aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

April 20-21, 1983
Washington Hilton Hotel

WEDNESDAY, April 20, 1983

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Dupont Room
7:30pm	COTH ADMINISTRATIVE BOARD RECEPTION Edison Room
8:30pm	COTH ADMINISTRATIVE BOARD DINNER Dupont Room

THURSDAY, April 21, 1983

9:00am	COTH ADMINISTRATIVE BOARD MEETING Farragut Room
1:00pm	JOINT ADMINISTRATIVE BOARDS LUNCHEON Map Room
2:00pm	EXECUTIVE COUNCIL BUSINESS MEETING Caucus Room

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

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

April 21, 1983
Washington Hilton Hotel
9:00am-1:00pm

XI.	MCAT Related Projects	Executive Council Agenda - page 37
XII.	Loan Forgiveness for Physicians in Research Careers	Executive Council Agenda - page 41
XIII.	Discussion Items	
	1. Trends in Graduate Medical Education Positions	Executive Council Agenda - page 51
	2. Status of Indirect Costs	Executive Council Agenda - page 58
	3. Legislation	
XIV.	Other Business	
XV.	Adjournment	

Association of American Medical Colleges
COTH Administrative Board Meeting
January 20, 1983

PRESENT

Mark S. Levitan, Chairman
Earl J. Frederick, Chairman-Elect
Mitchell T. Rabkin, MD, Immediate Past Chairman
James W. Bartlett, MD, Secretary
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Irwin Goldberg
Sheldon S. King
Glenn R. Mitchell
David A. Reed
Haynes Rice
John V. Sheehan
C. Thomas Smith
William T. Robinson, AHA Representative

GUESTS

Robert M. Heyssel, MD
John A. Reinertsen
Peter Roberts
Richard S. Wilbur, MD

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Charles Fentress, Jr.
Melinda Hatton
Joseph C. Isaacs
Richard M. Knapp, PhD
Nancy E. Seline
John F. Sherman, PhD
Emanuel Suter, MD
Melissa H. Wubbold

I. Call to Order

Mr. Levitan called the meeting to order at 9:00am in the Farragut Room of the Washington Hilton Hotel. He introduced the three new Board members: Glenn R. Mitchell, President, Alliance Health Systems, Norfolk, Virginia; David A. Reed, President, Samaritan Health Services, Phoenix, Arizona; and Tom Smith, President, Yale-New Haven Hospital, New Haven, Connecticut. He asked each of them to take a few minutes to describe briefly their career patterns and the institutions that they serve.

Mr. Levitan then indicated that he planned to resign as Chairman of the Council of Teaching Hospitals effective at the end of the day's Executive Council meeting. He indicated that he had asked last year's Nominating Committee, chaired by Stuart Marylander, to be responsible for recommending an individual to serve as Chairman-Elect when Earl Frederick takes the Chair. Mr. Marylander had agreed to do so and Mitch Rabkin, MD, a member of that Committee, will be prepared to read Stuart's letter on behalf of the Nominating Committee as the final item on the morning's agenda.

On behalf of the staff, particularly Joe Isaacs, he thanked those who had submitted comments on the Medicare conditions of participation. The staff had received more comments than was expected and is very appreciative. There were no other items that anyone wished to add to the agenda.

II. Consideration of the Minutes

Mr. Rice called attention to the fact that he should be recorded as present at the November 8, 1982 Administrative Board Meeting.

ACTION: It was moved, seconded, and carried to approve the minutes of the September 9 and November 8, 1982 Administrative Board Meetings.

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 the ST. VINCENT HOSPITAL AND HEALTH CARE CENTER for full membership.

IV. COTH Spring Meeting

Tom Smith, Chairman of the 1983 COTH Spring Meeting Planning Committee, reminded Board members that the meeting is to be held with registration on the evening of Wednesday, May 11 and adjourning at 12:30pm on Friday May 13, at the Fairmont Hotel in New Orleans. Other members of the Committee are Daniel Cooney, Veterans Administration Medical Center, Minneapolis; Gordon Derzon, University of Wisconsin Hospital, Madison; William Gonzalez, University of California Medical Center, Irvine; and James Mongan, MD, Truman Medical Center, Kansas City, Missouri. The Committee met on November 23 in Chicago and planned the program which was distributed and appears as Appendix A to the minutes of this meeting. All speakers have been contacted and have agreed to speak. It was noted that a dinner and speaker have not been scheduled on Wednesday evening. Mr. Smith reported that this had been done so that individuals could arrive late and get a full day in the office if they chose to do so. If such a change in scheduling appears to affect attendance, this can be corrected in 1984. A strong effort was made to put an emphasis on local and state events and to use COTH constituents as speakers to the greatest extent possible. The program and registration materials will be in the mail no later than February 15 and the hotel has been visited and reported to be in an excellent position to accommodate the needs of the meeting.

V. Report of the AAMC Officers' Retreat

Mr. Levitan described and highlighted the report of the AAMC Officers' Retreat which appeared on page 24 of the Executive Council Agenda.

VI. Commonwealth Fund Grant Proposal

Dr. Heyssel informed the Board that the Commonwealth Fund has established a $5 million grants program aimed at assisting teaching hospitals/academic health centers in areas where technical assistance is most needed. He suggested that these areas could include university governance and its impacts on hospital management, financial management data needs, marketing strategies, management information systems, or facility and strategic planning. Furthermore, he explained, grant funds could be used to support studies and to explode some myths such as all teaching hospitals being tertiary, research, and major referral centers.

Dr. Heyssel indicated that he chairs the project's Steering Committee, which includes Jerry Grossman, Harold Hines, Ginny Weldon and Eli Ginsburg as well as others. Its first meeting is scheduled for March 4, with the intention of putting the grant

program in place by summer. Dr. Heyssel asked the Board for advice with respect to what approaches should be taken to the granting of funds and what are the teaching hospital/academic health center issues most in need of addressing. He explained that this was an information item on the agenda to alert the Board of the program's existence. He asked that Board members contact him directly with specific ideas and suggestions.

VII. Prospective Payment Proposals for Hospitals

Dr. Bentley opened the discussion by reviewing Secretary Schweiker's prospective payment proposal and outlining the present characteristics of the American Hospital Association's proposal. After extensive discussion of both proposals and the specific needs and pricing problems of major teaching hospitals, the Board took the following actions:

ACTION(S): 1. It was recommended that the AAMC advocate a prospective payment system based on a hospital's own base year costs with full recognition of changes in case mix, as an alternative to the HHS proposal;

2. It was agreed to continue supporting the principles underlying the original American Hospital Association proposal while the AHA continues to develop a per case payment system based on a hospital's own historical costs and adjusting for changes in case mix;

3. It was agreed to evaluate prospective payment criteria using the following criteria:

   - o fully recognize the impact of the hospital's approved scope of services, its patient case mix, and the intensity of care required on operating costs,
   - o recognize regional differences in the costs of goods and services purchased by hospitals,
   - o calculate operating costs on a "going concern" basis with full recognition of hospital capital requirements,
   - o recognize physician costs for personal medical services and for medical program supervision and administration,

- o recognize costs resulting from manpower training programs which are accredited by an appropriate organization. Costs recognized should include those for educational instruction and supervision, student stipends where provided, program support and institutional overhead, and the decreased productivity accompanying training in the hospital setting,

- o recognize the costs associated with clinical research to bring advances in biomedical knowledge to the improvement of medical care, and

- o recognize increased costs accompanying the use of new diagnostic and treatment technologies;

4. It was voted eight to three to add an additional prospective payment criteria which would permit hospitals to charge patients for the differences between a prospectively determined price and the posted charges for the services used by an individual patient;

5. It was recommended that Association testimony on the Administration's proposal advocate, (1) federal payment of uncollectible deductibles and copayments incurred by Medicare patients, (2) "pass through" payment for Part A physician services costs, and (3), by a seven to five vote, removal of administrative expenses for the Administration's per case payment methodology; and

6. It was recommended that the Association make a strong and vigorous effort to replace the payment limits of TEFRA with a prospective payment system based on an individual hospital's costs (first preference) or a modified version of the Administration's proposal.

