AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

November 7, 1983
Washington Hilton Hotel
Chevy Chase Room
7:00am-9:00am

I.	Call to Order	
II.	Consideration of the Minutes	Page 1
III.	Membership Application	
	The Toledo Hospital Toledo, Ohio	Page 10
IV.	Relationships with the American Hospital Association	Mr. Kerr Page 17
V.	COTH Spring Meeting	Mr. Mitchell Page 35
VI.	Survey of Capital Financing Needs of Teaching Hospitals	Dr. Bentley
VII.	New Challanges for the Council of Teaching Hospitals and the Department of Teaching Hospitals	Attached*
VIII.	Commonwealth Fund Executive Nurse Leadership Program	Page 36
IX.	Report of the COTH Nominating Committee	Dr. Rabkin
X.	Adjournment	

* Separate enclosure

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
September 22, 1983

PRESENT

Earl J. Frederick, Chairman
Haynes Rice, 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
John V. Sheehan
C. Thomas Smith
William T. Robinson, AHA Representative

ABSENT

David A. Reed

GUESTS

Robert M. Heyssel, MD

STAFF

David Baime
James D. Bentley, PhD
Jeralyn Bernier
John A. D. Cooper, MD
Joseph C. Isaacs
Thomas J. Kennedy, Jr., MD
Richard M. Knapp, PhD
Nancy E. Seline
John F. Sherman, PhD
Kathleen S. Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MEETING
September 21-22, 1983

I. CALL TO ORDER

Mr. Frederick called the meeting to order at 6:30pm in the Farragut Room of the Washington Hilton Hotel. Before moving to the agenda, he asked if there were any announcements. Dr. Knapp took the opportunity to introduce Jeralyn Bernier who has completed the third year of a combined BA/MD program at Brown University. She joined the staff of the Department of Teaching Hospitals on September 6, and will be on the staff until mid-January. She hopes to gain a better understanding of teaching hospitals and the academic medical center environment prior to embarking on the MD portion of the combined seven year program.

II. NEW CHALLENGES FOR THE COUNCIL OF TEACHING HOSPITALS AND THE DEPARTMENT OF TEACHING HOSPITALS

At its June meeting, the COTH Administrative Board concluded its general discussion which focused on the future of the Council of Teaching Hospitals by requesting staff to prepare a discussion paper on this topic. Across the summer, AAMC staff prepared the requested paper and distributed it to the Board with the September agenda. After opening the Wednesday evening session, Mr. Frederick asked Board members to react critically to the paper "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." When the Board reconvened on Thursday morning, members continued their discussion of the paper.

In general, Board members were pleased with the draft and found it addressed most major issues and concerns facing COTH; however, a number of criticial issues were repeatedly raised:

- Inadequate attention was paid to the growing unwillingness of all payers to subsidize care for uninsured patients;
- The discussion of advocacy activities was focused on legislative and regulatory matters and should be expanded to include working with other organizations and advising consultants. In this regard, the matter of how the staff spends its time needs to be clarified. A more appropriate distinction between information and advocacy needs to be made;
- the paper understated the COTH/AAMC role and membership benefit and portrayed staff in a supportive rather than a leadership role; and
- More attention should be given to the non-economic interests that draw members together rather than the economic ones that place them in competition.

A number of other points were made by individual Board members:

- Two individuals questioned the conclusion that the economic interests (the kind of economic interests being addressed by VHA or Sun Alliance) are outside the scope of what COTH/AAMC should address;
- The role of trustees in the organization was raised;

- Perhaps a discussion of "who the ideal membership is" would be useful;

- It was asked whether COTH has a mission outside of bringing the hospital perspective to the AAMC;

- A note of "resignation" is apparent in the paper -- "they got us, we've got to change";

- All hospitals will want or need a national corporate headquarters -- can COTH play this role for some of its members?

- In some circles we're viewed as a deans' organization. We're called the Association of American Medical Colleges and deans manage medical schools. Some attention should be given to the possibility of a name change for the AAMC;

- The matter of technology assessment, and the COTH/AAMC role in it is not addressed in the paper.

In addition, the Board reached the consensus on a number of the issues raised in the paper.

- COTH and the AAMC should focus activities on the common elements of mission, purpose, and program scope which draw its members together. This focus will clearly serve the needs of core teaching hospitals and their CEO'S. For hospitals not closely affiliated with medical schools, it may be reasonable to expect less COTH/AAMC involvement and a number of membersip resignations. However, what is offered to this group of hospitals, and what role they find in the COTH/AAMC should be carefully reviewed;

- The two major policy issues requiring the most attention and increased emphasis are the financing of both charity care and graduate medical education under price oriented payment systems;

- The matter of more intensive educational programming for senior hospital executives and clinical faculty should be further developed in the paper.

It was agreed that the paper should be revised for review at the November Board meeting, discussed at the December Officers' Retreat and reviewed once again at the January Board meeting. The purpose of this final review would be to determine what form the paper should take so that it can be sent to the membership, discussed by various teaching hospital organizations (both formal and informal) and finally serve as a discussion paper at the COTH Spring Meeting on Friday morning, May 18.

III. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded and carried to approve the minutes of the June 30, 1983 COTH Administrative Board Meeting.

IV. COTH MEMBERSHIP

A. Investor-Owned Hospital Participation as a COTH Member

Dr. Knapp recalled that at its meeting on June 30, the Board had requested that legal counsel be asked to review the issue of having tax paying hospitals as members of a 501 (C)(3) association. A letter dated September 7 was included in the agenda for review. Essentially the letter stated that if the AAMC does wish to consider including in its membership proprietary institutions (other than as affiliated non-voting "contributors" receiving no material benefits), a ruling from the Internal Revenue Service should be sought in advance of any change. There was a consensus that the letter adequately addressed the issue and there was agreement that no further action be taken until an application by an investor-owned hospital is received.

B. COTH Membership Criteria

Since there was substantial discussion of the objectives of the Department of Teaching Hospitals and the question of which institutions are the primary beneficiaries of the Council of Teaching Hospitals in the paper entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals," it was decided that it would be unwise to recommend that the Executive Council take any action on the COTH membership criteria.

ACTION: It was moved, seconded and carried to recommend that the AAMC Executive Council defer action on the COTH membership criteria until such time as a more definitive statement of policy with respect to the goals and objectives of the AAMC for its teaching hospital membership is clarified.

C. Membership Applications

CHILDREN'S HOSPITAL in New Orleans was deferred and the staff was requested to gain further information.

ACTION: It was moved, seconded and carried to approve

(1) METHODIST HOSPITAL, Memphis, Tennessee for full membership;

(2) METROPOLITAN HOSPITAL CENTER, New York, New York for full membership;

(3) ORLANDO REGIONAL MEDICAL CENTER, Orlando, Florida for full membership;

(4) PITT COUNTY MEMORIAL HOSPITAL, Greenville, North Carolina for full membership;

(5) SOUTHERN NEVADA MEMORIAL HOSPITAL, Las Vegas, Nevada for corresponding membership.

V. MEDICAL CENTER OFFICIALS IN THE AAMC

Before moving directly to the item as presented in the agenda, the Chairman asked Mr. Rice if he would report on a meeting with representatives of the Association of Academic Health Centers since that meeting has a direct bearing on the matter of medical center officials and their relationship to the AAMC. Present at that meeting were Drs. Cooper, Sherman and Knapp as staff members from the AAMC, and Dr. Hogness and Mr. Agro as staff members of the Association of Academic Health Centers. The following individuals were present representing their respective organizations.

AAMC	AAHC
Robert Heyssel, MD	Albert Farmer, MD
Richard Janeway, MD	Ronald Kaufman, MD
Haynes Rice	Thomas Langfitt, MD
Edward Stemmler, MD	Charles Sprague, MD

Mr. Rice reported that Dr. Langfitt opened the meeting (which he chaired) by describing eight issues that are of concern to the medical center vice presidents with reference to their teaching hospitals:

1. Reimbursement and regulation at the federal level
2. State level issues of similar character
3. The possibility of obtaining a waiver for university hospitals to carry out a pilot reimbursement project
4. Competition
5. Vertical and horizontal integration as well as the impact of HMO's, PPO's and similar alternative delivery systems
6. The need to maintain mission balance as economic forces drive the institution in a specific direction
7. Sources of capital for modernization and equipment acquisition
8. Ownership and governance issues

He further indicated that there were three primary questions that the group needed to address.

- Do primary teaching hospitals have a common cause?
- Are the problems of these hospitals well understood and and are they being addressed as effectively as they might be?
- Would a joint task force of the two organizations be a useful way to address and resolve these matters?

After lengthy discussion concerning the question of what needed to be done that isn't being done as well as asking whether or not the "primary teaching hospitals" are represented as well as they might be, the issue was set forth on the table in very clear fashion. Mr. Rice stated that Dr. Langfitt made the

following statement, "At home we're on the firing line, we're in charge and we're responsible for the hospital and the college of medicine. Here we're on the periphery and not in the organization that seems to be affecting national decision making. At home we're the primary decision makers; here we are not."

Following Mr. Rice's report, the two significant questions set forth on the agenda were addressed by a variety of individuals. These questions are as follows:

- Is there some kind of participative role within the AAMC that can be identified for medical center officials, by whatever title, who hold positions above or equal to the dean or hospital administrator in the medical center hierarchy?

- Is the AAMC/AAHC relationship basically competitive or can it be cooperative?

There was lengthy discussion of this issue and the general direction of that discussion indicated that a more cooperative role with the Association of Academic Health Centers should be pursued.

ACTION: It was moved, seconded and carried to recommend that efforts be continued to move ahead and continue the dialogue with representatives of the AAHC with a goal of a more cooperative relationship. It was further recommended that a group be constituted to find ways to enhance and achieve more cooperation in an integrated fashion between the two organizations.

VI. PARTICIPATION OF TEACHING HOSPITAL EXECUTIVES IN THE AMERICAN HOSPITAL ASSOCIATION

The Chairman asked Mr. Rice to report on a meeting held with the President of the AHA on Tuesday, September 13. Mr. Rice reported that at the request of the American Hospital Association, the following individuals met with Alex McMahon, Bill Robinson, Danny Olsen and Joe Curl:

Jeptha W. Dalston, PhD, Executive Director, University of Michigan Hospitals, Ann Arbor, Michigan
William B. Kerr, Director of Hospitals and Clinics, University of California, San Francisco, California
Sheldon S. King, Executive Vice President and Director, Stanford University Hospital, Stanford, California
Richard M. Knapp, PhD, Director, AAMC Department of Teaching Hospitals, Washington, DC
Henry E. Manning, President, Cleveland Metropolitan Hospital, Cleveland, Ohio
Haynes Rice, Hospital Director, Howard University Hospital, Washington, DC
C. Thomas Smith, President, Yale-New Haven Hospital, New Haven, Connecticut
Gennaro J. Vasile, PhD, Executive Director, Strong Memorial Hospital, Rochester, New York

Mr. Rice reported that Alex McMahon indicated his concern about the lack of involvement of major teaching hospital executives in the American Hospital Association. He indicated that he would be receptive to efforts to strengthen the role and participation of major teaching hospitals in the governance and consular structure of the American Hospital Association. Mr. Rice further indicated that 50 new delegate positions had been made available as a result of the adoption of the report of the Committee on Future Directions of the American Hospital Association. In an attempt to capture those seats, Bill Kerr has been asked to chair a committee that would be charged with the establishment of criteria for membership in a Metropolitan Hospital Section. He reported that the full criteria of membership in such a section was currently under debate and a recommendation probably would come forward as a result of a second meeting of that group which Mr. Kerr had indicated would take place on October 5-6. At this point, Mr. Robinson was asked to comment on the meeting with Alex McMahon. He indicated that he felt there was definite sensitivity to the point of view that there had been inadequate participation of major teaching hospital executives and set forth the formula by which a percentage of the 50 new delegates could be captured by a given constituency section of the American Hospital Association. The formula is set forth as follows.

$$\frac{\frac{\text{\# of section members}}{\text{total members}} + \frac{\text{dues paid by section members}}{\text{total dues}}}{2}$$

As a result of this formula, Mr. Robinson indicated that if the Council of Teaching Hospitals were to become a section for purposes of delegate selection based on the current membership of the Council of Teaching Hospitals, probably eight or nine delegates would be the maximum that could be achieved. He indicated that if the most liberal definition of the Metropolitan Hospital Section were chosen, probabably 33 delegates could be garnered. Several members pointed out that the larger the number of delegates that were captured, the less likely it would be that the unique features of the relatively small number of teaching hospitals would be represented. Thus, the problem the AHA faces would be duplicated in the Section. In addition, it was suggested that the outcome that should be sought is that the Council of Teaching Hospitals gain a designated seat on the AHA Board of Trustees and each regional advisory board. Following further discussion, the Chairman appointed Mr. Rice and Mr. Smith to serve as liaison with Bill Kerr's group that is developing the Metropolitan Hospital Section of the AHA, and also to work with staff in determining what would be the best course of action to gain greater access to the governing structure of the AHA. In the absence of formal Board action, it was understood that Mr. Rice and Mr. Smith might be in a position where together with the Chairman, they may wish to take a necessary position with the AHA. In the meantime, the staff was requested to review the composition of the AHA Regional Advisory Boards and determine the level of COTH participation.

