aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

January 18-19, 1984
Washington Hilton Hotel

WEDNESDAY, January 18, 1984

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Grant Room
7:30pm	COTH ADMINISTRATIVE BOARD RECEPTION Hamilton Room
8:30pm	COTH ADMINISTRATIVE BOARD DINNER Grant Room

THURSDAY, January 19, 1984

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

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

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

January 19, 1984
Washington Hilton Hotel
Jackson Room
9:00am - 1:00pm

I.	CALL TO ORDER	
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V.	RELATIONSHIPS WITH THE ASSOCIATION OF ACADEMIC HEALTH CENTERS	Page 39 Dr. Heyssel
VI.	NEW CHALLENGES FOR THE COUNCIL OF TEACHING HOSPITALS AND THE DEPARTMENT OF TEACHING HOSPITALS	Executive Council Agenda - Page 35
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XII.	NIH RENEWAL LEGISLATION	Executive Council Agenda - Page 107
XIII.	RESEARCH FACILITY AND EQUIPMENT NEEDS (Status of Research Facilities and Instrumentation)	Separate Attachment
XIV.	INFORMATION ITEM	
	o UPDATE ON THE MEDICARE PROSPECTIVE PAYMENT SYSTEM	Executive Council Agenda - Page 152 COTH Administrative Board Agenda - Page 43

EXECUTIVE COUNCIL ACTION ITEM 'N'

COTH ADMINISTRATIVE BOARD AGENDA ITEM 'XIII.'

Status of Research Facilities and Instrumentation

Background. The continuing deterioration in the quality of research facilities and instrumentation in the academic laboratories, including those in medical centers, has become a matter of increasing concern to scientists, institution officials, and those science-oriented agencies within the Federal government responsible for science programs. A major constraint to prompt and sound planning to contend with this problem has been the absence of timely information as to the quantitative and qualitative dimensions of these research resources.

At the time of the June 1981 Executive Council meeting, the decision was made to establish an ad hoc committee to examine issues relating to the funding of research resources. This was prompted by a number of considerations, including concerns about the quality and quantity of instrumentation in academic institutions, increasing competition for available funds, and some uncertainty with respect to the future within NIH of the Division of Research Resources. No meeting of that committee was ever convened, in part because the threat to the continuing existence of DRR disappeared, and because it seemed that more comprehensive examination of these issues would be undertaken by organizations with a broader base than the Association.

Since that time, the concerns about the underlying problem have continued to grow, and several studies have been initiated or proposed in the two areas. They are summarized as follows.

(1) National Survey of Academic Research Instruments and Instrumentation Needs. Sponsored and supported by the National Science Foundation and NIH, and conducted by WESTAT, Inc., the purpose is to "provide a factual basis for the review of Federal equipment funding levels and priorities. This survey will document for the first time: (a) trends in the amount, condition and cost of existing research instrumentation in the nation's principal research universities and medical schools, and (b) the nature and extent of the need for upgraded or expanded research instrumentation in the major fields of academic science and engineering." The study involves a nationally representative sample of 43 major R&D universities and a partially linked sample of 24 medical schools. Information will be collected on a representative sample about each type of research instrument's age, cost, means of acquisition, condition and so forth. The findings will be used to develop quantitative indicators of trends over time and differences among fields in instrumentation costs, investment, condition, and need. The study will be conducted over a two-year period that commenced late in 1982. Medical schools will be involved only in 1983-84.

(2) A Project to Assess and Disseminate Alternative Approaches to Meeting University Research Equipment Needs. Originally supported

by NSF, DOA, DOD, DOE and NASA and carried out by AAU, NASULGC and COGR, this is a 16-month project, with the objective of "increasing awareness among research universities of opportunities for better planning and management of research equipment at all levels." The project is planned in three phases. In phase I, six analyses will be conducted to:

- Assess the role of debt-financing of research equipment and sound university financial practice;
- Identify and evaluate opportunities to improve the procurement, management, use, operation and maintenance of research equipment;
- Assess present tax incentives for the donation of research equipment and suggest ways to increase support from the private sector;
- Identify opportunities to eliminate or reduce state and university budget and policy barriers;
- Identify opportunities for changes in Federal regulations;
- Evaluate present methods of direct Federal investment and suggest improvements.

Phase II involves regional seminars to disseminate and discuss the results of the six analyses within the university community. The third phase is a briefing in Washington to present to Federal agencies and Congress the results of these analyses.

Apparently during the planning phase there was some confusion about the possibility of NIH also being a supporter of the project. As a consequence, there was no specific biomedical aspect to the study. Because of that, AAMC staff expressed their concern about this seemingly unnecessary and serious defect. Negotiations were therefore reopened with NIH, with the result that partial funding for part of the project to add a biomedical component has been assured. The project is to be completed in February 1985.

(3) Interagency Study of Academic Science and Engineering Laboratory Facilities. The House version of the Authorization bill for the Department of Defense for FY 1984 included the following provision: "The Committee also directs that a study be undertaken by the Secretary of Defense on the need to modernize university science laboratories essential to long-term national security needs. The study should be submitted to the Committee by March 15, 1984." The Congress also directed NSF to be a lead agency in encouraging other Federal agencies, state and local governments, and the private sector to support renewal of university research facilities. A steering committee was formed with representatives

from NSF, DOD, NIH and DOE to plan a study of such facilities. The objective is to obtain an understanding of the condition of university facilities currently being used for science and engineering research and the estimated future needs for construction, remodeling and refurbishment.