VIII. Report of the Committee on Future Directions for the American Hospital Association

Mr. Robinson reviewed this agenda item for the Board and began by noting that an AHA committee recently completed an assessment of the Association's future directions, the first such look since 1972, under John Stagl's leadership group. The AHA is seeking input on the committee report, prior to eventual presentation to its House of Delegates for action in August at the Association's Annual

Convention in Houston. Mr. Robinson explained that the committee addressed three general areas of interest: (1) dues, (2) membership, and (3) structure.

Regarding future dues, the committee recommended that AHA dues for individual institutions be calculated on the basis of net patient revenue (rather than expenses as at present), with a minimum dues level for individual institutions (there is none at present) and no maximum dues level for multi-institutional systems (there is a maximum currently). Basic to all its proposals was agreement by the committee that the individual hospital (and not systems, networks or associations of hospitals, or non-hospital facilities) should be the unit of institutional membership in the AHA. In addition, the committee held that dues should cover representation and advocacy, basic membership services, convening of members for policy development and governance activity, and further unity in the field.

Mr. Robinson explained that the AHA's current structure was considered adequate with moderate tinkering of the House of Delegates. Hospital constituency sections would be established as categories of institutional membership for hospitals sharing common interests, functions or concerns such as small and rural, community, urban, public-general, federal, or teaching hospitals. Individual hospitals would select membership in one constituency section, based on criteria for membership in that section. Each section would elect a governing council which would nominate individuals to the House of Delegates to fill 50 new seats, based on the ratio of the particular group's size to the total membership. The perspectives of these constituency groups would rise through the Regional Advisory Boards (RAB). State Associations in Region 9 (California) have already expressed opposition to this approach, claiming that they should be the sole voice for their area constituents.

Mr. Rice was concerned that leaving a hospital with the decision to choose its appropriate constituency group may lead to undesired inequities. Dr. Dalston saw the constituent group labels themselves as potentially troublesome. Mr. Robinson emphasized that these labels were created specifically to establish definite lines of input from such segments as the teaching hospital group which had no such direct say previously. Dr. Bartlett noted that just as Mr. Robinson sits on the COTH Board, the AHA's teaching hospital constituency group must have direct representation from COTH. Both will need to be informed with the other, he emphasized.

This was discussed by the Board as an information item. Therefore, no specific action was taken. Appearing as Appendix B to these minutes is a letter on this subject from Dr. Cooper to Dr. Drake.

IX. Career Preparation for Leadership in Teaching Hospitals

At the September Administrative Board meeting, Dr. Dalston raised the question of what can be done to ensure that future leaders of teaching hospitals have adequate knowledge and preparation to assume such leadership roles. After a brief discussion at that meeting, the Board asked Dr. Dalston to prepare a discussion paper detailing his perception of the problem and possible actions for COTH and the AAMC as a whole. The discussion paper was presented at the January meeting.

Dr. Dalston described three career path models - medical, business, and health services - that lead to leadership positions in teaching hospitals. He stated that each of these models left teaching hospital leaders inadequately prepared in some of the eight areas of essential skills and knowledge, which he identified as finance, general management, medical practice, medical education, political processes, the health care setting, information systems, and university affairs. Dr. Dalston suggested that COTH members are the ones who know the most about these subjects, and thus, should participate in developing programs to prepare future teaching hospital leaders.

He described a three-stage process during which this training of future leaders would occur. The first stage was university graduate education leading to a master's degree in administration. This was intended to give a foundation in administration. The second stage was post-graduate clinical practicums including administrative residencies and fellowships. Stage three was continuing career education, which is intended to offer the opportunity to update knowledge and skills and to acquire new skills:

Dr. Dalston recommended that COTH:

- Support changes in the Management Advancement Program (MAP) to make it more relevant to teaching hospital administration;
- Contribute ideas to the American College of Hospital Administrators' Task Force presently studying career preparation; and
- Influence and support current and future programs and organizations attemping to provide this training.

During the discussion following Dr. Dalston's presentation, Mr. King expressed concern that there is no way to appropriately identify early in their careers the candidates for future teaching hospital leadership positions. Acknowledging Mr. King's point, Dr. Foreman expressed a desire to support programs that help broaden the knowledge of midlevel managers to help them assume more expanded roles in managing the hospital. Dr. Dalston stressed the need to

ensure that future leaders are even better prepared than present ones.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council support activities to develop future teaching hospital leaders, including the refined MAP and the ACHA task force.

X. Undergraduate Medical Education Preparation for Improved Geriatric Care - A Guideline for Curriculum Assessment

Dr. John Sherman joined the Administrative Board and highlighted the background and future of Association activities in geriatrics and medical education, as set forth on page 35 of the AAMC Executive Council Agenda book. He also described the guideline for curriculum assessment that had been developed over the life of the geriatric project. Dr. Bartlett suggested that it may be appropriate to survey teaching hospitals concerning their activities in the long term care area and at the same time surveying the medical schools to determine what new initiatives are taking place in this area of geriatric medicine.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council accept and approve the guideline for curriculum assessment for publication and distribution.

XI. A Proposed Sliding Scale of Grant Awards for Biomedical Research

Dr. Sherman described a proposal that has been supported by some individuals in the reserarch community and referred to as a "sliding scale." Those who support the idea suggest that the competition for NIH grants is so intense that investigators spend an inordinate amount of time writing and re-writing proposals and reviewing proposals which, although they are considered meritorious, are not funded. A sliding scale would provide 100% funding to proposals with top priority scores. Other proposals with respectable priority scores would receive partial funding. The supporters of this effort envision that about half of the study section approved applications would be eligible for this formula-based partial funding. There are a variety of disadvantages to this approach which were then discussed, including the following:

- The investigator who receives only partial funding would be likely to seek local support to make up the difference;
- The question then can be asked as to whether or not those proposals which are funded at the 100% level could go forward at some lower amount of dollar funding;

- o Such a procedure would invite much tampering with the funding of research proposals at various levels;

- o Such a proposal would put the administration in an even stronger position to lower funding and still support a similar or higher number of competing grants.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board recommend that the AAMC Executive Council formally oppose the establishment of a sliding scale principle to grant awards for biomedical research.

XII. Compensating Research Subjects

Dr. Sherman reported on the current status of the longstanding issue of compensating research subjects and the notice that public omments are invited on the subject as reflected in the report of the President's Commission for the Study of Ethical Problems in Medical and Biomedical and Behavioral Research. Dr. Sherman reviewed a draft letter which appears as Appendix C to the minutes of this meeting.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council approve the letter appearing as Appendix C to these minutes.

XIII. Future of the AAMC's Management Education Programs

Dr. Knapp referred the Board to the brief description of the proposed changes in the AAMC's Management Advance Program (MAP) on page 91 of the Executive Council Agenda. He asked the Board to reaffirm that continuing education is important and to act on the recommendations of the AAMC's ad hoc committee.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board recommend the AAMC Executive Council adopt the recommendations of the ad hoc committee which are:

- o that the AAMC governance assert responsibility for this activity and adopt as one of the primary missions of the AAMC the continuing administrative education of its members; and

- o that an advisory committee, similar in constitution to the ad hoc group, but with a representative of the faculty (CAS), be appointed as an AAMC committee charged with advising on the planning and initiation of new efforts.

