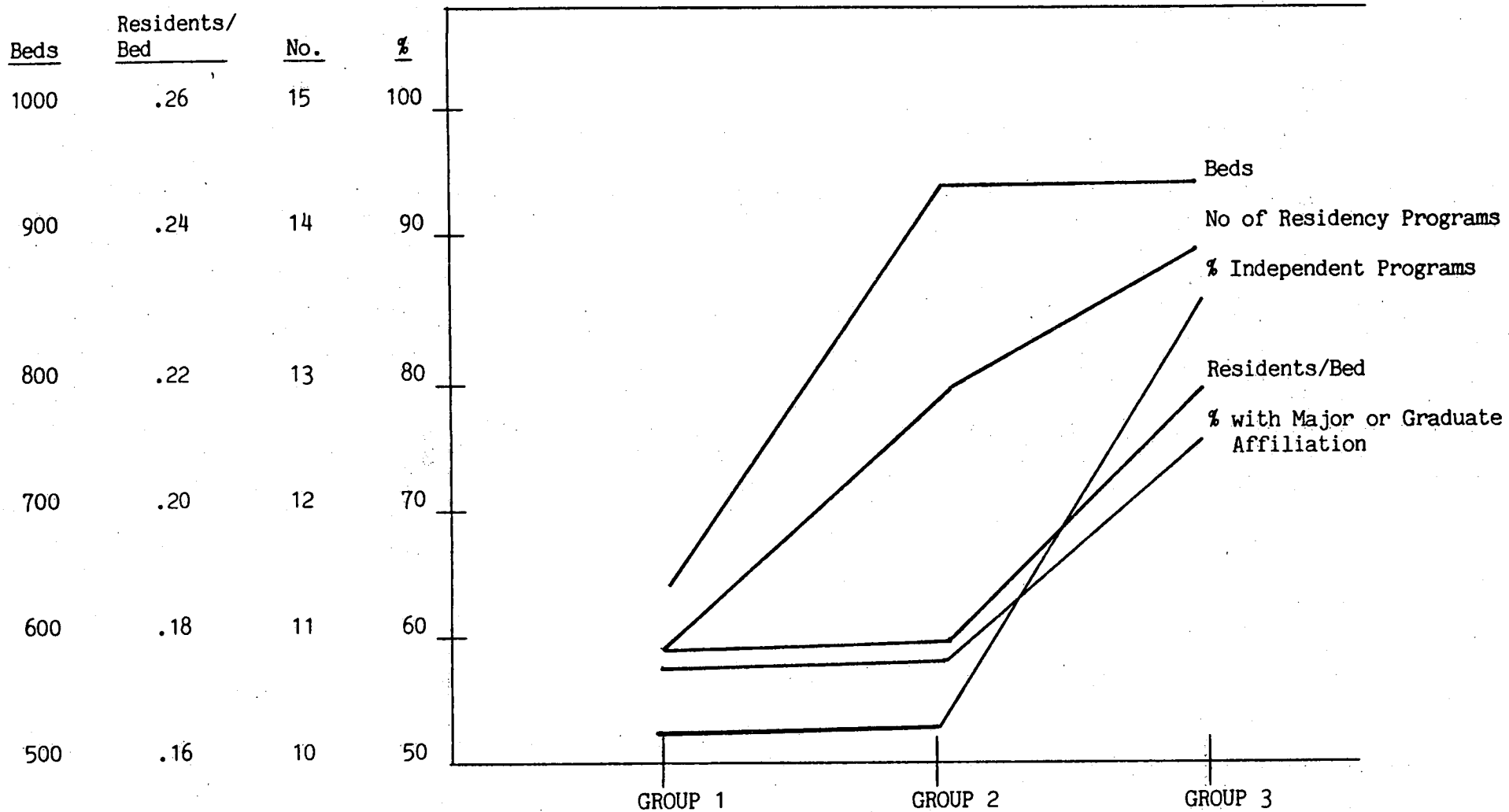
PRELIMINARY CLASSIFICATION OF 20 CITH HOSPITALS