A request has just been directed to the chief executives of approximately 25 institutions asking for 5-year facility plans and estimated expenditures for new construction and remodeling of existing structures over that period. The purpose of this request is to assist the steering committee in its planning of the study and the preparation of an interim response to the Congress.

No further details are available at the moment, except for the expectation that most research-intensive universities will be included in the final survey population. AAMC has urged that the planning for the study be certain to include recognition of the unusual circumstances of teaching hospitals with sizeable research programs.

(4) Legislative Incentives.

- S. 1537. Senators Danforth and Eagleton introduced S. 1537 last year, a bill which provides additional authorizations for appropriations for FY 1984 and each of the four following years with the goals of (1) strengthening support for fundamental research in science and engineering, (2) upgrading, modernizing and replacing university research equipment, (3) providing increased numbers of graduate fellowships, (4) supporting faculty career initiation awards, (5) supporting efforts to rehabilitate, replace or improve university research facilities, and (6) supporting modernization and improvement of undergraduate science education.

The authorized sums are specified for DOA, DOD, DOE, NASA and NSF, whereas for NIH the bill states "... those additional amounts necessary to restore the capacity of NIH to conduct and support adequate levels of biomedical research." The yearly authorized sums for the other five agencies total $139 million/year for acquisition, installation or modification of research instrumentation and $245 million available on a matching basis for programs to modernize, rehabilitate, replace, or improve existing university research facilities.

The sponsors of the Senate Bill now plan to introduce this subject in the House. Since S. 1537 was not intended to pass as a separate Bill, but to express a sense of the Senate about the urgent need to support the Nation's university research capability and to influence the outcome of the Appropriations Bills, it is possible that

a Resolution will be introduced in the House and passage of a Joint Resolution sought.

The objectives of this legislative proposal are highly commendable, but insofar as biomedical research and the NIH are concerned, two difficulties remain to be resolved. The first is the complication of introducing the concept of an authorization ceiling for NIH at the very time when we are vigorously opposing that concept in legislation directed more specifically at the NIH. The second, more pertinent to the facilities and instrumentation issues, is that NIH no longer has broad constructive authority on which any program for major construction or renovation of facilities might have to be based.

• H.R. 2350. One of the provisions of the House bill to reauthorize parts of the NIH, H.R. 2350, requires a study "concerning the use of live animals in biomedical and behavioral research." One component of that proposed study reads as follows:

> "Estimate:
>
> (A) the amounts that would have to be expended by entities which conduct biomedical and behavioral research with Federal financial assistance to equip and modernize their research facilities in order to meet the standards referred to in paragraph (2); and
>
> (B) The amounts that would be expended by entities which have not previously conducted such research with Federal financial assistance to establish, modernize, or equip facilities in order to meet such standards."

Other legislative initiatives have included the well-publicized efforts of several universities to obtain money for construction of research facilities through special-interest amendments in Congress. AAU, NAS, APS and AAAS have published statements strongly critical of that tactic, which bypasses the peer review processes of the scientific community and prospective funding agency.

(5) Current Mechanism for Funding Capital Improvements. Under OMB Circular A-21 it is possible to include depreciation or user charges for space and interest charges on money borrowed for major capital improvements in the indirect cost pool. The extent to which this mechanism is presently being employed is unknown.

Recommendations. The Association should:

1. urge its members to cooperate insofar as possible with any of the studies which are described above,

2. delay any further action as to additional surveys or other studies until the reports and analyses of the studies presently underway or pending are completed, and

3. monitor closely the progress and outcome of these studies.

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 [illegible] a new National Institute of Health be created?" A study has been [illegible] 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.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
November 7, 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
David A. Reed
Herluf Olsen, AHA Representative

ABSENT

John V. Sheehan
C. Thomas Smith

GUESTS

William B. Kerr

STAFF

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

COTH ADMINISTRATIVE BOARD MEETING
November 7, 1983

I. CALL TO ORDER

Mr. Frederick called the meeting to order at 7:00am in the Chevy Chase Room of the Washington Hilton Hotel. Before moving to the agenda, he introduced Mr. Dan Olsen, Vice President of the American Hospital Association, and Mr. Bill Kerr, Director of Hospitals and Clinics at the University of California, San Francisco.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the September 22, 1983 COTH Administrative Board Meeting.

III. COTH MEMBERSHIP

ACTION: It was moved, seconded, and carried to approve:

1. Arkansas Children's Hospital, Little Rock, AR for FULL MEMBERSHIP;
2. Carraway Methodist Medical Center, for FULL MEMBERSHIP;
3. Children's Hospital, New Orleans, LA for FULL MEMBERSHIP;
4. The Toldeo Hospital, Toledo, OH for FULL MEMBERSHIP.