XIV. AAMC Role in Providing Constituent Service Programs

At the September 9, 1982 Executive Council Meeting it was recommended:

- o AAMC staff should be requested to assess the access of teaching hospitals and medical schools to currently operating group purchasing activities for major capital equipment; and

- o AAMC staff should examine what group services are needed by teaching hospitals and medical schools. The staff was then directed to take these recommendations to the AAMC Officers' Retreat in December for further review.

At the AAMC Officers' Retreat it was agreed that with the growth and potential of a whole range of group purchasing services, it would be unwise for the AAMC to develop such a program. In addition, it was agreed that such a program for medical schools is not warranted based on any expression of interest thus far.

With respect to the second recommendation, there was extensive discussion at the Retreat of the fact that in some respects multihospital systems are taking on association functions and objectives, and some associations are assuming essentially service functions of multihospital systems. It was recognized that these hospital systems as well as other organizations will be competitors for the time, effort and loyalty of AAMC hospital constituents. Thus far excellent communication and participation by leaders of these organizations in the activities and programs of the AAMC have served the AAMC well in this regard. At the same time, it was agreed that the AAMC should not engage in service programs as a method of competing with these other organizations. Service programs should be developed only if there is a clearly expressed constituent desire for them, and only then if the service is a unique one or one which the AAMC is uniquely qualified to provide. After brief discussion, the following action was taken.

ACTION: It was moved, seconded, and carried to recommend that the AAMC staff should monitor constituent service needs and be alert to changing relationships of members of newly developing organizations or consortia to the AAMC. No formal service program should be initiated at this time.

XV. ACCME Essentials and Guidelines

Dr. Emanuel Suter, Director, Division of Educational Resources and Programs, presented the ACCME guidelines. He indicated that the original intent of the ACCME was to develop a set of guidelines as a companion to the Essentials, to interpret in greater detail the meaning of the Essentials and to provide examples of how the Essentials could be implemented at different institutions and organizations. He indicated that while more meaningful guidelines would be desirable, it seemed more urgent to have guidelines

that are acceptable to all than to delay the implementation of the Essentials until more substantial guidelines are improved.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council approve the guidelines as a companion to the Essentials as presented.

XVI. ACCME Protocol for Recognizing State Medical Societies as Accreditors of Local CME

Dr. Suter presented the protocol that had been developed by a special subcommittee composed of representatives from the state societies in the ACCME and which was reviewed and amended by an open conference attended by individuals involved in the state accreditation process. He indicated the protocol appears to have a number of weaknesses which make it questionable that the ACCME has authority over a nationally recognized state accreditation process. In response to a question he indicated that rejection or disapproval of the proposed protocol would not at this time result in a great deal of change or result in substantial disruption of continuing medical education programs.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council disapprove the proposed "protocol" and encourage the ACCME to negotiate a process which will establish some degree of accountability.

XVII. Information Item: Development of a Data Base and a Classification System for Independent Teaching Hospitals

Dr. Knapp explained that the matter was placed on the agenda to be sure that all Board members were well aware of this activity should some question arise about it. He indicated that he had called two individuals who are members of the newly formed Consortium of Independent Teaching Hospitals to be sure that the staff of the Department of Teaching Hospitals is not overlooking something which needs special attention, or engaging in an activity not favored by individuals who represent this set of thirteen institutions. Conversations with Mr. Anderson at Lenox Hill Hospital in New York and Dr. Brown of Hartford Hospital indicated that this was not the case.

XVIII. Nominating Committee Report

Dr. Rabkin reminded the group that the Committee was chaired by Mr. Marylander and that he and Mr. Jim Ensign were the other

members of the Committee. The Committee recommended that Haynes Rice, Hospital Director, Howard University Hospital, be elected to the position of COTH Chairman-Elect to fill the position created when Mr. Frederick assumes the Chair upon Mr. Levitan's resignation. The Committee also recommended that the vacancy created by Mr. Rice being removed from his Board term to the position of Chairman-Elect remain vacant and no recommendation for this position be made by the 1983 Nominating Committee. Dr. Rabkin moved that the report of the Nominating Committee be accepted. Such a motion was made and seconded. There being no further nominations from the Board, Mr. Rice was elected by acclamation.

At this time Mr. Frederick expressed on behalf of the Board its thanks for Mr. Levitan's contributions over the past three and a half years as a Board member, as an officer and as a leader in in the development of the case mix research project which has been underway for the last two years. On behalf of the Board he expressed his best wishes to Mr. Levitan as he takes on his new responsibilities later this Spring.

XIX. Adjournment

There being no further business, the meeting was adjourned at 12:50pm.

Draft Program Outline Appendix A

1983 COTH SPRING MEETING

WEDNESDAY, May 11

6:00 - 8:00pm — REGISTRATION

THURSDAY, May 12

7:30 - 8:45am — REGISTRATION AND CONTINENTAL BREAKFAST

8:45 - 11:00am — MORNING SESSION - Presiding

Earl J. Frederick
President
Children's Memorial Hospital
Chicago, IL

"California Medicaid - Social Institutions Confront Economic Limits"

William A. Guy
State Medi-Cal Negotiator
Office of Special Health Care Negotiations
Governor's Office
State of California

Paul D. Ward
President
California Hospital Association
Sacramento, CA

William H. Gurtner
Executive Vice President
Mt. Zion Hospital and Medical Center
San Francisco, CA

11:00am - 12:15pm — Local and State Developments in Payment Systems: Implications for Teaching Hospitals

"Commonwealth Health Care Corporation: A Case Management Approach for Medicaid Patients"

Rina Spence
Executive Director
Commonwealth Health Care Corporation
Boston, MA

THURSDAY, May 12 continued...

"A Hospital-Sponsored Preferred Provider Program"

Gary Brukardt
Vice President
Affiliated Corporations
Presbyterian-St. Luke's Health Care Corporation
Denver, CO

12:30 - 1:30pm — LUNCH

1:45 - 3:30pm — AFTERNOON SESSION - Presiding

Mitchell T. Rabkin, MD
President
Beth Israel Hospital
Boston, MA

Local and State Developments continued..

"The Hospital Experimental Payment Program: The Strong Memorial Hospital Experience"

Gennaro J. Vasile, PhD
Executive Director
Strong Memorial Hospital
Rochester, NY

"Trading Dollars for Volume: The North Carolina Medicaid Approach"

Eric B. Munson
Executive Director
The North Carolina Memorial Hospital
Chapel Hill, NC

"Arizona's Medicaid Alternative: Combining Capitation and Competitive Bidding"

David A. Reed
President
Samaritan Health Service
Phoenix, AZ

3:30 - 4:00pm — COFFEE BREAK

4:00 - 5:00pm — "Consumer Behavior Under Alternative Insurance Arrangements"

Joseph P. Newhouse, PhD
Head, Economics Department
The Rand Corporation
Santa Monica, CA

THURSDAY, May 12 continued...