BASED ON THE NUMBER OF RESIDENCY PROGRAMS

	Beds	Residents in Training	Residents/ Bed	Residency Programs			Percent Independent	Medical School Affiliation
				Primary Care	Other	Total		
<u>GROUP 1</u>								
Miami Valley	703	78	0.11	3	4	7	14	M
Wm Beaumont	926	N/A	N/A	3	12	15	93	M/L
Evanston	780	156	0.20	3	12	15	20	M
Va. Mason	310	N/A	N/A	1	8	9	56	L
Sinai	516	118	0.23	3	6	9	67	L
<u>GROUP PROFILE</u>	647	117	0.18	3	8	11	53	L
<u>GROUP 2</u>								
Allegheny	704	116	0.16	2	11	13	77	L
Wilmington	1065	122	0.11	4	9	13	69	M
Baptist	1914	152	0.08	2	10	12	50	L
Hartford	911	183	0.20	3	13	16	31	M/L
Ochsner	475	202	0.43	3	14	17	53	M/L
Rhode Island	719	241	0.34	3	10	13	38	M
Mt. Sinai	699	107	0.15	2	7	9	56	L
<u>GROUP PROFILE</u>	926	160	0.17	3	10	13	53	M
<u>GROUP 3</u>								
Charlotte	766	105	0.14	4	10	14	86	M
Orlando	933	N/A	N/A	3	3	6	84	L
St. Barnabas	705	115	0.16	3	8	11	100	G
Methodist	1103	139	0.13	4	11	15	87	G
Cleveland	1008	441	0.44	2	22	24	87	L
Greenville	1098	100	0.09	4	7	11	91	M
Henry Ford	1009	363	0.36	3	15	18	100	M
Lenox	690	159	0.23	3	8	11	74	M/L
<u>GROUP PROFILE</u>	914	203	0.22	4	10	14	88	M

FIGURE 1

PROFILES FOR THE THREE GROUPS OF HOSPITALS



Group 3 is similar to Group 2 in that the average hospital is over 900 beds. These hospitals offer slightly more residency programs (Av = 14 Specialties) and have more residents per bed than hospitals in the other two groups. In sharp contrast to Groups 1 and 2, three fourths of the hospitals that make up this group have a major affiliation with a medical school. Moreover, the characteristic that distinguishes this group of hospitals the most is the fact that almost 90 percent of the residency programs are independently offered by these hospitals.

In order to further investigate patterns of residency training programs, a cluster analysis was performed on measures of similarity between clinical specialties (Klastorin and Watts, 1982). Initially each specialty is considered to be a cluster of its own. At each step the two clusters with the shortest Euclidean distance between them are combined. This agglomerative algorithm is called average distance of average linkage (Dixon and Brown, 1979: 633-642).

The resulting dendrogram or tree is shown in Table 5 along with the percentage of hospitals offering each type of residency training program. The dendrogram is divided into a number of joining class levels that indicate groups of clinical specialties. Specialties that comprise groups formed at lower joining class levels are more similar than those combined into groups at higher levels.

The results indicate a well-defined hierarchy among clinical specialties. This suggests that teaching hospitals add residency training programs in new clinical specialties in a fairly continuous manner. The first specialties to be offered are internal medicine and general surgery. These are followed by obstetrics/gynecology, orthopedic surgery, pathology, radiology, urology,

Table 5

HIERARCHICAL CATEGORIES OF
RESIDENCY TRAINING PROGRAMS

Clinical Specialty	Dendrogram	% Hospitals Offering Residency Program
Internal Medicine		100
General Surgery		95
Obstetrics/Gynecology		90
Orthopedic Surgery		80
Pathology		80
Radiology		80
Urology		65
Surgical Specialties		70
Pediatrics		70
Neurology		25
Psychiatry		30
Otolaryngology		45
Ophthalmology		45
Flexible		55
Anesthesiology		45
Allergy/Immunology		25
Physical Medicine & Rehabilitation		5
Family Practice		30
Emergency Medicine		25
Nuclear Medicine		15

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other surgical specialties, and pediatrics generally in that order. It appears that only after residency programs in these specialties have been established, do most hospitals begin to offer training in other specialties such as neurology, psychiatry, otolaryngology, etc. Flexible programs also appear at about this point.

Residency programs in family practice and emergency medicine are grouped together at a low joining class level. This suggests that there is a tendency for hospitals that offer one of these residency programs to offer the other. It may also indicate that these two specialties are somewhat independent of the others. Hospitals may offer residencies in these two specialties even though they may not offer programs in most of the other specialties.