IV. RELATIONSHIPS WITH THE AMERICAN HOSPITAL ASSOCIATION

Mr. Frederick asked Mr. Kerr, Chairman of a Task Force responsible for the development of the AHA Metropolitan Hospital Constituency Section, to describe the thought and deliberation that have gone into the development of this Section thus far. Mr. Kerr stated that as a result of the Committee on Future Directions of the AHA, 50 new delegate positions have been made available, and the purpose of the Section is to amalgamate the Public General Hospital Section and the Center for Urban Hospitals and put together an organization that would compete for the 50 new delegate seats. The Task Force chaired by Mr. Kerr determined that to be effective the Section will have to have a strong community of interest. Thus, potential members of the Metropolitan Hospital Constituency Section will be those hospitals having one or more of the following characteristics:

- Provision of a significant proportion of Medicare/Medicaid and uncompensated care;
- Participation in undergraduate and/or graduate medical education programs and research;

- o Provision of high volumes of ambulatory care;
- o Provision of specialized services;
- o Involvement in professional and paraprofessional education and training programs; or
- o Location within a metropolitan statistical area.

The Section is to provide a forum for representation and advocacy on behalf of its member hospitals within and through the American Hospital Association. The Section is also to maintain collaborative relationships with other organizations working towards similar goals.

Mr. Kerr indicated that late in the month of November each AHA member will be receiving a ballot which will offer the opportunity to participate in the Metropolitan Hospital Constituency Section. In addition, there will be 22 seats on the governing board of the Section, 14 of which will be currently filled and eight of which will be open and for which he would appreciate suggestions. The recommendation in the Agenda was that 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, and that the Council of Teaching Hospitals take no position with respect to the organization of the AHA Metropolitan Hospital Section.

It was pointed out that the very liberal membership criteria could make it possible, perhaps likely, that the unique features, problems, and opportunities facing major teaching hospitals would not be well represented. Thus, the current problems the AHA faces with regard to representing teaching hospitals would be duplicated in the Section. However, there was general sentiment that this AHA effort should receive positive endorsement. Following this discussion, there was agreement that the Board should urge its members to participate in the Metropolitan Section.

The following Action was taken:

ACTION:
- o The Council of Teaching Hospitals lauds the AHA for its efforts to support expansion of its House of Delegates to provide a voice for distinct constituencies of hospital interests;
- o The Council of Teaching Hospitals urges its members to participate in the organization of the AHA Metropolitan Section.

A second matter with regard to relationships with the American Hospital Association was also discussed. The Chairman referred Board members to page 5 of the September 22 meeting minutes where Mr. Rice reported on a meeting that he and six of his colleagues attended at the request of Alex McMahon, President of the AHA, on Tuesday, September 13. Following discussion at the September 22 Administrative Board meeting, the Chairman asked Mr. Smith and Mr. Rice to

discuss the AHA Metropolitan Hospital Section with Mr. Kerr and also discuss the meeting with Mr. McMahon. Based on their discussion, the following recommendations were presented for consideration by the COTH Administrative Board:

- The Council of Teaching Hospitals requests 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 requests the COTH Nominating Commitee 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 and each year thereafter.

The staff had also been asked at the September 22 meeting to review the composition of the AHA Board and House of Delegates to determine the level of COTH participation. This review yielded the following information:

- 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 of these individuals are the hospital chief executive officers.

There was general discussion of the pros and cons of requesting seats on the AHA Board and RAB's, including an observation that Alex McMahon is not in a position to grant the request. Following this discussion, it was agreed that the two recommendations placed before the Board by Mr. Smith and Mr. Rice should be approved.

ACTION: It was moved, seconded, and carried that:

- The Council of Teaching Hospitals requests a seat on the AHA Board of Trustees and each Regional Advisory Board to be selected by the AHA Nominating Committee from nominations approved by the COTH Administrative Board. The staff was directed to draft a letter to AHA President Alex McMahon setting forth this recommendation. A copy of that letter appears as Appendix A to these minutes.

- The COTH Administrative Board requests 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

Administrative 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 and each year thereafter.

Following the approval of these motions, it was pointed out that the COTH Nominating Committee would need to move ahead prior to the next Board meeting on January 18-19, 1984. There was agreement that the Nominating Committee should have the authority to move ahead in the absence of approval of the recommendations by the COTH Administrative Board.

V. COTH SPRING MEETING

Mr. Mitchell reported that the Planning Committee met on October 3, and the staff is drafting a program for review based on the Committee's deliberations. He reminded the Board that the COTH Spring Meeting is to begin on the evening of May 16 and adjourn by noon on May 18, 1984 at the Hyatt Regency Hotel on the Harbor in Baltimore, Maryland. He further indicated that a question had been raised at the Planning Committee meeting 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. This does not at the present time preclude a chief executive officer bringing a board member.

A number of individuals felt that care needs to be taken so that the program is not designed with the informational and educational needs of trustees serving as the primary focus of the meeting. In other words, the character of the meeting should remain the same. Further discussion included the fact that the final morning will be devoted to a review of the document entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." There was some question as to whether or not this kind of a discussion about the nature and future of the organization would be one in which trustees would or should have an interest and whether they should participate. Subsequent to this discussion, it was agreed that the meeting announcement should indicate that trustees are invited if a chief executive officer wishes to bring them, and that trustees would be in addition to whatever individual a CEO wishes to bring with him. Thus, the addition of a trustee could mean that an institution could have more than two people represented at the meeting.