VII. PAYING CAPITAL COSTS UNDER MEDICARE

In July, 1983, a Working Party of the AHA's Council on Finance developed a proposal for including capital in the per case payments made under Medicare's prospective payment system. After consideration by the AHA's Board of Trustees, the paper was distributed to hospitals for comment.

Dr. Bentley introduced the discussion paper noting that the AHA Regional Advisory Boards are presently reviewing it and that the AHA has the proposal on a relatively fast track. Administrative Board members asked Mr. Robinson about the

AHA's plans for the paper and were informed that the AHA Board wants to consider the paper at its November meeting and plans to place it on the House of Delegates agenda in February. After a short discussion, the Administrative Board concluded that a special committee should be requested to evaluate the AHA proposal and, if necessary, recommend an AAMC alternative. It was further agreed that the AAMC should include on the committee a representative from a major accounting firm and a representative from a major underwriter of tax-exempt bonds.

VIII. SURVEY OF CAPITAL FINANCING NEEDS OF TEACHING HOSPITALS

Representatives of Peat, Marwick, Mitchell and Morgan Guaranty Trust Company have contacted the AAMC to inquire about the Association's interest in co-sponsoring a survey of capital expenditure plans/needs of teaching hospitals. In discussion of a possible survey, Board members expressed three major concerns: 1/ would the AAMC/COTH benefit from the survey as much as its commercial sponsors? 2/ would the questionnaire responses provide estimates of "wish-list" desires? and 3/ would the information gained be worth the time and effort to complete the questionnaire? The Board recommended staff meet with representatives of Peat, Marwick, Mitchell and Morgan Guaranty to address these questions before taking any action on the design of a capital needs survey.

IX. BLACKS AND THE HEALTH PROFESSIONS IN THE 1980'S: A NATIONAL CRISIS AND A TIME FOR ACTION

The Board received copies of a document from the Association of Minority Health Professions Schools entitled, "Blacks and the Health Professions in the 1980's: A National Crisis and a Time for Action." The document contained many findings and recommendations consistent with the Association's 1978 Task Force on Minority Student Opportunities in Medicine Report and a subsequent implementation plan adopted by the Executive Council. However, other findings and conclusions of the document were either outside the purview of the Association or not supported by data from the Association's database. Therefore, the Board was asked to recommend that the Executive Council commend the Association of Minority Health Professions Schools for its report which provides additional evidence in support of increasing opportunities for under-represented minorities in all levels of medical education. Additionally, it was suggested that the Association take this opportunity to reaffirm its own support of opportunities for minority students. Haynes Rice indicated Howard University's general support of the document and suggested that the Association should support it also.

ACTION: It was moved, seconded, and carried that the Council of Teaching Hospitals recommends that the Executive Council adopt the recommended resolution outlined above and specified on page 23 of the Executive Council Agenda.

X. ISSUES RELATED TO APPOINTMENT TO PGY-2

Dr. Cooper led this discussion by praising Jack Graettinger for his work on the National Residency Matching Program (NRMP). He gave a brief history of the NRMP, including the reasons some specialties such as ophthalmology have begun to break away and establish their own residency matching programs such as the Colenbrander Match. He said that the problem with having multiple matches is that the time schedule used by these independent efforts frequently requires students to make early decisions regarding the specialty in which they wish to practice as well as forcing deans of medical schools to make recommendations too early for them to have had an adequate opportunity to evaluate the performance of

the medical students. Dr. Cooper noted that the NRMP had been carefully timed to strike a balance between those forces which would like to see it delayed and those which would like to see it earlier. The current question was how to encourage the recalcitrant specialties back into using the NRMP. He suggested that the best approach would be to have the AAMC staff meet with top level people in the specialties that have strayed from the NRMP to ascertain what their problems are and how they might be corrected in order to draw them back into the NRMP. He also suggested that a special committee might be established to allow the specialists to have a continous opportunity for input into the resident match. After some discussion, the chairman suggested there was a consensus that the meeting would be a good idea, and that perhaps establishing a special committee should be recommended to the Executive Council. There was no opposition to this view. No further action was taken.

XI. PRINCIPLES FOR SUPPORT FOR BIOMEDICAL RESEARCH

Two documents were included in the Executive Council Agenda (pages 46-60) describing the draft proposal on principles for the support of biomedical research and the proposed strategy on NIH legislation. Dr. Sherman gave a brief history of the development of these papers, citing actions over the past few years in which the Congress has attempted to become more and more specific about the structure and operation of the National Institutes of Health (NIH) as the impetus for the development of these papers. Dr Sherman described the proposed strategy as allowing the "principles" paper to be used as a talking piece by those who had an interest in this issue. The paper was to be disseminated to the presidents of the academic societies that make up the Council of Academic Societies and request made that they consider this proposal at their next society meeting as a basis for this advocacy action with Congress.

Dr. Kennedy described a study by the Institute of Medicine which was just being started. The basic question to be answered by this study is, "when should a new National Institute of Health be created?" A study has been commissioned under the Institute of Medicine, and the Association has asked to comment before an IOM panel taking testimony on the subject.

ACTION: It was moved, seconded, and carried that the Board recommend to the Executive Council that it adopt the paper, "Principles for the Support of Biomedical Research" as an official AAMC policy and endorse the strategy for furthering the goals defined in that paper. Further, it was moved, seconded, and carried that this paper form the basis for testimony before the IOM study panel.

XII. RECENT ACTION ON MEDICAL EDUCATION FINANCING BY THE ADVISORY COUNCIL ON SOCIAL SECURITY

Dr. Knapp reported that at its August 24 meeting, the Advisory Council on Social Security adopted a resolution calling for a three year study of medical education financing as a first step in an "...orderly withdrawal of Medicare funds from training support." Following brief discussion, the following action was taken.

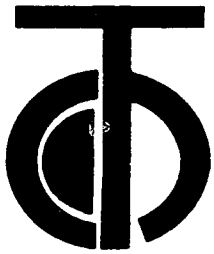
ACTION: It was moved, seconded and carried that the COTH Administrative Board recommend to the Executive Council:

- Believing that it is inappropriate to plan an "orderly withdrawal of Medicare funds from training support" before a comprehensive study of alternative methods for financing graduate medical education has been conducted and publicly reported, the AAMC should work to have the Advisory Council on Social Security reconsider its resolution. The Association should seek a revised resolution which recommends a study of alternative means of financing medical education and suggests that the findings of this study be used by a future advisory council to debate the reasonableness of terminating Medicare support from medical education;

- The AAMC should work with other national medical and hospital associations to develop a statement which all could endorse which opposes the present resolution on medical education financing adopted by the Advisory Council on Social Security.

XIII. ADJOURNMENT

The meeting was adjourned at 12:40pm.



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 Toledo Hospital

Hospital Address: (Street) 2142 North Cove Boulevard

(City) Toledo (State) Ohio (Zip) 43606

(Area Code)/Telephone Number: (419) 473-4000

Name of Hospital's Chief Executive Officer: Bryan A. Rogers

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

(-Newborn ICU 38 -Bassinets 44)

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 727

Average Daily Census: 709.9

Total Live Births: 4,128

Admissions: 33,768

Visits: Emergency Room: 47,372

Visits: Outpatient or Clinic: 21,256

B. Financial Data

Total Operating Expenses: $110,505,023

Total Payroll Expenses: $ 76,703,155

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $1,384,345
Supervising Faculty: $ 475,200

C. Staffing Data

Number of Personnel: Full-Time: 2605
Part-Time: 1537

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 253
With Medical School Faculty Appointments: 46

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

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	14	8-10	see Attachment A
Surgery	10	8-10	see Attachment A
Ob-Gyn	2-5	2-3	Elective
Pediatrics	10	6-7	see Attachment A
Family Practice	3	3	see Attachment A Required
Psychiatry	0		
Other: Anesthesiology	3	2-3	both
Emergency Medicine	39	10	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				
	Medicine	12	12	0	November, 1980
General	Surgery	4	3	1	1975
	Ob-Gyn	8	6	2	1970
	Pediatrics	5	3	2	January, 1973
	Family Practice	18	18	0	1977
	Psychiatry	0			
	Other: Anesthesiology	10	3	7	1981
	Orthopedics	5	5	0	1969
	Urology	2	1	1	1972
	Emergency Medicine	9	9	0	1977
	TOTAL	73			

[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: Medical College of Ohio

Dean of Affiliated Medical School: John P. Kemph, M.D.

Information Submitted by: (Name) Paul F. Baehren, M.D.

(Title) Director Medical Education

Signature of Hospital's Chief Executive Officer:

(Date) 10-14-83

ATTACHMENT A to Part III-A of APPLICATION FOR MEMBERSHIP

MEDICINE

General	10	required
Cardiology	1	elective
Pulmonary	1	elective
G.I.	1	elective
Neurology	1	elective
Total	14	Clerkships offered in Medicine

SURGERY

General	4	required
Plastic	2	required
Orthopedics	2	required/elective
Urology	2	required
Total	10	Clerkships offered in Surgery

PEDIATRICS

General	6	required
Neonatology	2	elective
Pulmonary	1	elective
Senior	1	elective
Total	10	Clerkships offered in Pediatrics

FAMILY PRACTICE

1 Clerkship also offered for non-MCO 4th year medical students

IV. SUPPLEMENTARY INFORMATION

The Toledo Hospital is actively involved in undergraduate, graduate and continuing medical education.

There are nine accredited residencies, seven affiliated with the Medical College of Ohio. Our Family Practice Residency (6-6-6) is freestanding. Our Emergency Medicine Residency is sponsored jointly with St. Vincent Hospital and Medical Center.

The attending staff and administration are deeply interested in the entire educational program and provide the support that a private practice hospital is proud to supply. The usual town-gown division is not found here.

Medical College of Ohio

Office of the Dean

419-381-4172

419-381-4242

3000 Arlington Avenue
Mailing Address: C.S. 10008
Toledo, Ohio 43699

September 26, 1983

Council of Teaching Hospitals
of the Association of American Teaching Colleges
Suite 200
1 DuPont Circle
Washington, D.C. 20036

Dear Sirs:

I am writing this letter in support of the Toledo Hospital's application for membership in the Council of Teaching Hospitals. The Toledo Hospital is one of our major teaching hospitals and as such, plays an important role in our undergraduate and graduate medical education programs. Twenty-five to thirty percent of all clinical undergraduate education for the medical students at the Medical College of Ohio is conducted at the Toledo Hospital. Student rotations occur in Family Medicine, Internal Medicine, Obstetrics & Gynecology, Orthopedic Surgery, Pediatrics, General Surgery and Urology. In addition, our resident programs are fully integrated with our associated hospitals and Toledo Hospital plays a major role in our educational programs at the residency level with nearly twenty-five percent of the residency training for residents being conducted at that institution. Their commitment as a major teaching hospital is documented by their employment of full-time program directors who are responsible for the educational program at Toledo Hospital. Our relationship with The Toledo Hospital is excellent and we support their membership in the Council of Teaching Hospitals.

Sincerely,

John P. Kemph

John P. Kemph, M.D.
Vice President for Academic Affairs
Dean of the School of Medicine

JPK/pw

RELATIONSHIPS WITH THE AMERICAN HOSPITAL ASSOCIATION

Mr. Kerr will report on development of the AHA Metropolitan Hospital Section. On October 13, Mr. Smith and Mr. Rice met with Mr. Kerr by telephone conference call. Based on this discussion the following recommendations are presented for consideration by the COTH Administrative Board.

It is recommended that:

- The Council of Teaching Hospitals take no position with respect to the organization of the AHA Metropolitan Section;
- The Council of Teaching Hospitals laud the AHA for its efforts to support expansion of its House of Delegates to provide a voice for distinct constituencies of hospital interests;
- The Council of Teaching Hospitals request a seat on the AHA Board of Trustees and each Regional Advisory Board to be selected from nominations approved by the COTH Administrative Board;
- The COTH Administrative Board request the COTH Nominating Committee recommend the names of three individuals to be approved by the Board in January, 1984 who would be recommended to the AHA Nominating Committee as candidates for the AHA Board of Trustees. Further, the Chairman of the COTH Board or COTH Nominating Committee should appear and present these three names to the AHA Nominating Committee at its hearing on the subject on January 30, 1984.

The 1983 Official Roster of the AHA House of Delegates appears on the following pages.

- There are six individuals from COTH member hospitals on the AHA Board. However, only two of them are from medical school based hospitals, and in neither case is the representative the hospital chief executive;
- In the House of Delegates (including the Board) there are 43 individuals representing COTH members. However, only 13 of these individuals represent medical school based hospitals, and of these 13, only four are the hospital chief executive.

Delegates who represent COTH members are designated on the right hand side of each page.

The following are the states which comprise the nine AHA Reginal Advisory Boards.

