MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

April 11-12, 1984
Washington Hilton Hotel

WEDNESDAY, April 11, 1984

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Grant Room (Discussion with Dr. Rubin)
7:30pm	COTH ADMINISTRATIVE BOARD RECEPTION Hamilton Room
8:30pm	COTH ADMINISTRATIVE BOARD DINNER Grant Room

THURSDAY, April 12, 1984

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

ROBERT J. RUBIN, M.D.

Assistant Secretary for Planning and Evaluation
Department of Health and Human Services

Robert J. Rubin, M.D., was sworn in July 9, 1981, as assistant secretary for planning and evaluation, Department of Health and Human Services. He was nominated by President Reagan April 27, 1981, and confirmed by the Senate June 2, 1981.

Rubin came to his HHS position from Boston, Mass., where he had been associate professor of medicine and assistant dean for government affairs at the Tufts University School of Medicine. He was also serving as chief of the Renal Division in the Lemuel Shattuck Hospital and since 1979 had been consultant to the Senate Labor and Human Resources Committee.

Dr. Rubin, the first M.D. to be appointed assistant secretary for planning and evaluation, is a primary policy adviser to the HHS Secretary, particularly in areas of health care, welfare, Social Security and social services. In these areas he is responsible for the development of the department's legislative program and other major initiatives, and oversees research and evaluation activities.

He was born in Brooklyn, N.Y., Feb. 7, 1946. He received an A.B. degree in 1966 from Williams College in Williamstown, Mass., having been elected to Phi Beta Kappa; and received his M.D. degree from Cornell University Medical College in New York in 1970.

Dr. Rubin interned at the New England Medical Center Hospitals in Boston (1970-71), was junior assistant resident there (1970-72) and a fellow in medicine (Nephrology) in 1974-76.

Dr. Rubin had previously been associated with the old Department of Health, Education, and Welfare and with Secretary Schweiker. As a student he was a U.S. Public Health Service trainee at the Harvard Tissue Immunology Laboratory at the Peter Bent Brigham Hospital, Boston, during the summer of 1968, and was an epidemic intelligence officer in the viral diseases division of the Center for Disease Control from 1972 to 1974. In 1977, as a Robert Wood Johnson Fellow, he worked with then-Senator Schweiker on the development of health policy for the Senate Committee on Labor and Human Resources.

From 1976 to 1978 he was assistant to the dean for government affairs at Tufts University School of Medicine; acting chief of the Renal Division, Lemuel Shattuck Hospital (1978-79); and consultant in Nephrology to the Lakeville Hospital Rehabilitation Center, to the Boston Veterans Medical Center and to the Faulkner Hospital.

Dr. Rubin is co-author of numerous articles published by leading medical and scientific journals. He is a member of the American Society of Nephrology, International Society of Nephrology, American College of Physicians, American Federation for Clinical Research and the Massachusetts Medical Society (member Council on Legislation 1980).

He was designated one of the Ten Outstanding Young Men in America in 1978 by the United States Jaycees.

Dr. Rubin is married and has two children.

July 9, 1981

AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

April 12, 1984
Washington Hilton Hotel
Jackson Room
9:00am - 1:00pm

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.

- o Do primary teaching hospitals have a common cause?
- o Are the problems of these hospitals well understood and and are they being addressed as effectively as they might be?
- o 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 "Should 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:

- o 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;

- o 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:

- o 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.

- o 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:

- o 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;

- o 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:

- o 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.

- o 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;

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

- 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.

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.

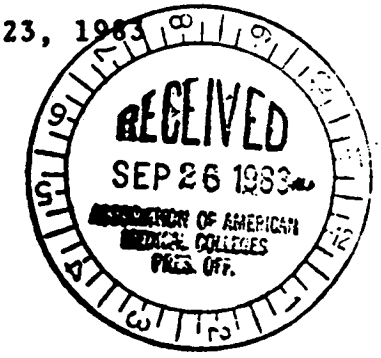
cc: Joseph Keyes

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

American Hospital Association

AHA

840 North Lake Shore Drive
Chicago, Illinois 60611
Telephone 312.280.6622

J. Alexander McMahon
President

February 13, 1984

Dear Haynes

This follows up your letter of December 7. I delayed responding pending the outcome of the addition of a number of delegates from the Metropolitan Hospital Constituency Section to our House of Delegates.

You are aware now of what has transpired, and I hope that we are meeting your goals. Obviously, there is still the matter of a seat on the Board of Trustees, and it is my impression that you have done well in your presentation to the nominating committee. The next step, of course, is up to them.