VI. SURVEY OF CAPITAL FINANCING NEEDS OF TEACHING HOSPITALS

Dr. Bentley reviewed the fact that representatives of Peat, Marwick, Mitchell and Morgan Guaranty Trust Company had contacted the AAMC to inquire into the Association's interest in cosponsoring a survey of capital expenditure plans/needs of teaching hospitals. At the September 22 Administrative Board meeting, the Board raised significant questions about the "wish list" possibilities of the survey and whether or not the information gained would be worth the time and effort to complete the questionnaire. Dr. Bentley reported that he had discussed the matter with individuals from the Morgan Guaranty Trust Company and Peat, Marwick, Mitchell and Company. Having done so, his view was that in order to get the information that would be valid and useful, a very

lengthy and detailed questionnaire would be necessary. His recommendation was that the Depoartment of Teaching Hospitals not undertake such a study and that the Department concentrate its efforts on gathering data concerning the impact of the Medicare prospective payment system. There was agreement with Dr. Bentley's recommendation.

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

Dr. Knapp briefly reviewed the document and indicated that the staff wished to have COTH Administrative Board approval to forward the document to the AAMC's Officers' Retreat. Dr. Daltson indicated that he felt the role of the Department with respect to educational programs for teaching hospital CEO's and administrative staff was not fully developed, and also that the matter of the role of the "vice presidents for medical affairs" in medical center hospitals and the AAMC is an issue that is related to the points that are presented in the paper. Mr. King indicated that the last paragraph in the document should be set forth more clearly. It currently reads as follows:

> 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 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.

Mr. King indicated that he felt there are two ways of looking at the problem. The first is that there are a whole variety of things that should or could be done. They all ought to be listed and then the staff requirements necessary to do them set forth. The second way of viewing the problem is to indicate that the staff is not going to increase beyond its present size and the question before us is which programs should get priority on the staff time and money that is available. This point needs to be made more explicit for purposes of any discussion of the document.

Following discussion, it was agreed tha the document as currently written should be approved for review at the AAMC Officers' Retreat with the recommendation that all of the points set forth in the minutes as having been discussed at the September 22 meeting of the Administrative Board and those points raised today be summarized and distributed to Retreat participants with the document. These points as they were distributed to Retreat participants are set forth as Appendix B to these minutes.

VIII. COMMONWEALTH FUND EXECUTIVE NURSE LEADERSHIP PROGRAM

Dr. Knapp reported that a decision was needed before the Administrative Board meeting with regard to sponsorship with the Commonwealth Fund of an Executive Nurse Leadership Program. Following discussion with Dr. Heyssel and Mr. Frederick, it was agreed that COTH should sponsor such a program. Correspondence briefly describing the program and Dr. Cooper's response to Ms. Mahoney is included as Appendix C to these minutes.

IX. REPORT OF THE COTH NOMINATING COMMITTEE

Dr. Rabkin, Chairman of the COTH Nominating Committee, reported for information the following nominations that will be presented to the COTH institutional membership at lunch later in the day.

Chairman-Elect	Sheldon S. King Stanford University Hospital
Secretary (Three year term)	Spencer Foreman, MD Sinai Hospital of Baltimore
Administrative Board (One year term)	William B. Kerr University of California Hospitals/Clinics
(Three year terms)	J. Robert Buchanan, MD Massachusetts General Hospital
	Eric B. Munson The North Carolina Memorial Hospital
	Thomas J. Stranova Veterans Administration Medical Center West Roxbury

X. ADJOURNMENT

The meeting was adjourned at 9:00am.

association of american medical colleges

December 7, 1983

J. Alexander McMahon
President
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Dear Alex:

The purpose of this letter is to report to you the outcome of a November 7 COTH Administrative Board discussion concerning medical center hospital representation in the affairs and governance of the American Hospital Association.

The first matter that was discussed concerned the development of the AHA Metropolitan Hospital Constituency Section. Bill Kerr was asked to attend the Board meeting, and provided an excellent summary of the history, current stage of development, and future plans for the Section. Following Bill's review of the criteria for membership in the Section, it was pointed out by several individuals that the very liberal membership criteria could make it possible, perhaps likely, that the unique features, problems, and opportunities facing major teaching hospitals would not be well represented. Thus, the current problems the AHA faces with regard to representing teaching hospitals would be duplicated in the Section. Notwithstanding this observation, the Board took the following actions:

- The Council of Teaching Hospitals lauds 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 urges its members to participate in the AHA Metropolitan Hospital Constituency Section.

The second matter discussed at the November 7 meeting concerned participation and representation of COTH members in the governance of the American Hospital Association. In preparation for this discussion, Dick Knapp was asked to review the facts with regard to COTH membership participation. Using the 1983 Official Roster of the AHA House of Delegates, he found the following:

- There are six individuals from COTH member hospitals on the AHA Board. However, only two of them are from medical center-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 center hospitals, and of these 13 only four are the hospital chief executive.

You'll recall at your invitation that six of my colleagues and I, and Dick Knapp met with you on September 13 to discuss this issue. The above stated factual situation I think clearly substantiates the view that medical center hospitals are not well represented in the affairs and governance of the American Hospital Association. At the meeting on September 13, you indicated an understanding of these facts, a willingness to review them, and receptivity to a reasonable proposal to improve the situation.

After full discussion, the Board took the following action:

- The Council of Teaching Hospitals requests a seat on the AHA Board of Trustees and each Regional Advisory Board (RAB) to be selected by the AHA Nominating Committee from nominations recommended by the COTH Administrative Board.

It should be clear to you that we do not feel that medical center hospitals are well represented in the development of AHA policy. I believe it is important for the AHA to be a strong and healthy organization representing all segments of the hospital industry. To achieve this full potential, I hope you will give our proposal full attention and consideration. My colleagues and I would be pleased to discuss this matter further with you.