REGION I	Maine, Vermont, New Hampshire, Massachusetts, Connecticut
REGION II	New York, Pennsylvania, New Jersey
REGION III	West Virginia, Virginia, Maryland, Delaware, North Carolina, Kentucky
REGION IV	Tennessee, Mississippi, Alabama, Georgia, South Carolina, Florida, Puerto Rico
REGION V	Wisconsin, Illinois, Indiana, Ohio, Michigan
REGION VI	North Dakota, South Dakota, Nebraska, Kansas, Missouri, Iowa, Minnesota
REGION VII	Oklahoma, Texas, Arkansas, Louisiana
REGION VIII	Montana, Idaho, Wyoming, Colorado, New Mexico, Utah, Arizona
REGION IX	Washington, Oregon, Nevada, California, Alaska, Hawaii

1983 OFFICIAL ROSTER OF HOUSE OF DELEGATES

OFFICERS

CHAIRMAN OF BOARD OF TRUSTEES
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Term Expires 1986

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Term Expires 1983

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Term Expires 1984

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Donald H. Goldberg, New England Sinai Hospital, Stoughton, MA
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Term Expires 1985

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John King, Evangelical Hospital Association, Oak Brook, IL
John J. Laverty, Methodist Health System, Memphis
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REGIONAL DELEGATES

Term Expires 1983

Charles L. Crockett, M.D., Roanoke Memorial Hospitals, Roanoke, VA
Thomas P. McElroy, United Hospital, Grand Forks, ND
John Pihas, Good Samaritan Hospital and Medical Center, Portland
Homer E. Wichern, M.D., Iowa Methodist Medical Center, Des Moines COTH
Admiral Joseph L. Yon, Chesapeake General Hospital, Chesapeake, VA
Vacancy

Term Expires 1984

Helen Barrett, Morgan County Hospital, Martinsville, IN
Leo Jivoff, M.D., University Hospital of Upstate Medical Center, COTH
Syracuse, NY
Clayton C. Morgan, M.D., Idaho Elks Rehabilitation Hospital, Boise, ID
John M. Nelson, M.D., Madison General Hospital, Madison, WI COTH
Jerome D. Winig, Mercer Medical Center, Trenton, NJ
David L. Wood, Poudre Valley Hospital, Ft. Collins, CO

Term Expires 1985

John Kendall Black Jr., M.D., Medical Center Hospital, Huntsville, AL
William C. Nolan Jr., Warner Brown Hospital, El Dorado, AR
William F. Ross, M.D., Parkland Memorial Hospital, Dallas COTH
Norman R. Stearns, M.D., New England Medical Center Hospital, Boston COTH
Jack P. Turner, Hamilton Memorial Hospital, Dalton, GA
Sheila D. Weeks, Lakes Region General Hospital, Laconia, NH

ALABAMA

1985

Del.: Jack B. Hethcox, Citizens Hospital, Talladega
Del.: H. Thurman Turner, East Alabama Medical Center, Opelika
Alt.: Perry E. Cox, Carraway Methodist Medical Center, Birmingham
Alt.: Austin K. Letson, Northeast Alabama Regional Medical Center, Anniston

ALASKA

1984

Del.: Al M. Camosso, Providence Hospital, Anchorage
Alt.: Mike Lockwood, Central Peninsula General Hospital, Soldotna

ARIZONA

1983

Del.: Daniel W. Capps, Camelback Hospitals, Scottsdale
Alt.: T. Abner Huff, St. Joseph's Hospital and Medical Center, Phoenix COTH

ARKANSAS

1984

Del.: Ben Light, Johnson County Regional Hospital, Clarksville
Alt.: S. Howard Johnson, Desha County Hospital, Dumas

CALIFORNIA

1983

Del.: Vacancy
Del.: Ronald J. Davey, Verdugo Hills Hospital, Glendale
Alt.: Samuel Sedell, Northridge Hospital Medical Center, Northridge
Alt.: Peter W. Kriger, St. Joseph Hospital, Eureka

1984

Del.: William H. Gurtner, Mount Zion Hospital and Medical Center, San Francisco COTH
Del.: W. Kevin Hegarty, Huntington Memorial Hospital, Pasadena
Alt.: John R. Williams, Children's Hospital at Stanford, Palo Alto
Alt.: Robert D. Hansen, Community Hospital of Chula Vista, Chula Vista

1985

Del.: William G. Gordon, Oak Valley District Hospital, Oakdale
Del.: Stuart J. Marylander, Cedars-Sinai Medical Center, Los Angeles COTH
Alt.: Lawrence F. Heise, Ukiah General Hospital, Ukiah
Alt.: Sister Marie Madeleine Shonka, Saint John's Hospital and Health Center, Santa Monica

CANADA

1985

Del.: Jean-Claude Martin, Canadian Hospital Association, Ottawa, Ont.
Alt.: Vacancy

COLORADO

1984

Del.: Thomas A. Nord, Clagett Memorial Hospital, Rifle
Alt.: John C. McFetridge, Boulder Community Hospital, Boulder

CONNECTICUT

1983

Del.: Edward M. Kenney, Manchester Memorial Hospital, Manchester
Alt.: Stanley W. Shepard, New Britain General Hospital, New Britain COTH

DELAWARE

1983

Del.: Joseph B. Ahlschier, Milford Memorial Hospital, Milford
Alt.: Eugene B. Crawford Jr., Wilmington Medical Center, Wilmington COTH

DISTRICT OF COLUMBIA

1983

Del.: Dunlop Ecker, Washington Hospital Center, Washington COTH
Alt.: Charles M. O'Brien Jr., Georgetown University Hospital, Washington COTH

FLORIDA

1983
Del.: Bently B. Lang, Manatee Memorial Hospital, Bradenton
Del.: Middleton T. Mustian, Tallahassee Memorial Regional Medical Center, Tallahassee
Alt.: S. A. Mudano, Memorial Hospital, Hollywood
Alt.: Ernest C. Nott Jr., Baptist Hospital of Miami, Miami

1985
Del.: Bernie B. Welch, Broward General Medical Center, Fort Lauderdale
Alt.: H. J. Floyd, Memorial Hospital, Sarasota

GEORGIA

1983
Del.: Patrick I. Fenlon, John D. Archbold Memorial Hospital, Thomasville
Alt.: Aldine A. Rosser, Bulloch Memorial Hospital, Statesboro

1984
Del.: J. W. Pinkston Jr., Grady Memorial Hospital, Atlanta COTH
Alt.: Edward J. Fechtel Jr., St. Mary's Hospital, Athens

HAWAII

1983
Del.: Masaichi Tasaka, Kuakini Medical Center, Honolulu
Alt.: Michael Matsuura, St. Francis Hospital, Honolulu

IDAHO

1985
Del.: Pearl S. Fryar, Caribou Memorial Hospital and Nursing Home, Soda Springs
Alt.: Sister Beverly Ann Nelson, Saint Alphonsus Regional Medical Center, Boise

ILLINOIS

1983
Del.: Robert F. Schinderle, St. Joseph Hospital, Joliet
Alt.: David M. McConkey, McDonough County District Hospital, Macomb

1984
Del.: Harold W. Maysent, Rockford Memorial Hospital, Rockford
Del.: Sister Rita Meagher, Mercy Center for Health Care Services, Aurora
Alt.: Earl J. Frederick, Children's Memorial Hospital, Chicago COTH
Alt.: Donald R. Oder, Rush-Presbyterian-St. Luke's Medical Center, Chicago COTH

1985
Del.: George L. Heidkamp, Northwestern Memorial Hospital, Chicago COTH
Del.: Steven L. Seiler, Lake Forest Hospital, Lake Forest
Alt.: William Kessler, Saint Anthony's Hospital, Alton
Alt.: Richard V. Livengood, Lakeview Medical Center, Danville

INDIANA

1983
Del.: David A. Johnson, Deaconess Hospital, Evansville
Alt.: Mark Slen, Parkview Memorial Hospital, Fort Wayne

1984
Del.: Roland E. Kohr, Bloomington Hospital, Bloomington
Alt.: Donald D. Hamachek, St. Francis Hospital Center, Beech Grove

IOWA

1984
Del.: Charles R. Linden, Boone County Hospital, Boone
Alt.: David S. Ramsey, Iowa Methodist Medical Center, Des Moines COTH

KANSAS

1983
Del.: Donald M. Stewart, Hadley Regional Medical Center, Hays
Alt.: Harold W. Steadham, William Newton Memorial Hospital, Winfield

KENTUCKY

1985
Del.: H. Earl Feezor, Western Baptist Hospital, Paducah
Alt.: Russell Hester, Garrard County Memorial Hospital, Lancaster

LOUISIANA

1983
Del.: Thomas R. Hightower, Woman's Hospital, Baton Rouge
Alt.: Haller Alexius, St. Tammany Parish Hospital, Covington

1985
Del.: James K. Elrod, Willis-Knighton Medical Center, Shreveport
Alt.: Frank R. Gayle, West Calcasieu-Cameron Hospital, Sulphur

MAINE

1984
Del.: Howard R. Buckley, Mercy Hospital, Portland
Alt.: William W. Young Jr., Central Maine Medical Center, Lewiston

MARYLAND

1984
Del.: Thomas G. Whedbee Jr., Church Hospital Corporation, Baltimore
Alt.: Mrs. Virginia B. Layfield, Peninsula General Hospital Medical Center, Salisbury

1985
Del.: James A. Oakey, Good Samaritan Hospital of Maryland, Baltimore
Alt.: Donald C. McAneny, Memorial Hospital, Cumberland

MASSACHUSETTS

1983
Del.: Charles F. Johnson, Lawrence Memorial Hospital of Medford, Medford
Alt.: Richard E. Lee, New England Deaconess Hospital, Boston

1984
Del.: William E. Hassan Jr., Ph.D., Brigham & Women's Hospital, Boston COTH
Alt.: Wayne M. Henry, Brockton Hospital, Brockton

1985
Del.: Patrick F. Roche, Union Hospital, Lynn
Alt.: Paul L. Downey, Choate Symmes Health Services, Woburn

MICHIGAN

983
Del.: John J. Freysinger, Peoples Community Hospital Authority, Wayne
Alt.: Charles W. McKinley, Port Huron Hospital, Port Huron

984
Del.: John C. Bay, Munson Medical Center, Traverse City — COTH
Del.: Forrest K. Neumann, Edward W. Sparrow Hospital, Lansing — COTH
Alt.: William J. Downer Jr., Blodgett Memorial Medical Center, Grand Rapids
Alt.: Edward B. McRee, Ingham Medical Center, Lansing

985
Del.: James T. Farley, St. John Hospital, Detroit — COTH
Alt.: Reginald P. Ayala, Southwest Detroit Hospital, Detroit

MINNESOTA

983
Del.: John P. Devins, Waconia Ridgeview Hospital, Waconia
Alt.: Earl G. Dresser, Methodist Hospital, Minneapolis

985
Del.: Howard M. Winholtz, Rochester Methodist Hospital, Rochester — COTH
Alt.: Thomas C. Lenertz, Riverview Hospital Association, Crookston

MISSISSIPPI

985
Del.: Sidney L. Whittington, Madison General Hospital, Canton
Alt.: Lowery A. Woodall, Forrest County General Hospital, Hattiesburg

MISSOURI

1984
Del.: William D. Blair, Farmington Community Hospital, Farmington
Alt.: Thomas J. Hesselmann, St. Joseph Hospital, St. Joseph

1985
Del.: E. Wynn Presson, Research Health Services, Kansas City
Alt.: James C. Culpepper, Moberly Regional Medical Center, Moberly

MONTANA

1985
Del.: Kyle Hopstad, Frances Mahon Deaconess Hospital, Glasgow
Alt.: Tom Gillespie, St. Joseph Hospital, Polson

NEBRASKA

1985
Del.: Jack E. Stiles, St. Elizabeth Community Health Center, Lincoln
Alt.: Rex J. Kelly, Phelps Memorial Health Center, Holdrege

NEVADA

1985
Del.: Michael J. Tuohy, St. Mary's Hospital, Reno
Alt.: Al Felgar, Desert Springs Hospital, Las Vegas

NEW HAMPSHIRE

1984
Del.: Francis E. Derrick, Mary Hitchcock Memorial Hospital, Hanover COTH
Alt.: Francis J. Cronin, Elliot Hospital, Manchester

NEW JERSEY

1983
Del.: Paul S. Cooper, Bridgeton Hospital, Bridgeton
Alt.: Donald A. Bradley, Morristown Memorial Hospital, Morristown COTH

1984
Del.: William J. Cornetta Jr., St. Michael's Medical Center, Newark COTH
Alt.: Richard J. Leone, Point Pleasant Hospital, Point Pleasant

1985
Del.: Sister Marie de Pazzi, St. Peter's Medical Center, New Brunswick
Alt.: Ronald B. Milch, Beth Israel Hospital, Passaic

NEW MEXICO

1984

Del.: Leo W. Huppert, St. Joseph Hospital, Albuquerque
Alt.: T. D. Smith, Gerald Champion Memorial Hospital, Alamogordo

NEW YORK

1983

Del.: John J. DePierro, St. Vincent's Medical Center of Richmond, Staten Island COTH
Del.: Arthur E. Liebert, Rochester General Hospital, Rochester COTH
Del.: David D. Thompson, M.D., Society of the New York Hospital, New York City COTH
Alt.: Frank M. Isbell, A. O. Fox Memorial Hospital, Oneonta
Alt.: Allan C. Anderson, Lenox Hill Hospital, New York City COTH
Alt.: Harold L. Light, Long Island College Hospital, Brooklyn COTH