Please let me know if you think there are additional steps that I can take to assure an adequate voice in our structure for that very important segment of our constituency, the medical center hospitals.

With warm regards.

Sincerely

J. Alexander McMahon

cc: Robert M. Heyssel, M.D.
Henry E. Manning
Gennaro J. Vasile, PH.D.

Haynes Rice
Chairman, Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle N.W.
Washington, DC 20036

ENCLOSURE B

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?

Healthcare Financial Management Association

MEMORANDUM

TO: Chief Financial Officers
COTH Member Hospitals

SUBJECT: Special HFMA Program for Teaching Hospital CFOs

DATE: March 19, 1984

At its June Annual National Institute, the Healthcare Financial Management Association will be offering a special two-day program for chief financial officers of major teaching hospitals. The program, developed by teaching hospital CFOs with the assistance of HFMA and AAMC staff, focuses on four major topics: the developing environment for major teaching hospitals, new organizational structures for managing teaching hospitals, data and cost accounting systems being developed for per case payment in teaching hospitals, and reimbursement studies and problems facing teaching hospitals. In each of these half-day sessions, the program is planned to allow attendees to have at least half of the time for discussion. The program will begin on Monday afternoon, June 18 and conclude at noon on Wednesday, June 20. Faculty for the program will include:

Jim Bentley
Association of American Medical Colleges

John Eresian
Northwestern Memorial Hospital

1900 Spring Road ● Suite 500 ● Oak B 60521 ● Telephone: 312/655-4600

Truman Esmond
Truman Esmond & Associates

Irv Kues
The Johns Hopkins Hospital

Bill Nelson
Intermountain Health Care

Richard Tompkins
Arthur Young & Company

Peter Van Etten
New England Medical Center

Along with this memo you will find an announcement of HFMA's Annual National Institute to be held June 17-22 in Boulder, Colorado. The seminar on "Critical Issues for CFOs of Teaching Hospitals" is one of the educational offerings included in the institute. Because registration for the teaching hospital CFO seminar is limited to 60 attendees, we have written this letter to alert you to this program, to provide you with as much advance notice as possible, and to encourage you to submit your registration application at once. Select course A15. You may also choose a course from the list of courses with a C prefix.

Act today.

Richard M. Knapp
Director
Department of Teaching Hospitals
Association of American Medical Colleges

Michael F. Doody
President
Healthcare Financial Management Association

January 23, 1984

Edward J. Stemmler, M.D., Dean
University of Pennsylvania
School of Medicine
36th and Hamilton Walk
Philadelphia, Pennsylvania 19104

Dear Ed:

I very much appreciate your call on Friday, not only as an expression of concern about my views, but also because you were able to provide some very helpful background and advice in regard to the dynamics behind the COTH recommendations.

I have been very pleased that the Association, in recent years, has consistently portrayed to many agencies that it considers the diversity of the institutions represented, not only in their construction, but in their missions to be a strength to the medical education establishment in the United States, and that its role was to assist in meeting the valid needs of all of its medical school members. It was against this background that I found the COTH proposal potentially quite disruptive. The goal of reassessing COTH at this point, and indeed that of the CAS and the COD, can hardly be questioned and much of the material and concerns raised are quite appropriate. Even the parts that I consider controversial are appropriate if it is the intention of the COTH or the Executive Council that these issues be extended for open and public debate. It is my opinion at this point however that to broach some of these issues publicly would be disruptive and counterproductive. Let me suggest what some of these issues are.

I refer to Page 41 of the Blue Book where under the heading "The Environment For COTH" various categories of membership are described which begins the process of identifying the "114 primary teaching hospitals." This is an important issue because on Page 58 it suggests that some members of COTH feel that the AAMC should focus its efforts only on these "primary teaching hospitals." The asterisk on Page 41 indicates the so-called primary indicator of an "inextricable relationship." I consider this definition that the chiefs of the hospital services are also chairmen of the medical school departments to be arbitrary, rigid and to rule out a number of alternative potentially better arrangements, particularly where more than one hospital is involved.