5:30 - 7:30pm — COCKTAILS AND HORS D'OEUVRES AND NEW ORLEANS DIXIELAND ENTERTAINMENT

FRIDAY, May 13

7:30 - 8:15am — CONTINENTAL BREAKFAST

8:15 - 9:00am — MORNING SESSION - Presiding
Haynes Rice
Hospital Director
Howard University
Hospital
Washington, DC

"Teaching Hospital Responsibilities for Long Term Care and Geriatric Medicine"

John F. Sherman, PhD
Vice President
Association of American
Medical Colleges
Washington, DC

Carl Eisdorfer, MD, PhD
President
Montefiore Hospital and
Medical Center
Bronx, NY

9:00 - 11:15am — Managing the Medical Enterprise

"Altering Residents' Use of Resources

John M. Eisenberg, MD
Chairman, General Medicine
University of Pennsylvania
School of Medicine
Philadelphia, PA

"Involving the Admitting Physicians: New Roles and Relationships Under Per Admission Payment Systems"

o A University Hospital Experience

J. Richard Gaintner, MD
Vice President and Deputy Director
The Johns Hopkins Hospital
Baltimore, MD

FRIDAY, May 13 continued...

o A Community Teaching Hospital Experience

Warren Nestler, MD
Vice President/Director for Quality Assurance
Overlook Hospital
Summit, NJ

11:15am - 12:30pm "Financing Graduate Medical Education: Update on a National Study"

Richard F. Tompkins, EdD
Manager
Arthur Young & Company
Washington, DC

12:30pm ADJOURN

association of american medical colleges

JOHN A. D. COOPER, M.D., PH.D.
PRESIDENT

202: 828-0460

February 15, 1983

David F. Drake, Ph.D.
Group Vice President and
Secretary Treasurer
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Dave:

As you know, Bill Robinson recently reviewed the draft "Report of the Committee on Future Directions of the American Hospital Association" with our Council of Teaching Hospitals' Administrative Board. It was generally acknowledged as a thorough evaluation.

I understand the need to ensure that the perspectives of the various constituent hospital groups within AHA are heard in your House of Delegates. However, the recommendation on page 24 to establish a teaching hospital constituency center is of concern. The currently established constituency centers have staff members assigned to them, develop educational programs and plan other activities related to the particular center. It would be counterproductive to develop a center in this fashion which would be competitive with our COTH and AAMC Department of Teaching Hospitals.

Our relationships with the American Hospital Association have been excellent. We've engaged in a number of joint activities and educational programs, and shared positions on many legislative and executive branch issues. Where necessary we have provided the focal point for those issues which arise from the unique features and problems of teaching hospitals. I do not believe the formation of a teaching hospital constituency center would be in the best interest of our relationship in the future.

I hope you will keep this point of view in mind as your discussion and deliberations move ahead.

Sincerely,

John

John A. D. Cooper, M.D.

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

D R A F T - 1/18/83 J. Keyes

Carol Young
Office for Protection of Research Risk
National Institutes of Health
5333 Westard Avenue
Room 3A18
Bethesda, MD 20205

Dear Ms. Young:

The Association of American Medical Colleges is pleased to respond to the notice of report for public comment on the Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research entitled, "Compensating Research Subjects" (Federal Register , November 23, 1982). As the Commission noted, the Association has engaged in extensive consultations on this subject with representatives of other educational associations and the insurance industry since early 1979. We are pleased to observe that the Commission's Report gave serious consideration to the issues we identified in our letter to Secretary Califano dated June 25, 1979 and reiterated to Chairman Abram in our letter of May 7, 1980. While the Commission concludes that many of these issues cannot be definitively resolved at this time, it has given serious study to most of them and suggests that a definitive resolution can be reached only through a "modest social policy experiment" which would determine "the need and feasibility of comprehensive programs to compensate injured subjects."

The AAMC is identified in the report as having argued for "instituting such a compensation system on a pilot basis limited by time, by relevant data on the basis of real experience." As a preliminary matter, we enter a mild demurrer to the suggestion that we argued for such an experiment. In the context of our previous communication, such a suggestion was offered as a possible alternative to a mandated program of comprehensive scope and national reach which we regarded

as premature. We consider a pilot program preferable to proceeding on the basis of untested assumptions. Neither then nor now, however, do we "argue for" such a program as of sufficient national priority in its own right to recommend that the Secretary should choose to implement it in preference to addressing other pressing matters.

While we continue to assent to the proposition that research subjects should not be left without adequate treatment for any adverse medical consequences of their participation in research, nor suffer personal financial devastation from their public spirited action, we are not yet persuaded that either of these outcomes is a current reality or a reasonable projection of the current system for conducting biomedical research. The issue appears to arise from a highly theoretical conception of a potential problem, not from a convincing demonstration of an unmet need.

Nor are we persuaded that the severe definitional problems which remain can be adequately resolved through such an experiment. We have remained in close contact with the Division of Medicine and Surgery of the Veterans Administration which has undertaken an agency-wide effort to gather the empirical data on the number of research subjects and the incidents of injury resulting from research which it sponsors. It is our understanding that the definitional problems encountered proved insurmountable and have led to the at least temporary abandonment of the project by the Veterans Administration. We believe that this experience justifies a high degree of skepticism regarding the feasibility of the experiment which the Commission proposes.

Notwithstanding our skepticism for a need of such an undertaking and our caution that definitional problems may prove to be recalcitrant , we assure you of our continued interest in this matter which is of substantial significance to our members. It is our desire to remain an active participant in any future

deliberations should there be a decision to explore the feasibility of the experiment recommended by the Commission.

Sincerely,

John A. D. Cooper, M.D.

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: The Germantown Hospital and Medical Center

Hospital Address: (Street) One Penn Boulevard

(City) Philadelphia (State) Pennsylvania (Zip) 19144

(Area Code)/Telephone Number: (215) 951-8000

Name of Hospital's Chief Executive Officer: Mr. Joseph F. Farrell

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year) ended: 6/30/82

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	282	Admissions:	8,597
Average Daily Census:	218	Visits: Emergency Room:	25,210
Total Live Births:	361	Visits: Outpatient or Clinic:	50,101

B. Financial Data

Total Operating Expenses: $ 35,951,812.

Total Payroll Expenses: $ 21,092,255.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 720,000.
Supervising Faculty: $ 50,000.

C. Staffing Data

Number of Personnel: Full-Time: 808
Part-Time: 266

Number of Physicians:

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

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

None

Does the hospital have a full-time salaried Director of Medical Education?: None

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	12	12	Required
Surgery	5	5	Required
Ob-Gyn			
Pediatrics			
Family Practice	5	5	Required
Psychiatry			
Other: Renal	2	2	Elective
Emergency Medicine	2	2	Required

*Students rotate from Temple University Medicine

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine	10	10		*
Surgery	4	4		*
Ob-Gyn	3	3		*
Pediatrics				
Family Practice				
Psychiatry				
Other:				
Radiology	4	2	2	1952
Pathology	1	1		**
Orthopaedic Surgery	2	2		***
Radiology	1-2	1-2		*

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

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

*Through alliliation with Temple University School of Medicine
**Through affiliation with The Medical College of Pennsylvania
***Through affiliation with The Hospital of the University of Pennsylvania

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.

*See Attachment I

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: Temple University School of Medicine

Dean of Affiliated Medical School: Leo M. Henikoff, M.D.

Information Submitted by: (Name) Mr. J. Donald Caccia

(Title) Vice President

Signature of Hospital's Chief Executive Officer:

J. D. Caccia (Date) 1/28/83

The Germantown Hospital and Medical Center
ONE PENN BOULEVARD ■ PHILADELPHIA, PENNSYLVANIA 19144

ATTACHMENT #1

January 5, 1983

SUPPLEMENT TO THE COUNCIL OF TEACHING HOSPITALS APPLICATION

Item IV

Since 1874 when the first "resident doctor" came to The Germantown Hospital, this institution has been actively and intimately involved in the education of medical practitioners. The role of the Hospital as an educational institution has, of necessity, changed over the years to meet the varying needs of the physicians in training, the Hospital's desire to intergrate both patient care and educational activities and the perceptions of the community at large concerning medical education. Training programs have run a full course from the late 1800's through the 1980's, from freestanding "residency" programs prior to the advent of the various specialty boards, through freestanding fully approved residency programs, to the extensive training programs through affiliations with medical schools and universities. Some brief highlights of this rich history and tradition will serve to demonstrate the Hospital's past and continuing commitment to the education and training of young physicians.