1984

Del.: Edwin B. Bolz, Vassar Brothers Hospital, Poughkeepsie
Del.: S. Stephen Bonadonna, Nassau Hospital, Mineola COTH
Alt.: John J. Murphy, General Hospital of Saranac Lake, Saranac Lake
Alt.: Robert Stone, Blythedale Children's Hospital, Valhalla

1985

Del.: Alexander H. Williams III, St. John's Episcopal Hospitals, Garden City
Del.: N. Donald Peifer, Lockport Memorial Hospital, Lockport
Alt.: Robert L. Kay, Samaritan Hospital, Troy
Alt.: Nicholas A. Prisco, Little Falls Hospital, Little Falls

NORTH CAROLINA

1984

Del.: Dennis R. Barry, Moses H. Cone Memorial Hospital, Greensboro COTH
Alt.: Harold C. Green, Charlotte-Mecklenburg Hospital Authority, Charlotte

1985

Del.: Paul S. Ellison, Cleveland Memorial Hospital, Shelby
Alt.: William F. Andrews, Wake County Hospital System, Raleigh COTH

NORTH DAKOTA

1984

Del.: D. D. Wightman, Dakota Hospital, Fargo
Alt.: Keith Korman, St. Andrew's Hospital, Bottineau

OHIO

1983
- Del.: James C. Brown, Elyria Memorial Hospital, Elyria
- Alt.: Robert H. Johnstone, Good Samaritan Hospital, Sandusky

1984
- Del.: Richard L. Sims, Doctors Hospital, Columbus
- Del.: Dale D. Stoll, Flower Hospital, Sylvania
- Alt.: L. Thomas Wilburn, Bethesda Hospital and Deaconess Association, Cincinnati
- Alt.: Lowell E. Thompson, Scioto Memorial Hospital, Portsmouth

1985
- Del.: Herman N. Menapace, Greene Memorial Hospital, Xenia
- Del.: Walter A. Mischley, Middletown Hospital, Middletown
- Alt.: Sister M. Consolata Kline, St. Elizabeth Hospital Medical Center, Youngstown
- Alt.: Bryan A. Rogers, Toledo Hospital, Toledo

OKLAHOMA

1984
- Del.: John C. Coffey, Comanche County Memorial Hospital, Lawton
- Alt.: James L. Henry, Baptist Medical Center of Oklahoma, Oklahoma City

OREGON

1985
- Del.: David R. Arnold, Merle West Medical Center, Klamath Falls
- Alt.: Ronald L. Purdum, Albany General Hospital, Albany

PENNSYLVANIA

1983
- Del.: Irwin Goldberg, Montefiore Hospital, Pittsburgh — COTH
- Del.: Eugene J. O'Meara, Sharon General Hospital, Sharon
- Alt.: Anthony M. Lombardi Jr., Monongahela Valley Hospital, Monongahela
- Alt.: Malcolm D. Strickler, Friends Hospital, Philadelphia

1984
- Del.: Stanley W. Elwell, Episcopal Hospital, Philadelphia — COTH
- Del.: Paul H. Keiser, York Hospital, York — COTH
- Alt.: Ralph H. Meyer, Robert Packer Hospital, Sayre
- Alt.: Paul G. Wedel, Lancaster General Hospital, Lancaster

1985
Del.: Clifford H. Boon Jr., Aliquippa Hospital, Aliquippa
Alt.: Thomas P. Saxton, Wilkes-Barre General Hospital, Wilkes-Barre

PUERTO RICO

1984
Del.: Sigifredo Martinez, Our Lady of Angels Hospital, Rio Piedras
Alt.: Rogelio Diaz-Reyes, Font Martelo Hospital, Humacao

RHODE ISLAND

1985
Del.: Thomas G. Parris Jr., Women & Infants Hospital of Rhode Island, Providence COTH
Alt.: Francis R. Dietz, Memorial Hospital, Pawtucket

SOUTH CAROLINA

1983
Del.: D. Kirk Oglesby Jr., Anderson Memorial Hospital, Anderson
Alt.: William B. Finlayson, Conway Hospital, Conway

SOUTH DAKOTA

1983
Del.: Henry J. Morris, McKennan Hospital, Sioux Falls
Alt.: Gale N. Walker, St. Michael's Hospital, Tyndall

TENNESSEE

1983
Del.: Robert F. Scates, Baptist Medical Center, Memphis
Alt.: Ralph K. Neff, Giles County Hospital, Pulaski

1984
Del.: J. D. Elliott, Nashville Memorial Hospital, Madison
Alt.: Earl G. Skogman, East Tennessee Baptist Hospital, Knoxville

TEXAS

1983
Del.: Jerry A. Howard, Highland Hospital, Lubbock
Alt.: Richard L. Epperson, King's Daughters Hospital, Temple

1984
Del.: George M. Fleming, Ed.D., San Jacinto Methodist Hospital, Baytown
Alt.: Ronald L. Smith, Harris Hospital-Methodist, Fort Worth

1985
Del.: James J. Farnsworth, Children's Medical Center of Dallas, Dallas
Del.: Kenneth W. Poteete, Georgetown Hospital, Georgetown
Del.: R. William Warren, Memorial Hospital System, Houston
Alt.: W. Clay Ellis, Wichita General Hospital, Wichita Falls
Alt.: Arthur L. McElmurry, Wadley Regional Medical Center, Texarkana
Alt.: Alton Pearson, Hillcrest Baptist Hospital, Waco

UTAH

1983
Del.: John A. Reinertsen, University of Utah Hospital, Salt Lake City COTH
Alt.: David B. Wirthlin, LDS Hospital, Salt Lake City

VERMONT

1985
Del.: Robert D. Stout, Putnam Memorial Hospital, Bennington
Alt.: William M. Milligan Jr., Brattleboro Memorial Hospital, Brattleboro

VIRGINIA

1984
Del.: John F. Harlan Jr., University of Virginia Hospitals, Charlottesville COTH
Alt.: Carl S. Napps, Winchester Memorial Hospital, Winchester

1985
Del.: W. Earl Willis, General Hospital of Virginia Beach, Virginia Beach
Alt.: E. L. Derring, Prince William Hospital, Manassas

WASHINGTON

1984
Del.: Fred A. Pritchard, Consolidated Hospitals, Tacoma
Alt.: Gerald W. Baker, Memorial Hospital, Pullman

WEST VIRGINIA

1983
Del.: Edwin L. Johnson, Highland Hospital, Charleston
Alt.: Samuel G. Nazzaro, Wheeling Hospital, Wheeling

WISCONSIN

1983
Del.: Dean K. Roe, Froedtert Memorial Lutheran Hospital, Milwaukee COTH
Alt.: T. E. Besser, New London Community Hospital, New London

1985
Del.: Kenneth Van Bree, Divine Savior Hospital and Nursing Home, Portage
Alt.: William E. Johnson Jr., Methodist Hospital, Madison

WYOMING

1983
Del.: William C. Nichols, Memorial Hospital of Laramie County, Cheyenne
Alt.: John O. Yale, Memorial Hospital of Sheridan County, Sheridan

SERGEANT AT ARMS
Elton TeKolste, Indiana Hospital Association, Indianapolis

ASSISTANT SERGEANT AT ARMS
Roger M. Busfield Jr., Ph.D., Arkansas Hospital Association, Little Rock

ASSISTANT SERGEANT AT ARMS
Louis P. Scibetta, New Jersey Hospital Association, Princeton

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COTH SPRING MEETING
May 16-18, 1984
Hyatt Regency Hotel on the Harbor
Baltimore, Maryland

The Planning Committee met on October 3 and the staff is drafting a program for review based on the Committee's deliberations. A question was raised concerning the possibility of recommending that hospital board members be invited to the meeting.

Current policy states that the hospital CEO may not send someone in his place, but he may bring someone. The Board is requested to discuss whether it would be productive to suggest that in addition to bringing a staff member, CEO's be encouraged to bring a board member as well.

association of american medical colleges

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

October 5, 1983

202: 828-0460

Margaret E. Mahoney
President
The Commonwealth Fund
Harkness House
One East Seventy-Fifth Street
New York, New York 10021

Dear Maggie:

As I told you on the phone, we are very pleased to accept the invitation to become a co-sponsor with the Commonwealth Fund for an Executive Nurse Leadership Program. The program is focused on an important problem in the management of complex teaching hospitals. There is a real need for more capable nurse executives in these institutions.

We are very pleased that Dick Knapp will become a member of the national selection committee. We, of course, will be interested in promoting the program in the AAMC membership.

As I discussed with you on the phone, I think it might be useful to examine the possibility of having the 20 nurses in the three programs selected participate in specially-organized management programs organized by the Association. As you know, management programs were originally funded by the Robert Wood Johnson Foundation and are now being conducted under the sponsorship of the Association. The program developed for new deans, appropriately modified, would be an important, broad introduction of management issues for the nurses. We cover areas which are generally not considered by business school programs and include consideration for the special issues of management in a teaching setting. We have kept class size small so that the students participate actively in the program and are not mere, passive receptors of information provided through lectures. There would be a great advantage in having the group of 20 from each institution at a program. They could begin to develop a group identity in the informal setting of a meeting. If necessary, this could be modified to increase the size of the group, but it would take something away from the approach used in the sessions.

If you are interested, I will have Joe Keyes, who directs the program, get in contact with you to discuss the possibility in more detail.

Warm regards.

Sincerely,

John A. D. Cooper, M.D.

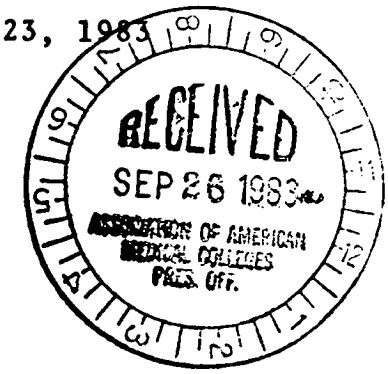
cc: Joseph Keyes

THE
COMMONWEALTH
FUND

HARKNESS HOUSE ONE EAST SEVENTY-FIFTH STREET, NEW YORK, N.Y. 10021 (212)535-0400

MARGARET E. MAHONEY
PRESIDENT

September 23, 1983



John A. D. Cooper, M.D., Ph.D.
President
Association of American
Medical Colleges
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear John:

This is our formal request that the Council of Teaching Hospitals of the Association of American Medical Colleges become co-sponsor, with the Fund, of an Executive Nurse Leadership Program. The program itself, as well as our process of developing it, are described in the enclosed memorandum presented to the Fund's Board at its July 12, 1983, meeting. I think it will interest you that Edward Connors, in helping us to develop the program, surveyed chief executive officers of teaching hospitals and found, overwhelmingly, that they believe a program to strengthen the management capabilities of nurse executives is badly needed. Sixty percent of those responding were willing to say, then and there, that their institution probably would contribute financial support for one of their nursing leaders to attend such a program.

As a co-sponsor of the Executive Nurse Leadership Program, the AAMC would not be required to provide financial support, since all such support would be supplied by the Fund and the teaching hospitals whose nurse managers attended the program. There are several ways, however, this AAMC/COTH sponsorship and participation in the program could make a critical difference:

1. Richard Knapp would become a member of the national Selection Committee charged with competitively selecting 60 nurse managers a year to attend the program, and I see this as a particularly important asset, given his broad range of competencies. I am enclosing our list of possible members of that committee.

2. Your co-sponsorship would be noted on all official bulletins and brochures of the program.

3. As you would deem appropriate, COTH could include in its meetings discussions of the purposes and progress of the program.

4. Where it could conveniently work them in, COTH could hold meetings regarding the program at AAMC headquarters.

5. COTH and the AAMC could include mention of the program in its publications and mailings, where this seemed appropriate.

We are inviting you to co-sponsor the program in these ways (and in other ways you might deem appropriate) because the express purpose of the program is to improve the management capabilities of COTH hospitals, and only hospitals that are members in good standing of COTH are eligible to nominate nursing leaders to attend the program.

The AAMC is in an excellent position to see that the purposes of the program are well understood by teaching hospitals and that the application and selection processes are fair and equitable. AAMC participation would help both teaching hospitals and the Fund itself to learn how to integrate this program into the other management and leadership concerns we share.

At the November 8 meeting of our Board, we will be recommending support for university programs that nursing leaders chosen by our national Selection Committee would attend. We would like to be able to announce, at that meeting, that the Council of Teaching Hospitals of the Association of American Medical Colleges is a co-sponsor of the program.

I hope very much that we can work together in making this project a success, and I look forward to hearing that you will indeed join us in the enterprise.

Yours sincerely,

Margaret E. Mahoney

MEM/fjw

Enclosures

Att. to Nov 4, 1983
Agenda

NEW CHALLENGES FOR THE COUNCIL OF TEACHING HOSPITALS AND THE DEPARTMENT OF TEACHING HOSPITALS

For over three decades, hospitals in the United States have faced a generally supportive environment characterized by increased third party coverage for institutional services, significant expansion and modernization of plant, and a payment system in which expense generated revenue. In the past three to five years, the environment for hospitals has become more constrained, if not hostile, and more competitive. While teaching hospitals flourished under the supportive environment, some observers feel teaching hospitals are especially threatened by a resource constrained, price competitive one. This observation is mirrored by increased anxiety among teaching hospital CEO's about the future prosperity, even survival, of their hospital.