I look forward to hearing from you.

Sincerely,

Haynes Rice

Haynes Rice
Chairman, AAMC
Council of Teaching
Hospitals

c: Robert M. Heyssel, MD
AAMC Chairman
COTH Administrative Board
Gennaro J. Vasile, PhD
Henry E. Manning

Appendix B

DISCUSSION POINTS BY COTH ADMINISTRATIVE BOARD MEMBERS

"New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals"

- 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;

- 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 are viewed as a deans' organization. We're called the Association of American Medical Colleges and deans manage medical schools. In this sense, the role of the AAMC as an advocate for teaching hospitals is not well understood. Perhaps 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;

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

- COTH and the AAMC should focus activities on the commmon 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 membership resignations. However, what is offered to this group of hospitals and what role they find in the COTH/AAMC should be carefully reviewed.

- The role of the Vice President for Medical Affairs as it relates to this issue and the role of the Association of Academic Health Centers are also matters which need to be discussed in the context of this paper;

- It needs to be clear that if the AAMC reached a conclusion that it should only represent primary teaching hospitals, there will be some medical schools who will not have an opportunity to include a teaching hospital as a member of the Council of Teaching Hospitals.

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.

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

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

John A. D. Cooper, M.D.

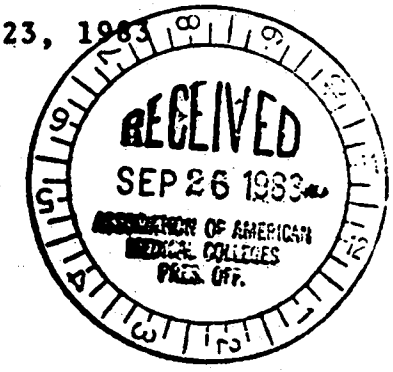
cc: Joseph Keyes

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.

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

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 Medical Center

Hospital Address: (Street) 710 Center Street

(City) Columbus (State) GA (Zip) 31994

(Area Code)/Telephone Number: (404) 571-1430

Name of Hospital's Chief Executive Officer: Max L. Brabson

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	417	Admissions:	15,595
Average Daily Census:	281	Visits: Emergency Room:	42,391
Total Live Births:	2904	Visits: Outpatient or Clinic:	34,467

B. Financial Data

Total Operating Expenses: $ 5,613,443.00

Total Payroll Expenses: $ 1,725,729.00

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 686,379.00
Supervising Faculty: $ 474,464.00

C. Staffing Data

Number of Personnel: Full-Time: 1248
Part-Time: 162

Number of Physicians:

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

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

Medicine | Ob-Gyn | Family Medicine | _____

Surgery | Pediatrics | _____ | _____

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

II. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	12	5	
Surgery	12	3	
Ob-Gyn	4	4	elective
Pediatrics	12	4	elective
Family Practice	12	8	elective
Psychiatry	--	--	
Other: _____			

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	4	4		
Medicine				
Surgery				
Ob-Gyn				
Pediatrics				
Family Practice	36	36		
Psychiatry				
Other:				

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: Medical College of Georgia

Dean of Affiliated Medical School: Fairfield Goodale, M.D.

Information Submitted by: (Name) George W. Shannon, M.D.

(Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

Max T Braselton (Date) 10/27/83

The Medical Center of Columbus, Georgia, has been since 1974 one of a consortium of Georgia hospitals affiliated with the Medical College of Georgia for the training of medical students in their core clinical clerkships. Elective rotations had been offered there even prior to that time.

At one time or another, core clerkships in Medicine, Surgery, Ob-Gyn and Pediatrics have been offered. At the present time the Medical Center is participating in the recently established core clerkships in Family Medicine. Also, we expect the clerkship in Obstetrics and Gynecology to be reestablished during this academic year.

The use of community hospitals allows our students to have quality training in non-university settings in other parts of the State. This exposes the student to a different type of patient and to a different type of teacher. It may also ultimately effect the distribution of physicians in the State.

The Director of Medical Education at the Medical Center holds a faculty appointment and is an Assistant Dean of the School of Medicine of the Medical College. The chiefs of service also may hold regular, part time faculty appointments.

The Medical Center, with its residency program and full time instructional staff, remains an integral part of the teaching program of the School of Medicine of the Medical College of Georgia.

F. Goodale

Fairfield Goodale, M.D.
Dean and Medical Director
Medical College of Georgia
September 29, 1983

The Medical Center
Columbus, Georgia

MAX L. BRABSON
President

November 14, 1983

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

Dear Dr. Knapp:

Enclosed is a copy of the affiliation agreement between The Medical Center Hospital Authority and the Board of Regents of The University System of Georgia (School of Medicine, Medical College of Georgia) which inadvertently was not enclosed with our application for membership in the Council of Teaching Hospitals. If there is additional information needed, please let me hear from you.