Results of this preliminary analysis suggest that it may be possible to group independent teaching hospitals into a number of groups that are relatively homogeneous with respect to the organization, level, and scope of their medical education and research programs. The initial typology makes significant distinctions among hospitals according to the amount of graduate medical education they offer and the way in which these programs are organized. Once the data base is constructed and more comprehensive measures are developed, a new typology will be constructed to reflect the hospital's involvement in graduate, undergraduate, continuing, allied medical education, and research.

Evaluation of the Results

Once the typology or classification has been created, the reliability or distinctiveness of the groups will be evaluated. Also the relationship of the groups to other hospital characteristics will be examined using analysis of variance. ANOVA will be used to assess whether the between-group differences

Table 6

ONE-WAY ANALYSIS OF VARIANCE COMPARING THE THREE GROUPS OF HOSPITALS

Dependent Variable	F	p	Duncan's Multiple Range Test		
Beds	1.34	0.28	Group 1 647	Group 3 914	Group 2 926
Residents/Bed	0.12	0.88	Group 1 0.18	Group 2 0.21	Group 3 0.22
No. of Primary Care Programs	1.40	0.27	Group 1 2.60	Group 2 2.31	Group 3 3.25
No. of other Residency Programs	0.45	0.64	Group 1 8.40	Group 3 10.57	Group 2 10.50
% Independent Residency Programs	8.54	0.003	Group 1 50.00	Group 2 53.42	Group 3 88.62

are more significant than the overall within-group variation on a number of important hospital characteristics.

This approach is illustrated in Table 6. The three groups identified in the preliminary study are compared on several characteristics. Because of the relatively small number of hospitals comprising each group, only one of the group differences is statistically significant. Hospitals in Group 3 offer significantly more independent residency programs than hospitals in the other two groups.

A second approach to evaluation is to examine profiles of descriptive statistics for each group to determine whether the groups seem reasonable. Thirteen hospitals that are members of the Consortium of Independent Teaching Hospitals have agreed to evaluate the profiles that are created for each group of hospitals.

PROJECT SCHEDULE

The project will extend over a 12 month period. Table 7 contains a detailed schedule indicating completion dates for the project's subtasks.

EVALUATION PLAN

In order to evaluate the reliability, validity, and utility of the data base and the classification system, all hospitals participating in this study will be provided with a list of the other hospitals that comprise their group and a group profile of descriptive data. They will be asked to indicate whether all relevant characteristics of their teaching and research programs have been taken into account.

Table 7
PROJECT SCHEDULE

Subtasks	J	F	M	A	M	J	J	A	S	O	N	D			
<u>Design of Study</u>															
Identification of Relevant Teaching Hospital Characteristics	x	-----	x												
Arrangements with AHA, AAMC to acquire available data								x	---	x					
Design of Questionnaire to Collect Data Currently Unavailable								x	---	x					
Preliminary Testing of Questionnaire								x	---	x					
Selection of Teaching Hospitals to be Included in Study								x	---	x					
<u>Data Collection</u>															
Acquisition of Available Data from AHA, AAMC								x	-----	x					
Administration of Questionnaire to Teaching Hospitals								x	-----	x					
<u>Construction of Data Base</u>															
Coding of Data												x	---	x	
Development of Computerized Data File												x	-----	x	
<u>Data Analysis</u>															
Construction of Quantitative Measures of Size, Scope, Organization of Medical Education/Research; Affiliation; Faculty Composition												x	---	x	
Selection of Variables on which to Base Classification System													x	---	x
Identification of Homogeneous Groups of Hospitals using Cluster Analysis													x	---	x
<u>Evaluation of Results</u>															
Statistical Analysis of the Homogeneity of the Hospital Groups													x	---	x
Assessment of the Relationship Between Teaching/Research Status and Other Hospital Characteristics													x	---	x
Dissemination of Group Profiles to Selected Hospitals for Evaluation													x	---	x
<u>Dissemination of Results</u>															
Preparation of Group Profiles and Description of Results for Dissemination to all Participating Hospitals													x	---	x
<u>Preparation of Reports</u>															
Preparation of Interim Report													x	---	x
Preparation of Final Report															x

Participating hospitals will also be asked to appraise the usefulness of the group profiles for management purposes. If the clusters of hospitals are relatively homogeneous, the data base can then be used in conjunction with the typology to create group profiles that describe the facilities and services; size, scope, and organization of the medical education programs; costs and financing of medical education; level of research activities; and case mix of independent teaching hospitals. These group profiles would provide individual hospitals with a standard to which they could compare their own medical education and research programs. The data base could also be used for comparative studies of the organization, financing, cost, and quality of medical education.