In 1958, teaching hospital chief executives began meeting formally with the Association of American Medical Colleges as a Section on Teaching Hospitals. As a result of the Coggeshall Report entitled, Planning for Medical Progress Through Education, completed in April, 1965, the AAMC underwent a significant reorganization, and the teaching hospitals were involved formally in the governance of the AAMC. Thus, the Council of Teaching Hospitals was organized in 1966 and followed shortly thereafter by the Council of Academic Societies. A major reason for involving teaching hospital chief executives and senior faculty leadership in the AAMC governance was the clear recognition that the organization needed to take a broader mandate including the substantially increasing importance of the academic medical center in providing medical services.

A new and continuing objective of the reorganized AAMC is the initiation and continuous interaction between the leadership of all components of the modern medical center in the development of AAMC policies and programs. All three AAMC

Councils retain their respective identity through their Administrative Boards. Thus, the AAMC, through COTH provides representation and services related to the special needs, concerns and opportunities facing teaching hospitals. COTH has been successful in attracting major teaching hospitals as members, and CEO's in most major teaching hospitals have been supportive of COTH/AAMC activities. However, the rapidly changing environment facing teaching hospitals necessitates a systematic assessment of how the AAMC should function on behalf of its COTH members.

This paper is not intended to be a definitive assessment of past or possible AAMC activities for COTH members. Rather, it is developed to stimulate and focus discussion on the activities and initiatives of the AAMC from a teaching hospital perspective. The paper is organized into three sections: (1) a description of the changing environment facing Council members, including a summary of significant trends and management needs facing teaching hospitals; (2) an assessment of the environment and competition confronting the Council and the hospital activities of the AAMC; and (3) an examination of future directions for COTH and the AAMC.

THE CHANGING ENVIRONMENT FACING COTH MEMBERS

Significant Major Trends Facing Teaching Hospitals

At least ten major environmental trends are presently confronting teaching hospitals.

1. Third party payers, public and private, are limiting their financial risk by imposing revenue limits on providers. Such revenue limits are taking a variety of forms, both regulatory and/or competitive in nature. Given an

"acceptable level" of quality in multiple service settings, payers will use the price of the least expensive setting to pay all other providers.

2. Public and private payers are developing systems which limit hospital payments to the costs incurred by their particular beneficiaries. As a result, and coupled with the trend set forth in item #1, these payers are increasingly unwilling to support, or share in, costs the hospital incurs in caring for charity care and bad debt patients. At the national policy level, there is little or no discussion of new or expanded programs to underwrite the care of these patients.

3. The hospital business is becoming more competitive. While cooperation and community responsibility have been hallmark values and attitudes of the past, the current competitive environment is developing a new set of attitudes and values. Information, management techniques, and organizational structures are beginning to be viewed as corporate assets to be protected rather than shared.

4. The increase in the supply of highly trained physicians is intensifying competition between groups of physicians and hospitals for the provision of capital intensive services.

5. Community hospitals have attracted well-trained subspecialists to their staffs, and have significantly enhanced their clinical capabilities. They can now provide many of the services once thought to be the exclusive province of teaching hospitals.

6. Hospitals will increasingly be required to select specific programs they will offer from an array of options that collectively exceeds the hospital's capital and operating revenues. As a result, teaching hospitals will become more specialized, emphasizing cost competitive care in a

limited number of high cost areas rather than limited volumes of care in a great many high cost areas.

7. Hospitals are increasingly developing formalized structural arrangements blurring hospital boundaries and reducing the distinction between hospitals and associations. Independent hospitals are increasingly looking to some form of "corporate headquarters" for guidance, technical assistance, and large scale identity.

8. Not-for-profit and investor-owned chains will increasingly formalize referral relationships for tertiary care to keep patients and revenues within the system.

9. Investor-owned hospitals will seek management contracts, leases, and ownership of some teaching hospitals to acquire prestige, legitimacy, and full service capabilities.

10. There will continue to be efforts by some in the Administration and some members of Congress to "mainstream" medical services to veterans by providing a voucher system, thereby radically altering the role and function of the Veterans Administration hospital and health care system. In addition, efforts will be made to reduce appropriations to the Veterans Administration, making it more and more difficult for some VA hospitals to maintain their "stature" as teaching hospitals.

Taken together these ten trends suggest the hospital industry is becoming a mature industry rather than a growth industry. In the future, one hospital's growth and economic stability are likely to come at the expense of other hospitals. Market segmentation is gradually occurring, most frequently as a result of corporate strategic planning rather than as a result of cooperative community planning. For a voluntary membership organization, a maturing industry

implies a need to undertake activities which advantage its members compared to other hospitals. It also implies that any activity may advantage one subgroup of members and thereby undermine the unity of the Association itself.

Significant Needs of Teaching Hospitals

Given the dramatic change in the trends facing teaching hospitals, the management agenda of CEO's in teaching hospitals is changing. New management topics are being addressed and the priorities assigned to old topics are being reweighted with at least the following four managerial needs receiving increased attention:

1. The development of systems to manage clinical and financial data in order to identify hospital services, specify costs for each service on a cost accounting basis, and evaluate future program changes;

2. The creation of new operational systems emphasizing revenue management, expense control, variable budgeting, variance analysis, input productivity, and economy of operation;

3. The identification of marketing strategies which include attention to market penetration, market segmentation, and pricing practices designed to meet established revenue objectives; and

4. The clear specification of net income and rate of return goals designed to ensure access to debt capital, and self-funding of new programs and services.

Each of these managerial needs emphasizes the economic elements of the hospital. Each also has major implications for a variety of other issues ranging from the cost of undergraduate and graduate medical education to the cost of providing hospital and physician services to indigent and medically indigent populations.

As a result, new associations and organizations are being created to respond to these economic and other concerns. In light of these new organizations, existing associations face a need to clarify the economic and non-economic benefits of membership.

THE ENVIRONMENT FOR COTH

COTH Membership

In order to examine the environment facing the hospital activities of the AAMC, it is important to understand the composition of the COTH membership. The following review of the membership is one helpful way of assessing the COTH/AAMC role.

		Number of Members	Percent
o	Common ownership with the college of medicine	64	15%
o	Separate non-profit corporation with inextricable relationships with the college of medicine	27	7%
o	Large public hospital with inextricable relationships with the college medicine	23	6%
o	Specialty hospital	27	7%
o	Federal hospital	74	19%

o	Public hospital with a secondary affiliation with college of medicine	18	4%
o	Affiliated non-profit hospital with significant commitments to medical education and research	58	14%
o	Affiliated non-profit community teaching hospital	122	29%

A list of the membership by these categories is included as Appendix A. The mean size of a COTH non-federal hospital is 562 beds, and the regional distribution of members is as follows:

	Percent of Members
Northeast	40%
South	20%
Midwest	27%
West	12%

It is of interest to note that 22% of COTH members are in the states of New York and Pennsylvania. TABLE I on the following page illustrates the fact that a majority of COTH members are in the seven states of New York, Pennsylvania, California, Ohio, Illinois, Massachusetts and Michigan. TABLE II shows that when the geographic distribution of primary teaching hospitals is analyzed, nine states account for a majority of members, and only Michigan drops out of the group. In TABLE II, primary teaching hospitals are defined as having: (1) common ownership with a university; (2) separate nonprofit corporations with

TABLE I

Distribution of COTH Members by State

State	Number of Members	Percent of Members	Cumulative Percent
New York	56	13.5%	13.5%
Pennsylvania	35	8.4	21.9
California	32	7.7	29.6
Ohio	26	6.3	35.9
Illinois	24	5.8	41.7
Massachusetts	21	5.1	46.7
Michigan	21	5.1	51.8
Texas	18	4.3	56.1
Connecticut	14	3.4	59.5
New Jersey	14	3.4	62.9
Missouri	11	2.6	65.5
Wisconsin	10	2.4	68.0
All Others	133	32.0%	100.0%
TOTAL	415	100.0%	

TABLE II

Distribution of Primary Teaching Hospitals by State

State	Number of Primary Teaching Hospitals	Percent of Members	Cumulative Percentage
New York	14	12.3%	12.3%
California	9	7.9	20.2
Pennsylvania	7	6.1	26.3
Massachusetts	6	5.3	31.6
Texas	6	5.3	36.8
Illinois	5	4.4	41.2
Georgia	4	3.5	44.7
Missouri	4	3.5	48.2
Ohio	4	3.5	51.8
All Other	55	48.2	100.0%
TOTAL	114	100.0%	

Table III

Medical Schools Without a Primary Teaching Hospital

University of Hawaii John A. Burns School of Medicine

Southern Illinois School of Medicine

Chicago Medical School/University of Health Sciences

University of Louisville School of Medicine

University of Louisiana School of Medicine

Uniformed Services University of the Health Sciences

Michigan State University College of Human Medicine

University of Minnesota - Duluth School of Medicine

University of Nevada School of Medicine

College of Medicine and Dentistry of New Jersey, Rutgers Medical School

East Carolina University School of Medicine

University of North Dakota School of Medicine

Wright State University School of Medicine

Northeastern Ohio Universities College of Medicine

Ponce School of Medicine

University of South Carolina School of Medicine

The University of South Dakota School of Medicine

East Tennessee State University Quillen-Dishner College of Medicine

Texas A&M College of Medicine

Marshall University School of Medicine

Provisional AAMC Members

Mercer University School of Medicine

Morehouse School of Medicine

TABLE IV

Distribution of COTH Veterans Administration Hospitals (74) by State

- California has nine and New York has seven VA members

- Five states have three VA members: Florida, Illinois, Missouri, Ohio and Texas

- Eleven states have two VA members:

Connecticut	Michigan
Georgia	Pennsylvania
Iowa	Tennessee
Kentucky	Virginia
Louisiana	Wisconsin
Massachusetts	

- Nineteen states, the District of Columbia and Puerto Rico have a single VA member:

Alabama	Minnesota	Oregon
Arizona	Mississippi	Rhode Island
Arkansas	Nebraska	South Carolina
Colorado	New Jersey	Vermont
Indiana	New Mexico	Washington
Maryland	North Carolina	West Virginia
	Oklahoma	

inextricable relationships with a college of medicine; or (3) public hospitals with inextricable relationships with a college of medicine. Medical schools without a hospital in any of these three categories are listed in Table III. The geographic distribution of COTH Veterans Administration hospitals is listed in Table IV.

In summary, the COTH membership varies substantially in terms of hospital ownership, hospital-medical school relationship, and geography. As a result, COTH members are not in an equal position to respond to the environmental and managerial issues they face; this underlies both the intensive debate over proper governance relationships of some medical centers and the services various members expect from COTH/AAMC.

New Hospital Organizations Competing for National Attention

The COTH was the first of a growing number of special interest hospital organizations. Since its establishment, a number of associations have developed and many of them compete with COTH for the allegiance of its members.

- The Federation of American Hospitals has become an effective and highly visible organization;
- The National Association of Public Hospitals is two years old and gaining strength;
- The Association of Academic Health Centers is exhibiting strong interest in major teaching hospital issues;
- The National Council of Community Hospitals, with the leadership of John Horty, has made its presence felt, and appears to be a viable organization;

- The National Association of Children's Hospitals and Related Institutions has recently moved to Washington, DC;

- The Association of Volunteer Trustees of Not-for-Profit Hospitals has taken on some specific issues, and made an impact;

- Increasingly, hospitals and hospital associations are hiring Washington-based law firms and consulting firms for "representation" purposes. Some (not all) of these law firms have very little substantive or technical knowledge in the areas in which they are engaged to provide "representation" services.

Clearly, the association environment for COTH has changed substantially over the past five to ten years. There is competition for constituents, and for the attention of legislators, legislative staffers, and executive branch political leaders and employees.

In addition, other organizations are developing for a variety of purposes.

- Voluntary Hospitals of America has become a substantial economic force since its inception in 1977;

- Associated Hospital Systems is engaged in a variety of economic and public policy activities;

- The Consortium for the Study of University Hospitals has organized to study governance and other matters peculiar to the operation of hospitals under common ownership with state universities;

- The Council of Independent Teaching Hospitals is a group of hospitals in an organizational stage which hopes to address the problems of hospitals with freestanding residency programs and which do not have a close medical school affiliation;

- The Federation of Jewish Hospitals has hired an individual to explore the possibility of exploiting the collective economic strength of its members;

- The "original" Council of Teaching Hospitals has engaged Howard Newman to explore the development of possible collective activities.

A list of COTH members belonging to some of these new organizations is included as Appendix B.

The development of these new organizations suggests that multi-hospital systems, cooperatives, and organizational entities are are to some degree taking on traditional functions of associations. For example, until very recently (the past six months), Voluntary Hospitals of America clearly did not envision a public policy advocacy role. This policy has been reversed, and such an advocacy function is being developed.