Sincerely,

Max L. Brabson
President

MLB:jv

Enclosure

710 Center Street / Post Office Box 951 / Columb 31994-2299 / Telephone 404/571-1000

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

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

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

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

I. HOSPITAL IDENTIFICATION

Hospital Name: St. Elizabeth Medical Center

Hospital Address: (Street) 601 Miami Boulevard West

(City) Dayton (State) Ohio (Zip) 45408

(Area Code)/Telephone Number: (513) 229-6494

Name of Hospital's Chief Executive Officer: Thomas A. Beckett

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	608	Admissions:	21,770
Average Daily Census:	535	Visits: Emergency Room:	39,754
Total Live Births:	1967	Visits: Outpatient or Clinic:	28,020

B. Financial Data

Total Operating Expenses: $ 70,813,000

Total Payroll Expenses: $ 38,820,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 915,600
Supervising Faculty: $ 898,610

C. Staffing Data

Number of Personnel: Full-Time: 1740
Part-Time: 172

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 214
With Medical School Faculty Appointments: 130

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

Family Med.	Medicine	Pediatrics	Surgery
OB/GYN			

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

I. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery	12	12	Required
Ob-Gyn			
Pediatrics	12	12	Required
Family Practice			
Psychiatry			
Other:			
Trauma	1/month	10	Elective
Emergency Med.	1/month	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				
Surgery	5	5	0	1979
Ob-Gyn				
Pediatrics				
Family Practice	30	30	0	1970
Psychiatry				
Other:				
Plastic	2	1	1	1974
Emer.Med.	3	3	0	1980

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

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

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: Wright State University School of Med.

Dean of Affiliated Medical School: William D. Sawyer, M.D.

Information Submitted by: (Name) Robert P. Turk, M.D.

(Title) Director Medical Education

Signature of Hospital's Chief Executive Officer:

T M Buchott (Date) 12/5/83

IV. SUPPLEMENTARY INFORMATION

Application for Membership in the Council of Teaching Hospitals

St. Elizabeth Medical Center has been a Family Practice oriented hospital for the 100 years that it has been in existance. For many years it was involved in medical teaching through a rotating internship program which was replaced approximately 10 years ago by a Family Practice Residency Program. Since its inception, the Family Medicine Program has graduated 80 Family Practice physicians all of whom have passed their Board Certification examinations. That program has now grown to where there are ten positions offered each year. The residents are culled from a group of over 80 applicants from midwestern medical schools. Although the program is free standing, it has been closely affiliated with Wright State University School of Medicine since that school was conceived in Dayton some six years ago. In fact, the Chairman of the Department of Family Practice is physically based at St. Elizabeth Medical Center and occupies one floor of a building constructed especially for a Family Medicine Center and the Wright State University School of Medicine Department of Family Medicine. A 180 seat auditorium with "state of the art" audio-visual capabilities (built with contributions by the medical staff) is utilized by the Family Practice Department to teach medical students.

Because of the physical location of this hospital on the border of the economically deprived section of the city, it has a large number of indigent patients. As a result, students and residents rotating through this Medical Center have an opportunity to see advanced disease, illnesses related to socio-economic

conditions and results of violent crime and its associated trauma. The vast majority of patients are those ordinarily seen in a community hospital so that the students and residents also see what the mainstream of medicine is about. St. Elizabeth Medical Center also has a large active Rehabilitation Medicine Service where medical students spend some time.

More recently, a chair of Emergency Medicine was established at Wright State University and since St. Elizabeth Medical Center Emergency Department is one of the busiest in the community, it has become an integral part of the rotations for the Emergency Medicine residents.

A Plastic Surgery residency was established in conjunction with Kettering Medical Center in 1976 and became sponsored by the Department of Surgery Wright State University School of Medicine in 1980. Approximately 70% of the Head and Neck Surgery training is done at this institution. There are always at least two Plastic Surgery residents rotating through St. Elizabeth at any given time to take advantage of the large number of indigent patients referred to the Plastic Surgery Service.

In 1979, Wright State University absorbed the Dayton free standing residencies in General Surgery into the Integrated Program in General Surgery of Wright State University School of Medicine. St. Elizabeth Medical Center funds a full-time Associate Director of the Surgery Program and five residents in the training program. In addition, the Center has allocated money toward the recruitment of another Assistant Professor in Surgery to be based and salaried part-time at this institution. St. Elizabeth Medical Center is important to the surgery training program because of its large number of staff patients, the number of trauma cases referred

to this hospital, as well as, providing well supervised experiences in the Emergency Department, Anesthesia, Orthopedics, Head and Neck Surgery and Cardiovascular Surgery. It should be noted that a number of University Surgery Programs are deficient in trauma and Head and Neck Surgery experience.

Finally, with the rapid development of Wright State University School of Medicine and the increases in class size, St. Elizabeth Medical Center will increasingly supply the clinical experience for the medical students.

St. Elizabeth Medical Center

601 Miami Boulevard West
Dayton, Ohio 45408

Sponsored by
the Franciscan Sisters
of the Poor

November 11, 1983

Richard M. Capp, Ph.D.
Director
Department of Teaching Hospitals
Suite 200
One Dupont Circle NW
Washington, D.C. 20036

Dear Dr. Capp:

Enclosed please find an application from St. Elizabeth Medical Center of Dayton, Ohio for a full membership in the Council of Teaching Hospitals.

St. Elizabeth Medical Center has been a corresponding member of the Council of Teaching Hospitals for a number of years and it is the desire of the Board of Trustees to upgrade our standing to Teaching Hospital Membership because of our active involvement with the Wright State University School of Medicine. Appended to the application is a letter from Dr. William Sawyers, Dean of the Medical School attesting to this fact. In addition, we have appended a copy of the Hospital/Medical School Affiliation Agreement.