INSTITUTIONAL COMMITMENT

The development and evaluation of the data base and classification system for independent teaching hospitals will be supported by Methodist Hospital of Indiana. (See attached letter from Dr. Frank P. Lloyd, President and Chief Executive Officer in the Appendix.) The involvement in the project of two of the principal investigators, Stephen Jay, M.D., and Edward Hackman, Ph.D., as well as a systems analyst and secretary/data clerk will be underwritten by Methodist Hospital of Indiana.

Also the following members of the newly formed Consortium of Independent Teaching Hospitals have agreed to participate in the design and evaluation of the results of this project:

Allegheny Health Education and Research Corporation
Pittsburgh, PA

Baptist Memorial Hospital
Memphis, TN

Charlotte Memorial Hospital and Medical Center
Charlotte, NC

Cleveland Clinic Foundation
Cleveland, OH

Greenville Hospital System
Greenville, SC

Hartford Hospital
Hartford, CT

Henry Ford Hospital
Detroit, MI

Lenox Hill Hospital
New York, NY

Methodist Hospital of Indiana
Indianapolis, IN

Orlando Regional Medical Center
Orlando, FL

Virginia Mason Hospital
Seattle, WA

William Beaumont Hospital
Royal Oak, MI

Wilmington Medical Center
Wilmington, DE

DISSEMINATION OF RESULTS

The results of the project in the form of group profiles of hospital characteristics will be distributed to all participating hospitals. These hospitals will also be asked to evaluate the usefulness of the data for management purposes.

If the evaluation of the results of the project is positive, a proposal will be made to initiate an annual survey of independent teaching hospitals under the sponsorship of the Consortium of Independent Teaching Hospitals.

ACGME LISTING

NRMP 1982 APPOINTMENT LISTINGS, OCTOBER 1981

NRMP 1982 RESULTS

NRMP 1983 APPOINTMENT LISTINGS, OCTOBER 1982

1/

Allegheny General Hospital
DIRECTOR OF MED. ED.
(Not Identified)
NP: MED. SCH. AFFIL.: L-04112
STAFF PHYSICIANS: 315; BEDS: 726;
ADC: 527; NECR: 16%
SPEC: AN, EM, IM, NM, OBG, OPH,
ORS, OTO, PTH, DR, TR, GS, TS, FLX

ASSOC: Z 1 PITTSBURGH						
ANESTHESIOLOGY C	164831	4	164814	6	5	
INTERNAL MEDICINE I	164810	3	164815	5	1	
INTERNAL MEDICINE C	164816	13	164818	13	12	
INTERNAL MEDICINE S	164856	1	164819	3	1	
NUCLEAR MEDICINE R	164876	2	164823	2	1*	
NUCLEAR MEDICINE S	164823	2	164825	2	2*	
OBSTETRICS-GYNECOLOGY C	164825	2	164831	4	0	
PATHOLOGY C	164842	3	164842	2	1	
RADIOLOGY - DIAGNOSTIC C	164843	1	164843	1	0	
RADIOLOGY-THERAPEUTIC C	164812	3	164856	2	0	
GENERAL SURGERY I	164819	3	164876	2	0	
GENERAL SURGERY C	164814	5				
FLEXIBLE						

ASSOC: Z 1 PITTSBURGH						
ANESTHESIOLOGY C	164831	2				
EMERGENCY MEDICINE C	164833	6				
MEDICINE C-PRELIMINARY	164815	5				
INTERNAL MEDICINE C	164816	15				
OBSTETRICS-GYNECOLOGY C	164823	2				
PATHOLOGY C	164825	1				
RADIOLOGY - DIAGNOSTIC C	164842	1				
RADIOLOGY-THERAPEUTIC C	164843	1				
SURGERY C-PRELIMINARY	164818	3				
GENERAL SURGERY C	164819	3				