COTH Strengths and Areas of Concern

With the exception of the Association of Academic Health Centers, all of the organizations identified in the previous section are "hospital" organizations. They were started by hospitals and their exclusive purpose is to serve their hospital constituents. A unique characteristic of the AAMC is that it brings together in one organization the deans, clinical and basic science faculty, and teaching hospital chief executives. Thus, it is not exclusively a medical school organization nor an organization devoted soley to the needs of academic physicians or teaching hospitals.

The Executive Council, which serves as the AAMC board of trustees, has a plurality of deans, but includes four hospital and four faculty representatives. Committees or task forces of the AAMC, regardless of the focus of their charge, include at least one member from each Council. This policy has been established to improve common understanding of issues, and to aid in the development of more broadly based AAMC policies or programs. Each constituency group may not get optimal outcome from its own point of view, but the unified voice enhances the strength of the AAMC policy position. For example, a position statement on a hospital issue can be given greater strength when it can be supported by the deans and faculty. At the same time, this method of operation appears to have reduced the friction and mistrust between the leadership of the three components of the medical center.

On numerous occasions, COTH members have expressed strong support for both the Council and the AAMC and its staff. This perception of the benefits of membership appears to be based on the following COTH/AAMC characteristics.

1. The hospital activities of COTH/AAMC focus on a limited set of concerns which in the past have not duplicated the efforts of other national organizations:

   a. clinical education issues including faculty relationships;

   b. clinical research issues; and

   c. issues of particular concern to large and/or complex hospitals.

2. In addressing issues and involving institutional representatives , the COTH/AAMC generally takes a corporate level viewpoint of the hospital rather than a departmental or functional one. Administrative Board, AAMC Assembly, and committee appointments are generally CEO appointments. The COTH Spring Meeting is directed at the CEO, and his/her attendance is required if others are to attend the meeting.

3. A teaching hospital CEO's involvement in COTH/AAMC activities involves him/her with other CEO's, deans, and faculty chairmen--all significant reference groups for the CEO.

4. The AAMC communicates its viewpoints directly to hospital CEO's without a state association as an intermediary. The message has frequently been more timely than others, but pending developments at other associations may decrease this advantage.

5. The AAMC staff promptly return telephone calls and correspondence to member CEO's and their staffs. The responsiveness reinforces the CEO perception that the staff pays attention to what concerns him.

In the development of the reorganized AAMC and the operation over the past 15 years, one could expect that a number of questions might be raised. Changes in the environments for both teaching hospitals and associations have

stimulated a number of major questions in recent years. The following are some examples.

Why have such a large number of special interest groups developed in the hospital community? "There appears to be a general lack of confidence that a large organization can deal with the special problems of 'my' kind of hospital," is a response that is frequently given in answer to this question. Clear examples are the development of the National Association of Public Hospitals and the Consortium for the Study of University Hospitals.

Does the staff of the AAMC perceive problems trying to represent a wide range of teaching hospital members? The large, private hospitals, which view themselves as the institutions which teach the teachers and support major research programs, on occasion express the view that their unique contributions and problems are not fully articulated. They and their colleagues in the other primary teaching hospitals seem to feel the rest of the COTH constituency dilutes their message. When asked specifically to show how the constituency has diluted or changed the AAMC objectives, the response has not been helpful. At the same time, the affiliated hospitals which are not primary seem to believe the organization is dominated by primary teaching hospitals.

Are there problems with the regional distribution of COTH members? Some constituents express the view that the organization is dominated by representatives from the Northeast corridor. A review of the list of COTH Past Chairmen could make a case for some bias, but a review of Administrative Board membership would not support this view. Since the largest number of COTH members are in the Northeast, it might be expected that this region has larger representation on the COTH Administrative Board and AAMC committees.

Who should be the COTH representative? A matter of some concern is the request of some members, primarily community teaching hospitals, that their institutional representative be someone other than the CEO of the hospital (e.g., medical director, vice president for medical affairs or a director of medical education). This suggests either: (1) that the role and responsibility of the COTH and its representation of the hospital viewpoint in the AAMC is not well understood; or (2) that in hospitals with limited educational programs, the CEO may not be heavily involved in the education and research issues, and the impact of these two missions has not significantly affected the character of the hospital.

What are the services provided to the COTH Veterans Administration members? In the "hospital community" there is not a full understanding and appreciation of the role of VA hospitals in medical education and as partners in the academic medical center. Over 7,700 residency positions are financed by the VA and a substantial research budget is supported. The AAMC is the only national hospital or medical association which testifies regularly on behalf of the Veterans Administration medical care appropriation. Additionally, the AAMC provides support for the VA in other legislative matters affecting the VA, ranging from chiropractic issues to special pay provisions for physicians. Routine meetings are held with the senior staff of the AAMC and the VA Chief Medical Director's office, and on occasion special consulting teams have been organized to resolve difficulties with some VA hospital-medical school affiliation arrangements.

What other complaints are heard? Many more CEO's wish to participate than can be accommodated. By design, the AAMC does not have standing committees in substantive areas and keeps the number of committees as small as possible. Participation is what generates loyalty and support of the

organization. To overcome this difficulty, the Department of Teaching Hospitals staff makes a strong effort to attend the meetings of the regional teaching hospital groups and seeks other ways to make personal contact with the teaching hospital constituents.

A final impression to which the staff sometimes finds it difficult to respond comes across as, "If only your organization would do something, I wouldn't have the problems I now have." Governance problems at the medical center level are a good example of this kind of problem.

FUTURE DIRECTIONS FOR COTH/AAMC

A Framework for Analysis

Associations of autonomous service and business entities, generally focus their activities on one or more of five goals.

Advocacy -- the association works to advantage its members by obtaining favorable or avoiding unfavorable treatment from the environment in which it operates. Advocacy activities may be directed at the political process (legislative and executive) or at the private sector environment.

Economic -- the association works to develop programs and member services designed to improve the efficiency and profitability of its members. Examples of such programs include group purchasing, standardized operating procedures, and multi-firm benefit and personnel programs.

Information -- the association provides its members with a convenient and reliable network designed to furnish members with significant information on developments in the environment. To the extent that

members are willing to share internal information with each other, the association provides a means of facilitating the exchange of "within member developments."

Education --- the association develops educational programs specifically designed to meet the specialized needs of its members.

Research -- the association develops an organized program to monitor the performance of its members, to develop methods or techniques which can be used by all members, and/or to identify early developments likely to affect the environment in which a member operates.

In most associations, each of these goals is present. Differences in associations seem to reflect differences in the emphasis given a particular goal and in the balance of activity across the five goals.

A review of the most recent paper on the "Selected Activities" of the AAMC's Department of Teaching Hospitals, Appendix C, shows staff activities focus primarily in the areas of advocacy, information, education, and research. Services in the economic area have not been developed. At the AAMC Officers' Retreat in December, 1982, agreement was reached that it would be unwise for the Association to develop service programs unless there is a clearly expressed constituent desire for a service and the Association would be uniquely qualified to provide that service. This decision was approved at the AAMC Executive Council meeting on January 20, 1983. Thus, the absence of these types of economic activities is the result of deliberate AAMC policy.

Within the four areas of existing activity, members commenting on the value of COTH generally cite its advocacy activities. While a large proportion of staff time is devoted to testimony, letters of comment, and personal representation at the Congressional staff level, more time is probably devoted to

interaction with HCFA and other executive agency staff, and to participation in advisory board and committees of other hospital associations and groups. Interaction with the staff of other associations or organizations whose interests overlap with those of the COTH/AAMC is particularly time consuming, and very important. Substantial staff time is also devoted to the development and distribution of information including a series of annual studies, the COTH Report, weekly activity report stories, and membership memoranda. In addition, a large proportion of staff time is spent on the telephone conveying information to members, consulting and law firms, and other callers. Thus, while advocacy may be the most valued staff service, information dissemination is also time consuming. The information dissemination function is supportive of the advocacy function (and in some cases is not distinguishable from it) since it serves to establish the credibility and reputation of the AAMC teaching hospital staff members.

Future Directions

The Council of Teaching Hospitals of the AAMC is less than twenty years old, and it grew and developed during the period of hospital expansion and retrospective cost reimbursement. With a changing environment, COTH and the AAMC's services need to be examined to help ensure that traditional activities of the Department of Teaching Hospitals are appropriate and that any new initiatives strengthen both the Council and the AAMC. As the membership and governance directs their attention to how the Association should function on behalf of its hospital members in the future, past services and emphases are only a prologue. Yet, past activities have demonstrated a commonality of interest. The selection and development of areas of common interest will become increasingly important in a more competitive future. As a result, staff suggests the the following directions for COTH/AAMC activities in the future.

Advocacy -- By its very nature and structure, the AAMC is focused on advocacy. In the past two decades, this advocacy has focused on supporting the expansion and development of member capabilities. In the near future, the advocacy emphasis will shift to protecting the diversity of the membership and preserving special benefits, subsidies, and advantages available to teaching hospitals. With third party payers increasingly setting fixed levels of expenditures for hospital services, the AAMC must work to protect the teaching hospital share.

Advocacy, however, is not limited to the political process of legislation, regulation and oversight. It includes building public awareness, appreciation for, and support of teaching hospitals. The predominately local nature of hospital service markets and the increasing emphasis on local payment arrangements stimulates the need for public advocacy of the generic benefits provided by teaching hospitals.

Economics -- Teaching hospitals compete in three markets: in an immediate local market for primary hospital services; in a somewhat broader local market for tertiary hospital services, and in a regional or national market for payer revenues. In each of these markets, many teaching hospitals are competing with each other as well as with community hospitals.

A decision to emphasize economic goals would require the AAMC to substantially expand its present teaching hospital staff. It also would require a willingness to advantage some members at the expense of others. This latter point does not seem to be understood by all who advocate service programs.

Information -- Information acquisition costs in all organizations can be dramatically reduced if a reliable and timely link to the environment is

established. Critical to the economy of this link is the external sources ability to sort and prioritize information in the same way the receiver himself would. In a competitive environment, low cost, accurate information is a valuable asset. Because the competitive value of the information is based upon its use, not its possession, competing organizations can generally share in supporting an information network.

In a rapidly changing environment, COTH/AAMC can offer members a valuable service by collecting, analyzing, and distributing information. This goal should continue to receive priority; however, a careful evaluation should be undertaken to assess the types of information presently distributed, the reliance on printed materials and mailed distribution, and the almost exclusive designation of CEO's as the addressee.

Education -- The recent success of the four regional workshops on the Medicare prospective payment methodology and physician payment regulations demonstrates the ability of the AAMC to mount programs and the favorable response of the constituents if the topics are timely and interesting. These workshops serve as an excellent example of the special role the AAMC can play as a result of its unique tripartite organization. The objective of the workshops was to serve the hospital CEO by educating the medical school dean and faculty about the change in their responsibilities which will accompany the new Medicare payment methodology. The Management Education Programs of the AAMC have been reorganized and are under intensive review and redevelopment. The needs of all AAMC constituent groups are being examined.

Research -- Traditionally, AAMC research on hospital topics has been a secondary goal undertaken to support either advocacy or information activities. Placing research in a secondary position has worked reasonably

well; however new advocacy and information requirements will require enhanced research capabilities (1) in monitoring member performance in the changed environment, (2) in analyzing environmental factors which threaten the survival of teaching hospitals, and (3) in identifying early developments which may be widely present in the environment in 3-10 years. To help ensure that the secondary or derived importance of research is not subject to sporadic attention as time permits, a small but continuous research program should be developed.

In a changing hospital environment, COTH/AAMC may need to refocus its services to hospital members. This paper proposes an enhanced emphasis on political and public advocacy, information distribution and education.

For these suggested directions to be attained, they need to be reflected in specific actions. A series of recommendations are presented for discussion.

Advocacy -- The role, responsibility and contributions of teaching hospitals to the health care system need to be articulated forcefully and constantly. In view of the rapidly changing hospital and medical service evironment, the increasing importance of the role of the COTH and its members in the development of policies and programs of the AAMC should be clearly recognized and understood. It is recommended that this paper be used as a discussion document at the December, 1983 AAMC Officers' Retreat, and that a revised version of this paper be presented at the May, 1984 COTH Spring Meeting in Baltimore.

The advocacy position articulated above in fact implies a policy of protecting the diversity of membership and emphasizing the generic contributions and values of all teaching hospitals. A number of COTH members believe, however, that they would be better served if the AAMC

perceived its role as advocating the particular needs of only the primary teaching hospitals (i.e., the first three categories shown in Appendix A). At this time, the staff of the Department of Teaching Hospitals does not believe that advocacy on behalf of this limited group of teaching hospitals is the proper policy course to pursue.

In the era of administered prices, federally sponsored and conducted studies will be used to direct the evolution of the system. It is recommended that COTH/AAMC explicitly work to have their members included on all relevant advisory and research committees.

It is recommended that COTH/AAMC sponsor an annual seminar for Congressional staff on innovations in teaching hospitals. Medical staff members active in the development of new technologies would describe and discuss the innovation.

It is recommended that the COTH/AAMC sponsor "issue development" conferences on such matters as teaching hospital/HMO relationships, the impact of PPO's, development of ambulatory service programs and similar topics.