In 1874 two positions were created at The Germantown Hospital for "resident physicians." In this context, the physicians were "residents" since their responsibility was for inpatient care in the Hospital. These two physicians, under the direction of a medical director, served a sort of "apprenticeship" in medicine and following a two year period, were eligible for their licensing examination.

In 1895 these "resident physician" posts became more and more popular and at the turn of the century, the Hospital's requirements for a "resident physician" included that he pass his State Licensing Examination before appointment at the Hospital. Also, at this time, the "residency" was formalized as a distinct educational unit at The Germantown Hospital. Throughout subsequent years, the number of resident physicians increased until, in 1918, six such positions existed at the Hospital and at this time the name was officially changed from "resident physician" to "intern." In light of the changing medical climate and following an inspection of its educational program by the State Bureau of Medical Licensure, the Hospital created two new positions, "Chief Resident - Medicine" and "Chief Resident - Surgery." These Chief Resident Physicians would be available to supervise the training and care rendered by the interns which now numbered nine. This change, reflecting the specialization of educational programs at the time, proved to be successful in maintaining the popularity of the Hospital's training programs.

It was not until 1936 that the Hospital's educational efforts took another significant step forward. At that time, the Hospital employed its first true resident physician, i.e., a licensed medical doctor entering a clearly defined program of postgraduate study in a particular disease speciality. This first resident was in the area of pulmonary disease and through the efforts of his supervising physician, the true era of postgraduate residency programs was begun at the Hospital. By the start of World War II, The Germantown Hospital and Medical Center could boast fully approved residency training programs in Surgery, Internal Medicine, Obstetrics and Gynecology, Pathology, and Pulmonary Disease.

Immediately following the end of the war, 1946, the Hospital moved further adding two residency programs, Radiology and Pediatrics, fully approved and intergrated into its educational efforts. There were, then, freestanding postgraduate residency training programs in six specialties and one subspeciality.

In the early 1950's the Hospital reached its zenith of freestanding residency programs with seven, Urology being added by 1953. The medical education climate, however, was changing. In early 1949, the Hospital entered into an affiliation agreement with the Jefferson Medical College for the training of undergraduate medical students. Affiliation agreements with medical schools would prove to be the wave of the future for the involvement of community hospitals, such as Germantown, in both undergraduate and graduate medical education.

The Hospital continued with its freestanding residency programs through the 1950's and 1960's and it was not until the 1970's that formal affiliation with the Medical School of Temple University, the Hospital of the University of Pennsylvania, the Medical College of Pennsylvania that the Hospital's affiliated residency programs came into being. At the present time, through the major affiliation with Temple University, the Hospital provides postgraduate residency training in Internal Medicine, Surgery, Obstetrics and Gynecology, as well as undergraduate training for third and fourth year medical students. The affiliation agreement with the Hospital of the University of Pennsylvania provides residency training in Orthopaedic Surgery. The affiliation with the Medical College of Pennsylvania provides postgraduate training in Pathology. The Hospital continues to operate a freestanding residency program in Diagnostic Radiology.

The attached copy of the Hospital's 1980 Annual Report may provide further insight into the Hospital's commitment and interest in postgraduate medical education.

TEMPLE UNIVERSITY
OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION
SCHOOL OF MEDICINE
TU-556-00
3400 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19140

LEO M. HENIKOFF, M.D.
Dean & Vice President
for Medical Affairs

January 24, 1983

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

Dear Dr. Knapp:

I am writing in support of membership on the Council of Teaching Hospitals of the AAMC for the Germantown Hospital and Medical Center in Philadelphia. Germantown has been a major teaching affiliate of Temple University School of Medicine over a long period of time. Currently the medical residency program is integrated, and students from our third and fourth year as well as other residents from Temple University Hospital rotate through the Germantown Hospital and Medical Center. The Department of Family Practice at Temple is responsible for operation of the outpatient clinics at Germantown which serve as a basis for clinical activities of our Institute on Aging as well.

These relationships are such that Germantown Hospital and Medical Center has a major commitment to the educational process and is truly a teaching institution that should properly be a member of the Council of Teaching Hospitals of the Association of American Medical Colleges. If I can be of further assistance in this process please let me know.

Best wishes in the new year.

Yours truly,

Leo M. Henikoff, M.D.

LMH/pb

bcc: Hugh Maker
Joseph Farrell

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: LATROBE AREA HOSPITAL

Hospital Address: (Street) West Second Avenue

(City) Latrobe (State) Pennsylvania (Zip) 15650

(Area Code)/Telephone Number: (412) 537-1000

Name of Hospital's Chief Executive Officer: Douglas A. Clark

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	316	Admissions:	13636
Average Daily Census:	280	Visits: Emergency Room:	37466
Total Live Births:	1100	Visits: Outpatient or Clinic:	56826

B. Financial Data

Total Operating Expenses: $ 37,749,758

Total Payroll Expenses: $ 21,934,848

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 279,000
Supervising Faculty: $ 387,000

C. Staffing Data

Number of Personnel: Full-Time: 8
Part-Time: 1

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 99
With Medical School Faculty Appointments: _____

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

Fam. Practice	Radiology		
Emergency	Anesthesia		

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			
Surgery			
Ob-Gyn			
Pediatrics			
Family Practice	6 Junior 3 Senior	48 Junior 29 Senior	Required
Psychiatry			
Other: _____			

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine				
Surgery				
Ob-Gyn				
Pediatrics				
Family Practice	12	10	2	1974
Psychiatry				
Other:				

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: Jefferson Medical College

Dean of Affiliated Medical School: Leah M. Lowenstein, M.D.

Information Submitted by: (Name) Douglas A. Clark

(Title) Executive Director

Signature of Hospital's Chief Executive Officer:

Douglas A. Clark (Date) 3/21/83

In affiliation with the Thomas Jefferson University Medical School our academic endeavors are in Family Medicine. We have both an undergraduate program and a graduate program. Our undergraduate program consists of a mandatory six week rotation in the junior year in which we receive six students in each rotation. The senior rotation is elective and we have been receiving three to four students every four to six weeks. Our postgraduate program consists of a three year residency in Family Medicine which consists of four residents in each year. Our first graduating class was in 1977 and we have graduated nineteen thus far. Our commitment to these endeavors have been extensive: 1. the establishing and maintaining of four offices, 2. the hiring of six full time and three part time faculty, 3. the establishment of a visiting monthly professor program to supplement and expand the areas of medicine in which we are lacking or deficient. Our administration and board of directors reinforced by the benefits of improved quality of medical care in our hospital, the placement of 55% of our graduates in our immediate area, and the increased notoriety because of press coverage and word of mouth concerning our post-graduate educational programs are totally committed to sustain and possibly expand this educational endeavor.

JEFFERSON MEDICAL COLLEGE
of
THOMAS JEFFERSON UNIVERSITY

Offices of the Dean

Philadelphia, 19107
(215) 928-6980

February 16, 1983

American Council of Teaching Hospitals
Washington, DC

To Whom It May Concern:

I am writing to support the Latrobe Area Hospital's application for associate membership in the American Council of Teaching Hospitals.

Since December 1973, Latrobe Area Hospital has been an active affiliate teaching hospital of the Jefferson Medical College of Thomas Jefferson University. Throughout each academic year, they accept undergraduate students for clinical clerkships, and they sponsor an affiliate community-university hospital family practice residency. Their contribution to Jefferson's teaching program is invaluable, and it is for this reason that I wholeheartedly endorse their application. I am sure that their associate membership will enhance their knowledge of the teaching hospital's role, and, in turn, that will improve their teaching contribution.

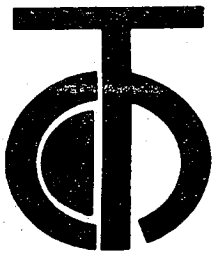
Thank you for your consideration.