2/

Baptist Memorial Hospital
DIRECTOR OF MED. ED.
Richard L. De Saussure, Jr, M.D.
899 Madison Ave
Memphis, TN 38146
CH: MED. SCH. AFFIL.: L-04706
STAFF PHYSICIANS: 1007;
BEDS: 1914; ADC: 1545; NECR: 9%
SPEC: AIM, IM, NS, NM, OBG, ORS,
PTH, PS, DR, GS, U, FLX

ASSOC: Y 2 TENNESSEE						
INTERNAL MEDICINE I	169410	16	169414	16	16*	
INTERNAL MEDICINE C	169425	5	169415	3	3*	
PATHOLOGY C	169442	4	169416	12	12*	
RADIOLOGY - DIAGNOSTIC C	169414	16	169425	5	4	
FLEXIBLE			169442	1	0	

ASSOC: Y 2 TENNESSEE						
MEDICINE C-PRELIMINARY	169415	2				
INTERNAL MEDICINE C	169416	14				
PATHOLOGY C	169425	5				
RADIOLOGY - DIAGNOSTIC C	169442	4				
TRANSITIONAL	169414	16				

3/

Charlotte Memorial Hospital and Medical Center
DIRECTOR OF MED. ED.
Bryant L. Galusha, M.D.
Box 32681
Charlotte, NC 28232
HDA: MED. SCH. AFFIL.: M-03601
STAFF PHYSICIANS: 623; BEDS: 901;
ADC: 622; NECR: 32%
SPEC: EM, FP, IM, OBG, ORS, PTH,
PD, GS, TS, U

ASSOC: Y 1 NORTH CAROLINA						
FAMILY PRACTICE C	152720	6	152714	2	2*	
INTERNAL MEDICINE C	152716	5	152716	5	5*	
OBSTETRICS-GYNECOLOGY C	152723	4	152719	2	2*	
ORTHOPEDIC SURGERY C	152738	2	152720	6	6*	
PEDIATRICS C	152728	5	152723	4	4*	
GENERAL SURGERY C	152719	2	152728	5	5*	
FLEXIBLE-S, OS	152714	2	152738	2	2*	

ASSOC: Y 1 NORTH CAROLINA						
EMERGENCY MEDICINE C	152733	2				
FAMILY PRACTICE C	152720	6				
INTERNAL MEDICINE C	152716	5				
OBSTETRICS-GYNECOLOGY C	152723	4				
ORTHOPEDIC SURGERY C	152738	2				
PEDIATRICS C	152728	5				
GENERAL SURGERY C	152719	2				

4/

Greenville Hospital System
DIRECTOR OF MED. ED.
Ramond C. Ramage, M.D.
701 Grove Road
Greenville, SC 29605
NP: MED. SCH. AFFIL.: M-04501
STAFF PHYSICIANS: 519; BEDS: 1098;
ADC: 917; NECR: 27%
SPEC: FP, IM, OBG, ORS, PD, GS, FLX

ASSOC: Y 2 SOUTH CAROLINA						
FAMILY PRACTICE C	168320	12	168314	4	4*	
INTERNAL MEDICINE C	168316	6	168316	6	6*	
OBSTETRICS-GYNECOLOGY C	168323	3	168318	4	2*	
ORTHOPEDIC SURGERY C	168338	3	168319	2	2*	
PEDIATRICS C	168328	5	168320	10	7*	
GENERAL SURGERY I	168312	4	168323	2	2*	
GENERAL SURGERY C	168319	2	168328	5	5*	
			168338	2	2*	

ASSOC: Y 2 SOUTH CAROLINA						
FAMILY PRACTICE C	168320	8				
INTERNAL MEDICINE C	168316	6				
OBSTETRICS-GYNECOLOGY C	168323	2				
ORTHOPEDIC SURGERY C	168338	3				
PEDIATRICS C	168328	4				
SURGERY C-PRELIMINARY	168318	1				
GENERAL SURGERY C	168319	2				
TRANSITIONAL	168314	6				