It is recommended that the COTH/AAMC develop a registered service mark or slogan which could be licensed to individual members meeting defined criteria. Examples of the slogan accompanying the service mark are:

Where Standards of Excellence are Routine

Where Education and Research Result in Better Care for You

World Class Medicine

Scholarship in Service of Patient Care

Information -- It is recommended that the CAS and COTH consider sponsorship of an annual symposium on recent developments in clinical care and technology. The objective of the symposium would be to provide the hospital chief executive officer a broader perspective of new and developing technology, and its implications for medical care in the teaching hospitals.

It is recommended that the AAMC develop an electronic communication capability which is regularly used to communicate time sensitive information to its constituents.

It is recommended that the AAMC supplement its present mailings to hospital CEO's with mailing lists for chief financial officers and directors of planning. Where appropriate, duplicate mailings of memoranda would be directed to one or both of these individuals.

It is recommended that the AAMC use the data and reports of the American Hospital Association and Healthcare Financial Management Association to develop and publish time series data on teaching hospital utilization, revenue, expense, charity care, staffing, and financial performance.

Research -- If HCFA cost reports permit, it is recommended AAMC survey COTH members to assess the differences in hospital revenue under cost based reimbursement and prospective payment. Where prospective payment results in reduced revenue, the AAMC should attempt to identify the characteristics of the adversely affected members.

It is recommended that the AAMC survey its members to determine the Medicare revenue being paid to COTH members under the medical education and capital pass throughs and under the "indirect adjustment for costs associated with medical education."

It is recommended that AAMC staff prepare papers on four survival issues facing teaching hospitals: alternative methods for funding residency training, new approaches to financing charity care, developing methods for estimating average and marginal costs per case, and the extent of price differences among payers paying "negotiated" prices. The COTH Administrative Board, at its September meeting, strongly recommended that immediate staff attention be focused on preparing papers detailing alternative methods for financing both charity care and graduate medical education under price oriented payment systems.

It is recommended that AAMC staff prepare a literature review on options and issues in determining capitation payments for Medicare and Medicaid patients.

These are not a set of exclusive recommendations; others could and should be added to the list. Also, the present staff probably couldn't accomplish all of the suggested tasks, projects, and programs. However, the staff has attempted to provide a framework for productive discussion and a set of recommendations for review.

Appendix A

Distribution of COTH Hospitals

by

Type of Hospital and School Relationship

64 Hospitals having Common Ownership with the College of Medicine

University of Alabama Hospitals
Birmingham, AL

University of South Alabama Medical Center
Mobile, AL

University Hospital
Tucson, AZ

University Hospital
Little Rock, AR

Loma Linda University Medical Center
Loma Linda, CA

UCLA Hospitals and Clinics
Los Angeles, CA

University of California, Irvine, Medical Center
Orange, CA

University of California, Davis, Medical Center
Sacramento, CA

University Hospital
San Diego, CA

University of California Hospitals and Clinics
San Francisco, CA

Stanford University Hospital
Stanford, CA

University Hospital
Denver, CO

University of Connecticut
Farmington, CT

George Washington University Hospital
Washington, DC

Georgetown University Hospital
Washington, DC

Howard University Hospital
Washington, DC

Crawford W. Long Memorial Hospital
Atlanta, GA

Emory University Hospital
Atlanta, GA

Eugene Talmadge Memorial Hospital
Augusta, GA

Rush-Presbyterian-St. Luke's Medical Center
Chicago, IL

University of Chicago Hospitals and Clinics
Chicago, IL

University of Illinois Hospital
Chicago, IL

Foster G. McGaw Hospital
Maywood, IL

Indiana University Hospitals
Indianapolis, IN

University of Iowa Hospitals and Clinics
Iowa City, IA

University of Kansas Medical Center
Kansas City, KS

University Hospital
Lexington, KY

Louisiana State University Hospital
Shreveport, LA

University of Maryland Hospital
Baltimore, MD

University of Massachusetts Hospital
Worchester, MA

University Hospital
Ann Arbor, MI

University of Minnesota Hospital
Minneapolis, MN

University Hospital
Jackson, MS

University of Missouri Hospital and Clinics
Columbia, MO

St. Louis University Hospitals
St. Louis, MO

University of Nebraska Hospital and Clinics
Omaha, NE

University Medical Center
Newark, NJ

Albany Medical Center Hospital
Albany, NY

State University Hospital
Brooklyn, NY

New York University Hospital
New York, NY

Strong Memorial Hospital
Rochester, NY

University Hospital
Stony Brook, NY

State University Hospital
Syracuse, NY

Duke University Hospital
Durham, NC

University of Cincinnati Hospital
Cincinnati, OH

Ohio State University Hospitals
Columbus, OH

Medical College of Ohio Hospital
Toledo, OH

University Hospital
Portland, OR

Milton S. Hershey Medical Center
Hershey, PA

Hahnemann University Hospital
Philadelphia, PA

Hospital of the Medical College of Pennsylvania
Philadelphia, PA

Hospital of the University of Pennsylvania
Philadelphia, PA

Temple University Hospital
Philadelphia, PA

Thomas Jefferson University Hospital
Philadelphia, PA

Medical University Hospital
Charleston, SC

George W. Hubbard Hospital
Nashville, TN

Vanderbilt University Hospital
Nashville, TN

University of Texas Medical Branch Hospital
Galveston, TX

University of Utah Hospital
Salt Lake City, UT

University of Virginia Hospitals
Charlottesville, VA

Medical College of Virginia Hospitals
Richmond, VA

University of Washington Hospital
Seattle, WA

West Virginia University Hospital
Morgantown, WV

University of Wisconsin Hospital and Clinics
Madison, WI

27 Separate Non-Profit Hospitals with Inextricable Relationships with College of Medicine

Yale-New Haven Hospital
New Haven, CT

Shands Hospital
Gainesville, FL

Northwestern Memorial Hospital
Chicago, IL

The Johns Hopkins Hospital
Baltimore, MD

Beth Israel Hospital
Boston, MA

Brigham and Women's Hospital
Boston, MA

Massachusetts General Hospital
Boston, MA

New England Medical Center
Boston, MA

University Hospital
Boston, MA

Harper Grace Hospitals
Detroit, MI

Rochester Methodist Hospital
Rochester, MN

St. Mary's Hospital
Rochester, MN

Barnes Hospital
St. Louis, MO

Creighton Omaha Health Care Corporation
Omaha, NE

Mary Hitchcock Memorial Hospital
Hanover, NH

Montefiore Hospital
Bronx, NY

The Mount Sinai Hospital
New York, NY

The New York Hospital
New York, NY

Presbyterian Hospital in the City of NY
New York, NY

North Carolina Baptist Hospitals
Winston-Salem, NC

University Hospitals of Cleveland
Cleveland, OH

Presbyterian-University Hospital
Pittsburgh, PA

Rhode Island Hospital
Providence, RI

Hermann Hospital
Houston, TX

Medical Center Hospital of Vermont
Burlington, VT

Medical Center Hospitals
Norfolk, VA

Froedtert Memorial Lutheran Hospital
Milwaukee, WI

23 Public Hospitals with Inextricable Relationships with the College of Medicine

LA County/USC Medical Center
Los Angeles, CA

Harbor-UCLA Medical Center
Torrance, CA

Jackson Memorial Hospital
Miami, FL

Tampa General Hospital
Tampa, FL

Grady Memorial Hospital
Atlanta, GA

Wishard Memorial Hospital
Indianapolis, IN

Charity Hospitals of Louisiana
New Orleans, LA

Truman Medical Center
Kansas City, MO

University of New Mexico Hospital
Albuquerque, NM

Kings County Hospital Center
Brooklyn, NY

Erie County Medical Center
Buffalo, NY

Bellevue Hospital Center
New York, NY

Westchester County Medical Center
Valhalla, NY

The North Carolina Memorial Hospital
Chapel Hill, NC

Oklahoma Memorial Hospital
Oklahoma City, OK

City of Memphis Hospitals
Memphis, TN

Parkland Memorial Hospital
Dallas, TX

Harris County Hospital District
Houston, TX

Lubbock General Hospital
Lubbock, TX

Bexar County Hospital District
San Antonio, TX

Harborview Medical Center
Seattle, WA

Milwaukee County Medical Complex
Milwaukee, WI

University Hospital
Rio Pierdras, PR

27 Specialty Hospitals

Children's Hospital of Los Angeles
Los Angeles, CA

Children's Hospital of San Francisco
San Francisco, CA

Children's Hospital National Medical Center
Washington, DC

Henrietta Egleston Hospital for Children
Atlanta, GA

The Children's Memorial Hospital
Chicago, IL

Schwab Rehabilitation Hospital
Chicago, IL

The Children's Hospital Medical Center
Boston, MA

Massachusetts Eye and Ear Infirmary
Boston, MA

St. Margaret's Hospital for Women
Boston, MA

Children's Hospital of Michigan
Detroit, MI

St. Louis Children's Hospital
St. Louis, MO

Hospital for Joint Diseases
New York, NY

Hospital for Special Surgery
New York, NY

Memorial Hospital for Cancer and Allied Diseases
New York, NY

Children's Hospital Medical Center
Akron, OH

Children's Hospital Medical Center
Cincinnati, OH

Children's Hospital
Columbus, OH

St. Christopher's Hospital for Children
Philadelphia, PA

Children's Hospital of Pittsburgh
Pittsburgh, PA

Eye and Ear Hospital of Pittsburgh
Pittsburgh, PA

Magee-Women's Hospital
Pittsburgh, PA

Western Psychiatric Institute and Clinic
Pittsburgh, PA

Women and Infant's Hospital
Providence, RI

Texas Children's Hospital
Houston, TX

M.D. Anderson Hospital and Tumor Institute
Houston, TX

Children's Orthopedic Hospital and Medical Center
Seattle, WA

Milwaukee Children's Hospital
Milwaukee, WI

77 Federal Hospitals

VA Medical Center

Birmingham, AL
Little Rock, AR
Tucson, AZ
Loma Linda, CA
Long Beach, CA
Los Angeles, CA (Brentwood)
Los Angeles, CA (Wadsworth)
Martinez, CA
Palo Alto, CA
San Diego, CA
San Francisco, CA
Sepulveda, CA
Denver, CO
Newington, CT
West Haven, CT
Washington, DC
Gainesville, FL
Miami, FL
Tampa, FL
Augusta, GA
Decatur, GA
Chicago, IL
Chicago, IL
Hines, IL
Indianapolis, IN
Des Moines, IA
Iowa City, IA
Lexington, KT
Louisville, KT
New Orleans, LA
Shreveport, LA
Baltimore, MD
Boston, MA
West Roxbury, MA
Allen Park, MI
Ann Arbor, MI
Minneapolis, MN
Jackson, MS
Columbia, MO
Kansas City, MO
St. Louis, MO
Omaha, NE
East Orange, NJ
Albuquerque, NM
Albany, NY
Bronx, NY
Brooklyn, NY
Buffalo, NY
New York, NY
Northport, NY
Syracuse, NY

Durham, NC
Cincinnati, OH
Cleveland, OH
Dayton, OH
Oklahoma, OK
Portland, OR
Philadelphia, PA
Pittsburgh, PA
Providence, RI
Charleston, SC
Memphis, TN
Nashville, TN
Dallas, TX
Houston, TX
San Antonio, TX
White River Junction, VT
Hampton, VA
Richmond, VA
Seattle, WA
Clarksburg, WV
Madison, WI
Wood, WI
San Juan, PR

NIH Clinical Center
Bethesda, MD

Wilford Hall USAF Medical Center
San Antonio, TX

Public Health Hospital
Seattle, WA

18 Public Hospitals with a Secondary Affiliation with College of Medicine

Maricopa County General Hospital
Phoenix, AZ

Martin Luther King Jr. General Hospital
Los Angeles, CA

District of Columbia General Hospital
Washington, DC

University Hospital of Jacksonville
Jacksonville, FL

Cook County Hospital
Chicago, IL

Baltimore City Hospital
Baltimore, MD

Worcester City Hospital
Worcester, MA

Hurley Medical Center
Flint, MI

Wayne County General Hospital
Westland, MI

Hennepin County Medical Center
Minneapolis, MN

St. Paul-Ramsey Medical Center
St. Paul, MN

Bronx Municipal Hospital Center
Bronx, NY

Nassau County Medical Center
East Meadow, NJ

City Hospital at Elmhurst
Elmhurst, NY

Harlem Hospital Medical Center
New York, NY

Charlotte Memorial Hospital and Medical Center
Charlotte, NC

Cleveland Metropolitan Hospital
Cleveland, Ohio

Erlanger Medical Center
Chattanooga, TN

58 Affiliated Non-Profit Hospitals with Significant Commitments to Medical Education (resident-to-bed ratio of at least 0.2)