As your records may indicate, we have not yet paid our dues statement for the period of July 1, 1983 to June 30, 1984 in hopes of upgrading our position with the Council.

Hoping for a favorable response from the Administrative Board of the Council of Teaching Hospitals. I remain.

Sincerely,

Robert P. Turk, M.D.
Director Medical Education

RPT/jmb

Enclosures

WRIGHT STATE

Wright State University
Dayton, Ohio

School of Medicine
Office of the Dean
P.O. Box 927
Dayton, Ohio 45401

513/873-2933

November 28, 1983

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

Dear Colleagues:

I support enthusiastically the application of St. Elizabeth Medical Center, Dayton, Ohio for full membership in the Council of Teaching Hospitals. The St. Elizabeth Medical Center is a major affiliate of the Wright State University School of Medicine and an important partner in our program of medical education. Our Departments of Family Practice and of Physical Medicine and Rehabilitation are administratively located within the Center. The Center is a site for clerkships in Family Practice and Emergency Medicine and of undergraduate electives in a number of clinical disciplines. In addition, the Center has active residency positions in Family Practice, General Surgery, Plastic Surgery, and Emergency Medicine.

The School of Medicine and the St. Elizabeth Medical Center have a long term mutual commitment to medical education. The Center is a fine example of the major teaching hospital. It has given strong support for the School of Medicine. Our relations are cordial and productive.

The St. Elizabeth Medical Center meets criteria for membership in the Council of Teaching Hospitals. I strongly recommend its acceptance to the Council.

Cordially,

William D. Sawyer, M.D.

William D. Sawyer, M.D.
Dean

WDS:hkc

ASSOCIATION OF ACADEMIC HEALTH CENTERS

MEETING OF AAMC AND AAHC REPRESENTATIVES
November 22, 1983

Representatives of the AAMC and of the AAHC held a meeting on September 21, 1983 to discuss a proposal that the two associations sponsor a joint task force to address issues related to the principal teaching hospitals of academic health centers. At the conclusion of that meeting, it was decided to convene a group of representatives of the AAMC and AAHC Boards to continue and expand the discussions, and to try to identify some of the issues the task force would be asked to address.

This follow-up meeting is scheduled to be held on November 22, 1983. The AAHC delegation wishes to submit the following agenda for the meeting:

1. Purpose of the Task Force

It is the viewpoint of the AAHC representatives that:

a) There are significant differences of scale and kind in the issues confronting the approximately 120 principal teaching hospitals, compared to the remainder of the larger group of teaching hospitals represented by COTH;

b) In many instances the issues confronting these principal teaching hospitals have implications that go beyond the hospital, and could place an entire university at risk. The academic health centers' chief administrative officers (CAOs) are often the links between the hospitals and the university (and often a state as well). It is essential that these academic health center officers, many of whom have administrative and budgetary responsibilities for their teaching hospitals, participate in the development and determination of health service related policy and of the political strategies to be adopted at the national level. It is essential that any conclusions reached include a consensus of the academic health centers CAOs, and of the directors of the principal teaching hospitals. A task force as proposed would help bring together the interested parties, regardless of national affiliation and would help unify and strengthen the roles of advocacy and research each now pursues independently.

The task force would:

a) Identify and define the issues which affect the principal teaching hospitals in ways different from the other teaching hospitals, or that affect the principal teaching hospitals to a much larger degree than the others.

b) Suggest ways in which these issues can be addressed.

c) Serve in an advisory capacity to study groups that might be formed as a result of the task force recommendations.

d) Act as a coordinative body for advocacy on behalf of the principal teaching hospitals.

2. Composition of the Task Force

The task force would be sponsored by the AAMC and by the AAHC. The two associations might wish to invite the Institute of Medicine to participate in the task force to help identify some of the issues to be addressed.

The task force would be composed of individuals who are directors of principal teaching hospitals, academic health centers CAOs, medical school deans, and possibly others from the academic community. It might include perhaps ten to twelve persons.

The activities of the task force would be supported by staff recruited to serve in such capacity. Funds to carry out the task force's activities would be contributed initially by the two associations, with additional extramural assistance to be sought and anticipated.

3. Issues Relevant to the Task Force

The AAHC representatives suggest four categories under which the issues relevant to the task force might be clustered:

a) The mission of the principal teaching hospitals and the nature of the activities which occur within them.

- Intrinsic in the mission and purpose of the principal teaching hospitals is their relationship to the universities. For many of these hospitals, while the service function is of paramount importance, it would not justify the existence of the hospital as an integral part of the university, were it not for the teaching and research functions which are university-related missions. The relationships between the universities and the other teaching hospitals are of a difference nature.

- The teaching and research missions affect the service function of the principal teaching hospitals to a much greater extent than the other hospitals. It is in the principal teaching hospital that the highly specialized care and emerging technology are introduced. Should the teaching and research activities in these hospitals be reduced substantially, with corresponding reduction of practicing faculty and

clinical researchers, the highly specialized services and technological break-throughs now available to the public in these hospitals would not be possible, and a serious gap in the health care system would result. This fundamental aspect of the nature and role of the principal teaching hospitals can be communicated to the public more forcefully, if they are regarded as distinct from the larger group of teaching hospitals.