Sincerely,

Joseph S. Gonnella

Joseph S. Gonnella, M.D.
Acting Dean

jm



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Lubbock General Hospital

Hospital Address: (Street) 603 Indiana - P. O. Box 5780

(City) Lubbock (State) Texas (Zip) 79417

(Area Code)/Telephone Number: (806) 743-3313

Name of Hospital's Chief Executive Officer: Jake Henry, Jr.

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 273

Average Daily Census: 168.1

Total Live Births: 2159

Admissions: 9313

Visits: Emergency Room: 14,417

Visits: Outpatient or Clinic: N/A

B. Financial Data

Total Operating Expenses: $27,567,130 (unaudited)

Total Payroll Expenses: $12,659,396 (Unaudited)

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 480,000 (unaudited)
Supervising Faculty: $ -0-

C. Staffing Data

Number of Personnel: Full-Time: 666
Part-Time: 131

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 226
With Medical School Faculty Appointments: 226

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

Surgery	Family Medicine	Orthopedics	OB/GYN
Ophthalmology	Dermatology	Radiology	Pathology
Internal Med.	Pediatrics	Neurosciences	Psychiatry
Anesthesiology	Preventive Medicine		

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships**	Are Clerkships Elective or Required
Medicine	7 (12 wks.)	37	Required
Surgery	7 (12 wks.)	37	Required
Ob-Gyn	11 (8 wks.)	37	Required
Pediatrics	11 (8 wks.)	37	Required
Family Practice	11 (4 wks.)	37	Required
Psychiatry	11 (8 wks.)	37	Required
Other: Family Med. Preceptorship	16 (4 wks.)	37	Required

*Clinical Education Curriculum is 2 years in length.

**In addition, there are 25-30 Senior students in elective clerkships.

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	0	0	0	-
Medicine	21	15	1	1979
Surgery	16	12	0	1978
Ob-Gyn	12	10	0	1978
Pediatrics	18	0	13	1978
Family Practice	30	23	0	1973
Psychiatry	12	3	1	1982
Other: Anes.	18	9	4	1978
Dermatology	6	3	0	1978
Ophthalmology	9	9	0	1976
Orthopedic Surgery	10	10	0	1976
Preventive Medicine	4	0	1	1979

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: Texas Tech University Health Sciences Center

Dean of Affiliated Medical School: J. Ted Hartman, M.D.

A letter of recommendation from J. Ted Hartman, M.D. , Dean of Texas Tech University Health Sciences Center was mailed to you on December 17, 1982. A copy of this letter is attached.

Information Submitted by: (Name) Jake Henry, Jr.

(Title) Executive Director

Signature of Hospital's Chief Executive Officer: Jake Henry, Jr. (Date) Feb 10, 1983

IV. Supplementary Information

Lubbock General Hospital is a 273 bed, acute secondary and tertiary care facility located in Lubbock, Texas. It serves as the primary teaching hospital for the Texas Tech University Health Sciences Center School of Medicine. In this capacity, Lubbock General Hospital serves as the primary clinical training facility for approximately 400 medical students and 115 resident physicians. The Hospital participates in residency training programs in the areas of Orthopedic Surgery, Internal Medicine, Anesthesiology, Surgery, Pediatrics, Obstetrics and Gynecology, Ophthalmology, Family Practice, Psychiatry, Dermatology and Preventive Medicine.

Lubbock General Hospital also serves as the primary clinical facility for the Texas Tech University Health Sciences Center School of Nursing. A number of School of Nursing faculty members hold joint positions with the Hospital as clinical staff members. In addition, the Hospital recently opened a 36 bed medicine unit which will serve as a model practice unit for the school.

Lastly, it is anticipated that Lubbock General Hospital will become a major clinical site for the Health Sciences Center newly created School of Allied Health. Initially, the School of Allied Health will focus on programs in Occupational and Physical Therapy and the Hospital is already actively involved in the development of these programs.

From the perspective of services, Lubbock General Hospital serves as a tertiary care facility for a large portion of West Texas and Eastern New Mexico. Included in the geographically unique services offered by Lubbock General Hospital is a 28 bed Level III Neonatal Intensive Care Unit, a high risk obstectrics unit, and a 6 bed regional burn intensive care unit. In addition to this, the Hospital operates the Emergency Medical Services system for Lubbock County and serves as the coordinating center for all Emergency Medical Services programs within the HSA-2 region.

Texas Tech University Health Sciences Center
SCHOOL OF MEDICINE/Office of the Dean
Lubbock, Texas 79430/(806) 743-3000

December 17, 1982

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

Dear Dr. Knapp:

This letter is to support the application of the Lubbock General Hospital at Lubbock for membership in the Council of Teaching Hospitals.

The Lubbock General Hospital is our primary teaching hospital in Lubbock for Texas Tech University School of Medicine. We are housed in the same building complex and the Hospital was designed from its inception to be the Medical School's primary hospital resource. The Hospital is staffed totally by faculty of the School of Medicine, both full-time and clinical. There is a formal, as well as informal, relationship between the Vice President of the Health Sciences Centers and myself to the Executive Director of the Hospital and the Board of Managers. There is also a working relationship between the Board of Regents of the School of Medicine and Board of Managers of the Hospital. Our teaching program is dependent upon our relationship and I, therefore, heartily endorse the application.

Sincerely yours,

J. T. Hartman, M.D.
Dean

JTH:jg
xc: Jake Henry

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: THE METHODIST HOSPITAL

Hospital Address: (Street) 6565 Fannin

(City) Houston (State) Texas (Zip) 77030

(Area Code)/Telephone Number: (713) 790-3311

Name of Hospital's Chief Executive Officer: A. Frank Smith, Jr. (Acting)

Title of Hospital's Chief Executive Officer: Acting President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	1218	Admissions:	42,943
Average Daily Census:	979	Visits: Emergency Room:	19,666
Total Live Births:	2745	Visits: Outpatient or Clinic:	24,537

B. Financial Data

Total Operating Expenses: $ 184,723,274

Total Payroll Expenses: $ 109,624,958

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 3,368,573
Supervising Faculty: $ - 0 -

C. Staffing Data

Number of Personnel: Full-Time: 4612
Part-Time: 1027

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 701
With Medical School Faculty Appointments: 701

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

Does the hospital have a full-time salaried Director of Medical Education?: No (Medical College has full-time salaried Director responsible for coordinating all affiliated hospital graduate medical education programs.)

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	N/A	178	Required
Surgery	N/A	169	Required
Ob-Gyn	N/A	185	Required
Pediatrics	N/A	183	Required
Family Practice	--	--	--
Psychiatry	N/A	169	Required
Other: Amb. Medicine	N/A	158	Required
See attached			
electives	N/A	N/A	Elective

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads *	Positions Filled by Foreign Medical Graduates *	Date of Initial Accreditation of the Program[2]
First Year Flexible	1			
Medicine	51	94%	6%	9-55
Surgery	17	100%	0%	9-58
Ob-Gyn	4	96%	4%	8-60
Pediatrics	3	95%	5%	10-58
Family Practice	0			
Psychiatry	5	84%	16%	4-62
Other: Anesthesiology	6	76%	24%	4-59
Dermatology	1.5	100%	0%	10-57
Neurology	7	92%	8%	6-58
Otorhinolaryngology	4	100%	0%	12-58
Ophthalmology	5	100%	0%	9-55
Pathology	9	80%	20%	9-55

(SEE ATTACHED)

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

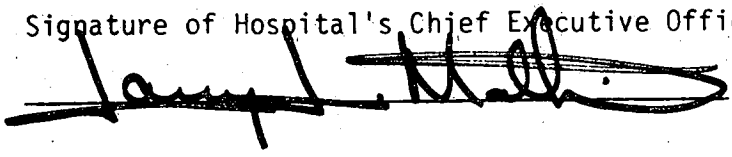
Name of Affiliated Medical School: Baylor College of Medicine

Dean of Affiliated Medical School: William T. Butler, M.D.