Good Samaritan Hospital
Phoenix, AZ

Kern Medical Center
Bakersfield, CA

Valley Medical Center
Fresno, CA

Mt. Zion Hospital and Medical Center
San Francisco, CA

Presbyterian Hospital of Pacific Medical Center
San Francisco, CA

Hartford Hospital
Hartford, CT

Hospital of St. Raphael
New Haven, CT

Washington Hospital Center
Washington, DC

Illinois Masonic Medical Center
Chicago, IL

Mercy Hospital and Medical Center
Chicago, IL

Michael Reese Hospital and Medical Center
Chicago, IL

Mount Sinai Hospital Medical Center
Chicago, IL

Evanston Hospital Corporation
Evanston, IL

Ochsner Medical Foundation
New Orleans, LA

Franklin Square Hospital
Baltimore, MD

Sinai Hospital of Baltimore
Baltimore, MD

Faulkner Hospital
Boston, MA

New England Deaconess Hospital
Boston, MA

St. Elizabeth's Hospital of Boston
Boston, MA

Detroit Receiving Hospital
Detroit, MI

Henry Ford Hospital
Detroit, MI

Hutzel Hospital
Detroit, MI

Sinai Hospital of Detroit
Detroit, MI

Providence Hospital
Southfield, MI

Jewish Hospital of St. Louis
St. Louis, MO

Monmouth Medical Center
Long Branch, NJ

Middlesex General Hospital
New Brunswick, NJ

Newark Beth Israel Medical Center
Newark, NJ

St. Michael's Medical Center
Newark, NJ

The Bronx Lebanon Hospital Center
Bronx, NY

Misericordia Hospital Medical Center
Bronx, NY

Brookdale Hospital Medical Center
Brooklyn, NY

Brooklyn-Cumberland Medical Center
Brooklyn, NY

Jewish Hospital and Medical Center
Brooklyn, NY

Long Island College Hospital
Brooklyn, NY

Maimonides Medical Center
Brooklyn, NY

Methodist Hospital
Brooklyn, NY

Booth Memorial Medical Center
Flushing, NY

North Shore University Hospital
Manhasset, NY

Nassau Hospital
Mineola, NY

Long Island Jewish/Hillside Medical Center
New Hyde Park, NY

Beth Israel Medical Center
New York, NY

Cabrini Medial Center
New York, NY

Lenox Hill Hospital
New York, NY

St. Vincent's Hospital and Medical Center
New York, NY

Highland Hospital of Rochester
Rochester, NY

St. Vincent's Medical Center of Richmond
Staten Island, NY

Akron City Hospital
Akron, OH

The Cleveland Clinic Hospital
Cleveland, OH

Mt. Sinai Medical Center
Cleveland, OH

Geisinger Medical Center
Danville, PA

Albert Einstein Medical Center
Philadelphia, PA

The Graduate Hospital
Philadelphia, PA

Pennsylvania Hospital
Philadelphia, PA

Presbyterian-U of Penn Medical Center
Philadelphia, PA

Mercy Hospital of Pittsburgh
Pittsburgh, PA

Montefiore Hospital Association
Pittsburgh, PA

Scott and White Memorial Hospital
Temple, TX

121 Affiliated Non-Profit Community Teaching Hospitals (resident-to-bed ratio below 0.2)

Baptist Medical Centers
Birmingham, AL

St. Joseph Hospital and Medical Center
Phoenix, AZ

Tucson Medical Center
Tucson, AZ

Memorial Hospital of Long Beach
Long Beach, CA

Cedars-Sinai Medical Center
Los Angeles, CA

Hospital of the Good Samaritan
Los Angeles, CA

Huntington Medical Center
Pasadena, CA

Riverside General Hospital
Riverside, CA

Mercy Hospital and Medical Center
San Diego, CA

Kaiser Foundation Hospital
San Francisco, CA

Presbyterian-St. Luke's Medical Center
Denver, CO

Bridgeport Hospital
Bridgeport, CT

St. Vincent's Medical Center
Bridgeport, CT

Danbury Hospital
Danbury, CT

Mount Sinai Hospital
Hartford, CT

St. Francis Hospital
Hartford, CT

New Britain General Hospital
New Britain, CT

Stamford Hospital
Stamford, CT

Waterbury Hospital
Waterbury, CT

Wilmington Medical Center
Wilmington, DE

Mt. Sinai Medical Center
Miami Beach, FL

MacNeal Memorial Hospital
Berwyn, IL

St. Joseph Hospital
Chicago, IL

St. Mary of Nazareth Hospital Center
Chicago, IL

Christ Hospital
Oak Lawn, IL

Lutheran General Hospital
Park Ridge, IL

St. Francis Hospital-Medical Center
Peoria, IL

Memorial Medical Center
Springfield, IL

St. John's Hospital
Springfield, IL

Methodist Hospital of Indiana
Indianapolis, IN

St. Vincent Hospital and Health Center
Indianapolis, IN

Iowa Methodist Medical Center
Des Moines, IA

St. Francis Regional Medical Center
Wichita, KS

St. Joseph Hospital Medical Center
Wichita, KS

Wesley Medical Center
Wichita, KS

Jewish Hospital
Louisville, KT

Touro Infirmary
New Orleans, LA

Maine Medical Center
Portland, ME

Maryland General Hospital
Baltimore, MD

Union Memorial Hospital
Baltimore, MD

Carney Hospital
Boston, MA

Mt. Auburn Hospital
Cambridge, MA

Berkshire Medical Center
Pittsfield, MA

Baystate Medical Center
Springfield, MA

St. Vincent Hospital
Worcester, MA

Worcester Memorial Hospital
Worcester, MA

St. Joseph Mercy Hospital
Ann Arbor, MI

Oakwood Hospital Corporation
Dearborn, MI

Mount Carmel Mercy Hospital
Detroit, MI

St. John Hospital
Detroit, MI

Blodgett Memorial Medical Center
Grand Rapids, MI

Butterworth Hospital
Grand Rapids, MI

St. Mary's Hospital
Grand Rapids, MI

Sparrow Hospital
Lansing, MI

St. Joseph Mercy Hospital
Pontiac, MI

St. Luke's Hospital
Kansas City, MO

St. John's Mercy Medical Center
St. Louis, MO

St. Mary's Health Center
St. Louis, MO

Cooper Hospital/University Medical Center
Camden, NJ

Hackensack Medical Center
Hackensack, NJ

St. Barnabas Medical Center
Livingston, NJ

Morristown Memorial Hospital
Morristown, NJ

Jersey Shore Medical Center
Neptune, NJ

St. Joseph's Hospital and Medical Center
Paterson, NJ

Muhlenberg Hospital
Plainfield, NJ

Overlook Hospital
Summit, NJ

Buffalo General Hospital
Buffalo, NY

Millard Fillmore Hospital
Buffalo, NY

Mary Imogene Bassett Hospital
Cooperstown, NY

Catholic Medical Center
Jamaica, NY

United Health Services
Johnson City, NY

The Genesee Hospital
Rochester, NY

Rochester General Hospital
Rochester, NY

St. Mary's Hospital
Rochester, NY

Moses H. Cone Memorial Hospital
Greensboro, NC

Wake County Hospital System
Raleigh, NC

Akron General Medical Center
Akron, OH

St. Thomas Hospital Medical Center
Akron, OH

Aultman Hospital
Canton, OH

Christ Hospital
Cincinnati, OH

Good Samaritan Hospital
Cincinnati, OH

St. Luke's Hospital
Cleveland, OH

Grant Hospital
Columbus, OH

Riverside Methodist Hospital
Columbus, OH

Good Samaritan Hospital and Health Center
Dayton, OH

Miami Valley Hospital
Dayton, OH

Kettering Memorial Hospital
Kettering, OH

The Youngstown Hospital Association
Youngstown, OH

St. Francis Hospital
Tulsa, OK

Emanuel Hospital
Portland, OR

Lehigh Valley Hospital Center
Allentown, PA

The Bryn Mawr Hospital
Bryn Mawr, PA

Crozer-Chester Medical Center
Chester, PA

Mercy Catholic Medical Center
Darby, PA

Hamot Medical Center
Erie, PA

Harrisburg Hospital
Harrisburg, PA

Conemaugh Valley Medical Hospital
Johnstown, PA

Episcopal Hospital
Philadelphia, PA

Frankfort Hospital
Philadelphia, PA

The Lankenaw Hospital
Philadelphia, PA

Alleghany General Hospital
Pittsburgh, PA

St. Francis General Hospital
Pittsburgh, PA

The Western Pennsylvania Hospital
Pittsburgh, PA

York Hospital
York, PA

The Memorial Hospital
Pawtucket, RI

The Miriam Hospital
Providence, RI

Roger Williams General Hospital
Providence, RI

Greenville Hospital Systems
Greenville, SC

Baptist Memorial Hospital
Memphis, TN

Baylor University Medical Center
Dallas, TX

Methodist Hospital of Dallas
Dallas, TX

Presbyterian Hospital of Dallas
Dallas, TX

St. Paul Hospital
Dallas, TX

The Methodist Hospital
Houston, TX

The Fairfax Hospital
Falls Church, VA

Charleston Area Medical Center
Charleston, WV

Ohio Valley Medical Center
Wheeling, WV

Madison General Hospital
Madison, WI

Mount Sinai Medical Center
Milwaukee, WI

St. Joseph's Hospital
Milwaukee, WI

St. Luke's Hospital
Milwaukee, WI

COTH Members Belonging to New Hospital Organizations

Organization	COTH Members
Associated Hospital Systems (founded 1977) (11 members including 5 COTH)	Forbes Health System, Pittsburgh East Suburban Health Center (Corresponding)
	Greenville Hospital System
	Intermountain Health Care, Inc., Salt Lake City LDS Hospital (former member)
	Metropolitan Hospitals, Portland Oregon Emanuel Hospital
	SamCor, Phoenix Good Samaritan Hospital
	Sisters of Mercy Health Corporation, Farmington Hills St. Joseph Mercy Hospital, Ann Arbor
National Association of Public Hospitals (founded 1981) (24 members including 15 COTH)	Harris County Hospital District, Houston
	College Hospital, Newark
	D.C. General, Washington
	Cleveland Metropolitan General
	Grady Memorial, Atlanta
	Los Angeles County/USC Medical Center
	Parkland Memorial Hospital, Dallas
	Truman Medical Center, Kansas City
	University of Maryland Hospital
	Wishard Memorial Hospital, Indianapolis
	New York City Health and Hospitals Corp. Bronx Municipal Kings County City Hospital at Elmhurst Bellevue Hospital Harlem Hospital Medical Center
	Worcester City Hospital
	Cook County Hospital
	Westchester County Medical Center

	Milwaukee County Medical Center
Voluntary Hospitals of America (founded 1977) (54 members including 22 COTH)	Abbott-Northwestern Hospital, Minneapolis (former member)
	Akron General Medical Center
	Baptist Medical Centers, Birmingham
	Baptist Memorial Hospital, Memphis
	Barnes Hospital
	Baylor University Medical Center, Dallas
	Butterworth Hospital, Grand Rapids
	Charleston Area Medical Center
	Christ Hospital, Cincinnati
	Community Hospital of Indiana (corresponding)
	Evanston Hospital Corporation
	Henry Ford Hospital, Detroit
	Lutheran General Hospitals, Park Ridge
	Madison General Hospital
	Medical Center Hospitals, Norfolk
	Memorial Hospital Medical Center, Long Beach
	Miami Valley Hospital, Dayton
	Ochsner Foundation Hospital, New Orleans
	Pennsylvania Hospital, Philadelphia
	Riverside Methodist Hospital, Columbus
	Tucson Medical Center
	Wesley Medical Center, Wichita
	Yale-New Haven Hospital
Consortium of Jewish Hospitals (17 members including 15 COTH)	Albert Einstein Medical Center, Philadelphia
	Touro Infirmary, New Orleans

Sinai Hospital of Baltimore

Jewish Hospital of St. Louis

Mt. Sinai Medical Center, Miami Beach

Montefiore Hospital, Pittsburgh

Mt. Sinai Medical Center, Milwaukee

Cedars-Sinai Medical Center, Los Angeles

Beth Israel Hospital, Boston

Mt. Sinai Hospital & Medical Center, Chicago

Miriam Hospital, Providence

Sinai Hospital of Detroit

Michael Reese Hospital & Medical Center, Chicago

Mt. Sinai Medical Center, Cleveland

Jewish Hospital, Louisville

Consortium for the Study of University Hospitals (all COTH members)

University of Alabama Hospital

University of South Alabama Medical Center

University of Arkansas Hospital

UCLA Hospitals and Clinics

University of California Hospitals and Clinics, San Francisco

University of Colorado Hospital

Shands Hospital, Gainesville

University of Illinois Hospital

University of Kentucky Hospital

University of Maryland Hospital

University of Massachusetts Medical

University of Michigan Hospitals

University of Minnesota Hospital and Clinics

University of Nebraska Hospital and Clinics

	State University Hospital, Downstate, Brooklyn
	State University Hospital, Stonybrook, New York
	North Carolina Memorial Hospital
	Medical College of Virginia Hospitals
	University of Virginia Hospitals
	University of Washington Hospitals
	West Virginia University Hospital
	University of Wisconsin Hospital and Clinics
"Original" Council of Teaching Hospitals (all COTH members)	The Johns Hopkins Hospital
	Massachusetts General Hospital
	The New York Hospital
	Presbyterian Hospital in the City of New York
	Hospital of the University of Pennsylvania
	Strong Memorial Hospital of the University of Rochester
	University Hospitals of Cleveland
	Yale-New Haven Hospital