5/

Hartford Hospital
DIRECTOR OF MED. ED.
Donald L. Brown, M.D.
80 Seymour St
Hartford, CT 06115
NP: MED. SCH. AFFIL.: M-00802,
L-03201
STAFF PHYSICIANS: 55; BEDS: 911,
ADC: 806; NECR: 25%
SPEC: AN, FP, IM, NS, N, NM, OBG,
ORS, OTO, PTH, BBK, PD, P, DR, GS,
U, FLX

ASSOC: Y 1 CONNECTICUT						
INTERNAL MEDICINE C	108316	16	108314	11	11*	
OBSTETRICS-GYNECOLOGY C	108323	4	108316	16	16*	
PATHOLOGY C	108325	2	108318	6	6*	
GENERAL SURGERY I	108312	0 R	108319	6	6*	
SURGERY C-PRELIMINARY	108318	2	108323	4	4*	
GENERAL SURGERY C	108319	6				
FLEXIBLE	108314	10 R				

ASSOC: Y 1 CONNECTICUT						
INTERNAL MEDICINE C	108316	16				
OBSTETRICS-GYNECOLOGY C	108323	4				
PATHOLOGY C	108325	3				
GENERAL SURGERY C	108319	14				
TRANSITIONAL	108314	10				

6/

Henry Ford Hospital

DIRECTOR OF MED. ED.

Frank Cox, M.D.
2799 W Grand Blvd
Detroit, MI 48202

NP: MED. SCH. AFFIL.: M-02501

STAFF PHYSICIANS: 411; BEDS: 1049;

ADC: 865; NECR: 27%

SPEC: AIM, CRS, D, EM, IM, NS, OBG,

OPH, ORS, OTO, PTH, PD, P, DR, TR,

GS, U, FLX

ASSOC: Y 1 MICHIGAN, UNIV

INTERNAL MEDICINE C	130016	26			
MEDICINE C-PEDIATRICS	130030	2			
NEUROLOGICAL SURGERY C	130034	2			
OBSTETRICS-GYNECOLOGY C	130023	3			
ORTHOPEDIC SURGERY C	130038	6			
PATHOLOGY C	130025	4			
PEDIATRICS C	130028	6			
PSYCHIATRY C	130041	4			
RADIOLOGY - DIAGNOSTIC C	130042	6			
RADIOLOGY-THERAPEUTIC C	130043	2			
GENERAL SURGERY C	130019	6			
UROLOGY C	130044	2			
FLEXIBLE	130014	23			

130014	22	22*
130016	23	21
130019	6	6*
130023	3	3*
130025	4	0
130028	6	0
130030	2	1
130034	2	2*
130038	6	6*
130041	4	1
130042	6	6*
130043	2	0
130044	2	2*

ASSOC: Y 1 MICHIGAN, UNIV

INTERNAL MEDICINE C	130016	26			
MEDICINE C-PEDIATRICS	130030	2			
NEUROLOGICAL SURGERY C	130034	1			
OBSTETRICS-GYNECOLOGY C	130023	3			
ORTHOPEDIC SURGERY C	130038	6			
PATHOLOGY C	130025	4			
PEDIATRICS C	130028	6			
PSYCHIATRY C	130041	4			
RADIOLOGY - DIAGNOSTIC C	130042	6			
RADIOLOGY-THERAPEUTIC C	130043	2			
GENERAL SURGERY C	130019	6			
UROLOGY C	130044	2			
TRANSITIONAL	130014	23			

7/

Lenox Hill Hospital

DIRECTOR OF MED. ED.

Robert E. McMasters, M.D.
100 E 77th St
New York, NY 10021

NP: MED. SCH. AFFIL.: M-03509,

L-03520

STAFF PHYSICIANS: 705; BEDS: 690;

ADC: 634; NECR: 35%

SPEC: IM, OBG, OPH, ORS, OTO, PTH,

PD, PS, P, DR, GS, U

ASSOC: Y 1 NEW YORK MEDICAL

Z 1 CORNELL					
INTERNAL MEDICINE I	148310	8			
INTERNAL MEDICINE C	148316	16			
OBSTETRICS-GYNECOLOGY C	148323	3			
PEDIATRICS C	148328	5			
RADIOLOGY - DIAGNOSTIC C	148342	4			
GENERAL SURGERY C	148319	12			

148315	9	9*
148316	16	16*
148319	12	12*
148323	3	3*
148325	2	2*
148328	5	4

ASSOC: Y 1 NEW YORK MEDICAL

Z 1 CORNELL					
MEDICINE C-PRELIMINARY	148315	8			
INTERNAL MEDICINE C	148316	16			
OBSTETRICS-GYNECOLOGY C	148323	3			
PEDIATRICS C	148328	5			
RADIOLOGY - DIAGNOSTIC C	148342	2			
GENERAL SURGERY C	148319	12			

8/

Methodist Hospital of Indiana

DIRECTOR OF MED. ED.