Information Submitted by: (Name) Mark A. Wallace

(Title) Vice President

Signature of Hospital's Chief Executive Officer:



(Date) _____

B. GRADUATE MEDICAL EDUCATION (continued)

Physical Medicine	2	50%	50%	8-51
Radiology	2	90%	10%	9-55
Thoracic Surgery	2	83%	17%	9-56
Neurosurgery	9	92%	8%	9-55
Orthopedic Surgery	7	100%	0%	9-55
Plastic Surgery	2	87%	13%	7-62
Urology	2	100%	0%	9-56
Flexible Residents	1	100%	0%	9-82

Baylor College of Medicine
OFFICE OF THE PRESIDENT • 713 790-4400

February 17, 1983

John A. D. Cooper, M.D., Ph.D.
President
Association of American Medical
Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

Re: Application for Membership to the Council of Teaching Hospitals
by The Methodist Hospital, Houston, Texas

It's a pleasure to recommend The Methodist Hospital for membership in the Association of American Medical Colleges' Council of Teaching Hospitals. The Methodist Hospital is the Baylor College of Medicine's principal private hospital affiliation. Our relationship which spans 33 years has several main features:

- Under the terms of our affiliation agreement, the Chairmen of our clinical departments are chiefs of service in The Methodist Hospital.
- For staff privileges in The Methodist Hospital, a Baylor faculty appointment is required.
- Five of our Board members are also members of The Methodist Hospital Board.
- We own jointly a $35-Million building which houses the departments of Neurology, Ophthalmology, Neurosurgery, and Otorhinolaryngology. This building combines teaching, research, and patient care space--155 beds with appropriate operating rooms,etc.
- We also own jointly the Alkek Tower which houses the Cardiovascular Research Center.

TEXAS MEDICAL CENTER • HOUSTON, TEXAS 77030

- Members of Baylor faculty and administration serve on many key Methodist Hospital committees including the current search committee for a new chief executive officer.

I take great pleasure in recommending acceptance of The Methodist Hospital for membership to the Council of Teaching Hospitals.

With personal regards,

William T. Butler, M.D.
President

WTB:ag

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

Consortium
~~Hospital~~ Name: Tulsa Medical Education Foundation, Inc.

~~Hospital~~ Address: (Street) 2808 South Sheridan Road

(City) Tulsa (State) Oklahoma (Zip) 74129

(Area Code)/Telephone Number: (918) 838-3464

Consortium
Name of ~~Hospital~~'s Chief Executive Officer: C. S. Lewis, Jr., M.D.

Consortium
Title of ~~Hospital~~'s Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	2,616	Admissions:	89,605
Average Daily Census:	1,942	Visits: Emergency Room:	111,167
Total Live Births:	9,451	Visits: Outpatient or Clinic:	184,270

B. Financial Data

Total Operating Expenses: $297,481,002

Total Payroll Expenses: $101,706,435

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 3,124,097
Supervising Faculty: $ 2,387,601

C. Staffing Data

Number of Personnel: Full-Time: 7,760
Part-Time: 1,227

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 1036*
With Medical School Faculty Appointments: 580

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

Psychiatry, Pediatrics, Genetics, Perinatology, Nutrition, Infertility/In Vitro, Fetal/Maternal, Pathology, Physical Medicine, Emergency Medicine, Radiology,

Does the consortium have a full-time salaried Director of Medical Education?: no

*This number is not accurate due to some physicians who are staff members at more than one hospital.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	40	40	required
Surgery	40	40	required
Ob-Gyn	40	40	required
Pediatrics	40	40	required
Family Practice	40	40	required (OPC)
Psychiatry	40	40	required
Other: Medicine OPC	40	40	required
Pediatric OPC	40	40	required
Medical/Surgical Subspecialties	374	113	required

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	0	0	0	
Medicine	40	37	1	July 1968
Surgery	15	15	0	March 1948
Ob-Gyn	16	15	0	September 1958
Pediatrics	24	12	6	October 1958
Family Practice	48	42	4	September 1974
Psychiatry	8	5	0	February 1980
Other: none				

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

A. When returning the completed application, please enclose a copy of the hospital's current medical school affiliation agreement.

B. A letter of recommendation from the dean of the affiliated medical school must accompany the completed membership application. The letter should clearly outline the role and importance of the applicant hospital in the school's educational programs.

Name of Affiliated Medical School: University of Oklahoma Tulsa Medical College

Dean of Affiliated Medical School: Edward J. Tomsovic, M.D., Dean

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Information Submitted by: (Name) Jene' Busch

(Title) Administrative Assistant

Signature of ~~Hospital~~ Consortium's Chief Executive Officer:

_____ (Date) 2-7-85

C. S. Lewis, Jr., M.D.

The University of Oklahoma
Health Sciences Center

TULSA MEDICAL COLLEGE
Office of the Dean

February 7, 1983

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

Dear Doctor Knapp:

This letter is in support of the request of the Tulsa Medical Education Foundation, Inc., to become a corresponding member of the Council of Teaching Hospitals.

The Tulsa Medical Education Foundation is a consortium of hospitals which have associated themselves with the University of Oklahoma Tulsa Medical College to achieve mutual educational objectives. The hospitals provide access to medical students and residents of this community-based medical school. They also participate directly in the funding of residency training programs, ambulatory teaching centers and other academic enterprises. Each hospital plays a particular role in offering certain types of educational experiences and all are essential to the College's smooth functioning.

The consortium would like to enjoy the benefits of membership in the Association of American Medical Colleges. The information which the AAMC makes available to its members will be very beneficial in planning for and adjusting to the changing economic and regulatory climate for hospitals and medical schools.

I recommend this request receive favorable consideration.

Sincerely,

Edward J. Tomsovic

Edward J. Tomsovic, M.D.
Dean

EJT:jb

2808 South Sheridan Road oma 74129 (918) 838-3464

AAMC ANNUAL MEETING
COTH GENERAL SESSION THEMES

1972	EXTERNAL FISCAL CONTROLS ON THE TEACHING HOSPITAL
1973	THE ECONOMIC STABILIZATION PROGRAM AND OTHER HEALTH INDUSTRY CONTROLS
1974	NEW MANAGEMENT AND GOVERNANCE RESPONSIBILITIES FOR TEACHING HOSPITALS
1975	RECENT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM: IMPLICATIONS FOR THE TEACHING HOSPITAL
1976	CLINICAL CASE MIX DETERMINANTS OF HOSPITAL COSTS
1977	PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR CONTROLLING THE DEMAND FOR HOSPITAL SERVICES
1978	MULTIPLE HOSPITAL SYSTEMS AND THE TEACHING HOSPITAL
1979	CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT
1980	THE HIGH COST PATIENT: IMPLICATIONS FOR PUBLIC POLICY AND THE TEACHING HOSPITAL
1981	IMPLEMENTING COMPETITION IN A REGULATED HEALTH CARE SYSTEM
1982	HEALTH CARE COALITIONS: TRUSTEES IN A NEW ROLE OR BUSINESS AS USUAL?

The staff would appreciate some discussion and guidance in selecting a topic and speaker(s) for the COTH portion of the November, 1983 AAMC Annual Meeting.