- The activities of the principal teaching hospitals include a much larger proportion of effort expended in teaching and in research than in the other teaching hospitals. These necessary efforts affect to some degree the efficiency, thus the cost, of the hospital operations. By contrast, the other teaching hospitals can adjust their teaching and research loads to levels consistent with a higher level of efficiency and can therefore compete more effectively in the marketplace. In fact, some of the most intense competition occurs between the principal teaching hospitals and the other teaching hospitals affiliated with the medical schools.

b) Unreimbursed and under-reimbursed care

- This problem is considerably more serious for the principal teaching hospitals because so many of them are located in the inner cities and serve a much larger proportion of patients unable to pay for services. There is a trend to refer poor patients with inadequate health coverage, or no coverage at all, from non-teaching hospitals and from hospitals with minor teaching commitments to the principal teaching hospitals of academic health centers. Of all the problems principal teaching hospitals face, inadequate reimbursement for poor patients could entail the greatest risk. This is less true of the other teaching hospitals.

c) Capital replacement and the cost of technology.

- Because of their research mission, the principal teaching hospitals have a responsibility for developing and applying new technology. The developmental and testing costs of first-time equipment are higher than those incurred by other hospitals which do not have to be at the leading edge of new knowledge and can therefore wait for less costly commercial products. On the capital-formation side there are differences of scale as well, because the principal teaching hospitals must provide the necessary facilities -- laboratories, etc. -- for a much larger student and researchers presence than the other hospitals.

d) Relationship to the university and to the state.

- University hospitals and other affiliated principal teaching hospitals have special responsibilities and constraints because of their relationship to the university. These are factors in creating a more costly, thus less competitive environment than in the other teaching hospitals.

- Another major constraint is that in evaluating the risk-benefit factors inherent to given decisions the principal teaching hospitals which are part of universities must take into consideration that some risks which the hospital would find worth taking might be unacceptable because of the potential threat to the university.

The AAHC representatives believe that the above four categories set apart the approximately 120 principal teaching hospitals sufficiently to warrant special consideration.

Questions which might be posed to the task force include:

If these hospitals are indeed different, what are the issues that are likely to be more pertinent to them than to the other teaching hospitals?

How do we give attention to their special needs on a national level?

What is the audience to be reached for an effective advocacy effort on behalf of these institutions?

What do we need in terms of federal legislation?

Should there be mechanisms for continuously monitoring the effect of federal legislative initiatives on these "very different" hospitals?

Should there be studies and demonstrations to develop different approaches for paying these principal teaching hospitals, and if so what can be done to develop models and justify their acceptance?

association of american medical colleges

December 23, 1983

Judith R. Lave, PhD
The University of Pittsburgh
Graduate School of Public
Health
Pittsburgh, Pennsylvania 15261

Dear Judy:

As we discussed, the "indirect medical education adjustment" payment under the Medicare prospective payment plan has been misunderstood and incorrectly described by many individuals who have written and spoken about the subject. To help redress these misconceptions, we have prepared and distributed a brief statement (attached) describing the direct medical education "passthrough" and the indirect medical education "adjustment."

In addition to this brief statement, we need a more scholarly written and detailed description of the history, development, and future prospects for this indirect "adjustment" payment. The history and development of the adjustment should include its implicit and explicit purposes, the decision-making process by which its implementation was achieved, and the basic computations used to develop it for both Medicare routine service and TEFRA limits and for the Medicare prospective payment system. The purpose of this letter is to confirm our telephone conversation indicating your interest and willingness to write such a paper.

We do wish to engage your professional services to write this paper. We propose to pay you $5,000 plus expenses for this purpose. It would be my understanding that expenses would only entail long distance telephone calls for the purpose of interviewing various individuals in the executive and legislative branches who participated in the process of developing or implementing the adjustment. if you found it necessary to make one trip to Washington, DC we would pay your expenses for that purpose. In return we would expect a 25-50 page paper addressing the matters set forth in the above paragraph. In preparing the paper we would hope you would do so as if the paper were to be submitted to a refereed journal for publication. This is the scholarly approach we desire.

Having written the paper and reviewed the subject carefully, I assume you will have some recommendations concerning what actions COTH/AAMC should take with regard both to the direct medical

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education passthrough and the indirect medical education adjustment. Separate from the paper we would ask that you provide a three or four page summary of your thoughts and recommendations in this regard.

The outside date for the completion of these tasks would be May 17, 1984. As we discussed, this letter should confirm your agreement to speak at the annual COTH Spring Meeting in Baltimore at the Hyatt Regency Hotel on the Inner Harbor on May 17, and in a 30-40 minute presentation present a summary of your paper on the indirect medical education adjustment. We would, of course, pay your expenses for attending the meeting in Baltimore. I've enclosed a draft outline of the program to give you an idea of who the other speakers may be (not all of them are confirmed).

I hope you find this letter consistent with our conversation on Friday, December 16. If there are matters we need to discuss, please call me at 202/828-0490. If you agree with the expectations as I've set them forth above, please sign the bottom of this letter and return the signed original to me; we'll use this letter as the basis for our agreement.

We are very pleased that you have agreed to take on this task. We consider it a very important and high priority issue.

Best wishes for the holidays.

Sincerely,

Richard M. Knapp, PhD
Director
Department of Teaching Hospitals

_____ _____
Judith R. Lave, PhD date

_____ _____
Richard M. Knapp, PhD date