Stephen J. Jay, M.D.
1604 N Capital Ave
Indianapolis, IN 46202

CH: MED. SCH. AFFIL.: G-01720

STAFF PHYSICIANS: 768; BEDS: 1075;

ADC: 965; NECR: 26%

SPEC: EM, FP, IM, OBG, ORS, PTH,

PD, DR, NR, GS, U, FLX

ASSOC: Y 1 INDIANA

FAMILY PRACTICE C	118820	8			
INTERNAL MEDICINE C	118816	6			
OBSTETRICS-GYNECOLOGY C	118823	3			
PATHOLOGY C	118825	2			
PEDIATRICS C	118828	6			
RADIOLOGY - DIAGNOSTIC C	118842	3			
GENERAL SURGERY I	118812	4			
GENERAL SURGERY C	118819	2			
FLEXIBLE-B MED	118813	4			

118813	4	4*
118814	9	9*
118816	6	6*
118818	4	3
118819	2	2*
118820	8	8*
118823	3	3*
118825	2	2*
118828	6	3
118828	2	2*

ASSOC: Y 2 INDIANA

EMERGENCY MEDICINE C	118833	4			
FAMILY PRACTICE C	118820	8			
INTERNAL MEDICINE C	118816	6			
OBSTETRICS-GYNECOLOGY C	118823	3			
PATHOLOGY C	118825	2			
PEDIATRICS C	118828	5			
RADIOLOGY - DIAGNOSTIC C	118842	3			
SURGERY C-PRELIMINARY	118818	4			
GENERAL SURGERY C	118819	2			
TRANSITIONAL	118814	9			

9/

Orlando Regional Medical Center

DIRECTOR OF MED. ED.

Samuel E. Crockett, M.D.
1414 S Kuhl Ave
Orlando, FL 32806

NP: MED. SCH. AFFIL.: L-01103

STAFF PHYSICIANS: 467; BEDS: 1004;

ADC: 711; NECR: 30%

SPEC: IM, OBG, ORS, PTH, PD, GS

ASSOC: Z 2 FLORIDA

INTERNAL MEDICINE C	110716	6			
OBSTETRICS-GYNECOLOGY C	110723	3			
PEDIATRICS C	110728	4			
GENERAL SURGERY C	110719	4			

110716	6	3
110719	5	1
110723	3	3*
110728	4	0

ASSOC: Z 1 FLORIDA

INTERNAL MEDICINE C	110716	6			
OBSTETRICS-GYNECOLOGY C	110723	3			
PEDIATRICS C	110728	4			
GENERAL SURGERY C	110719	5			

10/

Virginia Mason Hospital

DIRECTOR OF MED. ED.

James J. Coalsworth, M.D.
925 Seneca
Seattle, WA 98101

NP: MED. SCH. AFFIL.: L-05404

STAFF PHYSICIANS: 256; BEDS: 321;

ADC: 245; NECR: 34%

SPEC: AN, IM, O, OTO, DR, TR, GS,

U, FLX

ASSOC: Z 2 WASHINGTON, UNIV

ANESTHESIOLOGY C	175631	2			
INTERNAL MEDICINE I	175610	5			
INTERNAL MEDICINE C	175616	7			
RADIOLOGY - DIAGNOSTIC C	175642	1			
GENERAL SURGERY I	175612	1	R		
GENERAL SURGERY C	175619	3			
FLEXIBLE	175614	5	R		

175614	6	6*
175615	3	3*
175616	6	6*
175618	2	2*
175619	2	2*
175631	1	1*
175642	1	1*

ASSOC: Z 2 WASHINGTON, UNIV

ANESTHESIOLOGY C	175631	2			
MEDICINE C-PRELIMINARY	175615	4			
INTERNAL MEDICINE C	175616	7			
RADIOLOGY - DIAGNOSTIC C	175642	1			
SURGERY C-PRELIMINARY	175618	2			
GENERAL SURGERY C	175619	3			
TRANSITIONAL	175614	5	R		

11/

• William Beaumont Hospital

DIRECTOR OF MED. ED.