COTH SPRING MEETINGS

1978 - 1984

1978	St. Louis, Missouri
1979	Kansas City, Missouri
1980	Denver, Colorado
1981	Atlanta, Georgia
1982	Boston, Massachusetts
1983	New Orleans, Louisiana
1984	Baltimore, Maryland

The staff recommends that consideration be given to the following four cities for the 1985 COTH SPRING MEETING:

Chicago

Dallas

Los Angeles

San Francisco

DEPARTMENT OF TEACHING HOSPITALS
ACTIVITIES AND INITIATIVES

During the past three years, the Department has focused particular emphasis on the issues of diagnostic case mix and hospital payment methods. Five publications have resulted from this effort:

- o Describing and Paying Hospitals: Developments in Patient Case Mix, May, 1980
- o The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report, December, 1981
- o The Disease Staging Case Mix of a Sample of Teaching Hospitals: A Technical Report, February, 1982
- o Selected Data for a Small Sample of Teaching Hospitals, October, 1982
- o A Description of Teaching Hospital Characteristics, December, 1982

Attention to the subject area will remain high, data gathering and publication efforts will not be pursued with the same intensity.

The Department continues to develop and publish the COTH Report, COTH Directory of Educational Programs and Services, Executive Salary Survey, Housestaff Stipends, Benefits and Funding Survey, and the Survey of University Owned Teaching Hospitals' Financial and General Operating Data. Plans are underway to expaned the "university-owned" hospital survey.

The time is appropriate for a review of the Department's project activities. It would be helpful if the Board would review and discuss the following items as possible departmental initiatives.

1. Workshop on Case Mix Payment

The Medicare payment limits established under TEFRA and the payments proposed under prospective pricing both are determined on a per case basis. For hospitals to prosper under per case payments, new management structures and techniques combining administrative and clinical decisions must be developed. This is particularly true for teaching hospitals because of their role in high cost patient care, the large number of physicians and residents involved in clinical decision making, and the relatively high use of ancillaries. The following workshops could be developed.

A. Physician Education Seminars

Physicians practicing in these hospitals must understand the significance of per case payment and the change in financial incentives it incorporates. From informal discussions, it appears that few faculty physicians appreciate either the practice management or service planning implications of per case payments. To increase physician awareness, the AAMC could arrange and conduct a series of workshops for clinical chairmen and chiefs of service. Such seminars, held on a medical specialty or geographic area basis, would summarize new payment arrangements, demonstrate the need to have case-specific information systems to assess hospital financial impacts, discuss alternatives developing to portray the financial implications of physician practice patterns, and describe newly developing arrangements for managing the medical activity of the hospital. By organizing the seminars through the AAMC, it would be hoped that physicians could understand the changes and their implications without developing an adversarial "look what my hospital is doing to me" attitude.

B. Hospital Team Seminars

Across the COTH membership, hospitals are at different levels of sophistication and readiness for adapting to a per case payment system. To assist members needing to make significant changes, the AAMC could conduct a series of seminars in which members with sophisticated per case management information systems would describe their system and its uses to other members. The seminar could begin by describing why case specific information systems are necessary to understand the implications of per case payment. Specific systems at selected hospitals could then be described along with a review of the steps necessary to implement the system. Finally, hospitals with case-specific information systems would describe how the system is used for operational control, budgeting, and strategic planning. Hospitals participating in the seminars would be encouraged to send teams representing at least medical records, financial management, and general administration.

C. New System Workshops

A relatively small number of COTH members have developed case specific information systems allowing the analysis of clinical and financial data on a product line basis. Many of these systems are being developed independently of one another. To stimulate a cross-fertilization of ideas and findings among

these members, the AAMC would convene quarterly two-day meetings allowing hospitals to present their systems to each other, share findings, and discuss new uses for the information. If the systems begin to converge on one or more key ideas, these dominant ideas would be summarized and distributed to the membership.

2. Teaching the Financial Performance of Teaching Hospitals

New payment systems involving contracting, discounting, and per case payments are rapidly being implemented. The impact of these payment systems on teaching hospitals is an area which has not received systematic attention. To monitor these changes and compare different subgroups within the COTH membership, the AAMC could sponsor all of its non-federal members in the Financial Analysis Service (FAS) of the Healthcare Financial Management Association for a five year period. FAS uses audited financial statements to compute and display 29 standard financial ratios. A five year time series, 1982-1986, would permit comparisons among COTH subgroups (university-owned, primary affiliate, affiliated) and between COTH members and nonteaching hospitals.

3. Medical Education Costs in Teaching Hospitals

In May, 1980 the Department of Teaching Hospitals published the annotated bibliography on medical education costs in teaching hospitals which appears as a separate enclosure with this agenda material. The question of what useful contributions remain to be made in this area is a matter which requires attention.

- Should additional studies of the impact of medical education costs on teaching hospitals be encouraged?
- What specific questions should be pursued?
- Are there ways of making better use of the work that has already been completed?
- The current AAMC position is that graduate medical education is a legitimate patient care cost. With increasing price/cost competition, is a new examination of this issue in order?

4. Comparative Hospital Data

Increasingly, executives in COTH hospitals are interested in comparative data which could be used to assess their hospital's performance. When questioned about participation in the AHA's Monitrend, most callers say its usefulness is limited by inconsistent data collection and reporting practices. To assist COTH member hospitals, at least three options are available.

A. Improving Monitrend Comparability

If the basic Monitrend reports are useful to the membership but the weakness is the data, AAMC staff could establish a joint project with AHA staff and participating COTH hospitals to help obtain more uniform input data. This could be supplemented by meetings of COTH subscribers where hospitals could explain atypical organizational and financial characteristics that underlie data differences. In addition, and dependeing upon member interest, Monitrend staff might be willing to develop special reports and comparison groups (university-owned, primary affiliate, affiliated) for COTH members.

B. Expanding the Yale-New Haven Hospital Study

Yale-New Haven Hospital is presently undertaking its second collection and analysis of case mix data in university-owned and primary affiliated hospitals. The first study assisted Yale-New Haven in a presentation to the Connecticut cost commission and provided participating hospitals with comparative data on length of stay by DRG. The current study uses the new DRG's and additional cost information from the hospitals. Depending upon Yale-New Haven's interests, the AAMC could assist the hospital in establishing a center to gather and analyze comparative financial, operational, and utilization data for university-owned and primary affiliated hospitals.

C. Commercial Teaching Hospital Database

If a sufficient number of COTH members were interested and willing, the AAMC could form a joint venture with a commercial data processor to create and maintain uniform database information on teaching hospitals. Data included could be organized at the specific patient level, the operational departments, or both.

5. Technology Assessment Clearinghouse

As COTH members introduce new technologies and services (e.g., NMR, PET scanners, bone marrow transplants), the hospital often prepares an internal report for adopting and/or planning the change. The AAMC could establish a clearinghouse on new projects/services which member hospitals could share. If sufficient interest exists, the clearinghouse could be expanded to include evaluation/assessment reports prepared by member hospitals for new services.

6. Insurance Access

As new payment and delivery arrangements develop, price sensitive

insurers may be reluctant to provide beneficiaries with access to high cost teaching hospitals. The AAMC could identify services generally requiring care in major teaching hospitals, develop a directory of member hospitals performing minimum service thresholds in a specific service, and allow insurers to use a registered service mark on policies providing coverage for specialized services in teaching hospitals listed in the directory.

7. Impacts of Clinical Research on Hospitals

In the recent AAMC report on 33 COTH hospitals and in the report describing teaching hospitals, no adequate information on research activity in teaching hospitals was found. As a result, it is difficult to describe the impacts of research on teaching hospitals. As both research agencies and third party payers face more constrained budgets, they may dispute which expenses should be paid by research or patient care dollars. The AAMC is in no position at this time to provide either general data on the cost impacts of research or methodologies individual hospitals could use to estimate research-related costs. A project to develop measures of research activity and methods for estimating their cost impacts could be developed.