Gary Welsh, M.D.
3601 W 13 Mile Rd
Royal Oak, MI 48072NP: MED. SCH. AFFIL.: M-02507,
L-02512STAFF PHYSICIANS: 630. BEDS: 926.
ADC: 800; NECR: 18%SPEC: CRS, IM, NM, OBG, OPH, ORS.
PTH, BBK, PD, PS, DR, NR, TR, GS, U,
FLX

ASSOC: Y 2 WAYNE							
+ INTERNAL MEDICINE I	197810	3	R	197814	12	12*	
INTERNAL MEDICINE C	197816	15		197815	13	0	
NUCLEAR MEDICINE C	197836	4		197816	5	5	
OBSTETRICS-GYNECOLOGY C	197823	5		197818	3	3*	
ORTHOPEDIC SURGERY C	197838	2		197819	3	3*	
PATHOLOGY C	197825	3		197823	4	4*	
+ PEDIATRICS C	197828	3		197825	3	0	
RADIOLOGY - DIAGNOSTIC C	197842	5		197828	4	2	
RADIOLOGY - DIAGNOSTIC S	197862	5		197838	2	2*	
RADIOLOGY-THERAPEUTIC C	197843	3		197842	3	3*	
GENERAL SURGERY I	197812	3	K				
GENERAL SURGERY C	197819	4					
UROLOGY C	197844	1					
FLEXIBLE	197814	14					

- 3 -

ASSOC: Y 2 WAYNE							
MEDICINE C-PRELIMINARY	197815	3					
+ INTERNAL MEDICINE C	197816	15					
MEDICINE C-PEDIATRICS	197830	4					
NUCLEAR MEDICINE C	197836	4					
OBSTETRICS-GYNECOLOGY C	197823	5					
ORTHOPEDIC SURGERY C	197838	2					
PATHOLOGY C	197825	3					
+ PEDIATRICS C	197828	4					
RADIOLOGY - DIAGNOSTIC C	197842	7					
RADIOLOGY-THERAPEUTIC C	197843	2					
SURGERY C-PRELIMINARY	197818	3					
GENERAL SURGERY C	197819	4					
UROLOGY C	197844	1					

12/

• Wilmington Medical Center

DIRECTOR OF MED. ED.

E Wayne Martz, M.D.
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NP: MED. SCH. AFFIL.: M-04102

STAFF PHYSICIANS: 625. BEDS: 1057.
ADC: 891; NECR: 28%SPEC: EM, FP, IM, NS, N, OBG, OPH,
PD, PS, DR, GS, TS, FLX

ASSOC: Y 1 JEFFERSON							
FAMILY PRACTICE C	109920	6		109913	6	4	
INTERNAL MEDICINE I	109910	2		109914	4	4*	
INTERNAL MEDICINE C	109916	9		109915	2	0	
OBSTETRICS-GYNECOLOGY C	109923	4		109916	8	8*	
PEDIATRICS C	109928	5		109918	4	4*	
RADIOLOGY - DIAGNOSTIC C	109942	2		109919	3	3*	
GENERAL SURGERY I	109912	4		109920	6	6*	
GENERAL SURGERY C	109919	3		109923	4	4*	
FLEXIBLE	109914	6		109928	5	0	
				109942	2	0	

ASSOC: Y 1 JEFFERSON							
EMERGENCY MEDICINE C	109933	6					
FAMILY PRACTICE C	109920	6					
MEDICINE C-PRELIMINARY	109915	2					
INTERNAL MEDICINE C	109916	9					
OBSTETRICS-GYNECOLOGY C	109923	4					
PEDIATRICS C	109928	5					
RADIOLOGY - DIAGNOSTIC C	109942	2					
SURGERY C-PRELIMINARY	109918	4					
GENERAL SURGERY C	109919	3					
TRANSITIONAL	109914	4					

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