An additional concern is raised on Page 42 where the asterisks show that a definition as to whether the hospital has a "significant commitment to medical education and research" is determined by the ratio of residents to beds. As I suggested to you in our telephone conversation, we have in Springfield an accredited medical school, quite happily maturing and expanding its activities, which is blessed with two 600-bed very prosperous hospitals seven blocks apart with whom we have essentially equal affiliations. The hospital staff chairmen are appointed on the basis of "advise and consent" by the Dean of the medical school. These Chairmen take care of a lot of scut work while supporting our academic full-time chairmen who are completely responsible for the educational programs. In addition, from the very first we have been committed to small, high-quality residency programs, particularly since all of the hospital floors and service functions can operate efficiently without residents if necessary. Since both hospitals support the residency programs, the result is that the ratio in any one of them is less than 0.2 residents per bed. The financial investments that the two hospitals and the community of Springfield have made not only directly, but in terms of the tremendous economic impact in a relatively small community, has resulted in a bond perhaps more inextricable than the simple naming of chairmen. All of these nice attributes notwithstanding I find, according to the COTH tables, that I do not have any "primary teaching hospitals" and those I have are without "significant commitments" to medical education and research. I would be prepared to consider this might simply be clumsy and inadvertent were it not for the phraseology on Page 58 that suggests that at least on behalf of some COTH members this pejorative hierarchy is intentional.

I am not raising this issue because of the potential of hurt feelings, however. We all have concerns about the financing of teaching hospitals and thus the direct and indirect pass-throughs related to residency programs are of great interest, not only to the so-called "primary" teaching hospitals, but also to those large comprehensive hospitals which have more recently joint-ventured with universities to start new academic medical centers. It seems to me almost inevitable that the direct costs and certainly the so-called indirect costs will be challenged by DHHS with the intent to try to ratchet them down in the years to come. The tables prepared in this COTH document, should they become public, would present several ideal cleavage planes with apparent AAMC blessing.

Should the traditional academic health centers persist in trying to position themselves as in some way more uniquely pure or specifically more deserving for federal Medicare funding, it takes no great imagination to picture how some nasty battle lines could be drawn from the perspective of those schools thus left out. One could anticipate that there should be a category of hospitals where the ratio of residents to beds clearly is in excess of any reasonable opportunity for quality teaching. Another category for those hospitals where the residency program exists primarily to meet the service needs of the institution or the ego needs of the chief of the service, rather than a primary commitment to the education of these young men and women. And, finally, it takes no imagination to picture that federal authorities would decide to stop this squabble by using the leverage of their funding to solve both the

problems of the numbers and the geographic distribution of the various medical specialties. From the point of view of the newer schools, many of which were specifically started to help solve geographic problems, this could be a very positive outcome and I suspect some of them might be quite supportive.

I have no doubt that a number of community based institutions will become quite exercised about this draft proposal, and as we discussed on the telephone, the real question is do we want the debate to go on inside or outside the AAMC. Obviously, I hope that we can settle this inside. I see no real good and potentially a great deal of harm to the Association by having this draft go out, even as a discussion piece, and certainly if it is adopted as policy. I very much appreciate your consideration and your attention to these concerns and will be most interested in your further advice and counsel.

Sincerely,

Richard H. Moy, M.D.
Dean and Provost

Southern Illinois University
School of Medicine
P.O. Box 3926
Springfield, Illinois 62708

Office of the Dean and Provost
801 North Rutledge Street

March 23, 1984

TO: Richard M. Knapp, Ph.D., Director
Department of Teaching Hospitals
Association of American Medical Colleges

RE: New Challenges for the Council of Teaching Hospitals

FROM: Richard H. Moy, M.D.
Dean and Provost

One of the concerns I have about the document in general is that it tends to take a photograph of the current situation in regard to hospital categories and does not include a sense of change. Accordingly, it might be appropriate to consider including a trend No. 11 on Page 39 to read as follows:

11. COTH may be a shifting population as

a) hospitals affiliated with newer medical education programs mature and become more integrated,
b) older hospital relationships with medical schools which were highly integrated may disintegrate,
c) unbundling of traditional hospitals may create a new set of concepts relating to affiliation,
d) investor owned hospitals are becoming affiliated with medical schools.

On Page 41, I would suggest that the term "inextricable" be replaced by the more traditional term "integrated." However, I think your suggestion of simply describing hospitals where chairmen are chiefs rather than using the footnote is probably a better way to go. I would suggest as a fourth bullet following the first three would be:

Affiliated hospitals without integrated relationships but which are designated by their medical schools as primary teaching hospitals. (You might keep in mind that at this point one and soon two hospitals will probably designate for profit hospitals as their primary teaching hospitals.)

Finally on Page 42, I would agree in striking the footnote about the resident-to-bed ratio and combining the affiliated hospital categories.

On Page 43, I would strike the part of the top paragraph that begins on

the fourth line with Table 2. Then on Pages 45 and 46, I would strike Tables 1 and 2. Appendix A probably should be deleted, but if it is continued the word "integrated" should replace "inextricable."

On Page 72, there should be the new category of those hospitals designated as primary teaching hospitals by their medical schools and Pages 77 through 87 should be combined.

Also, in regard to Page 48, would it be appropriate to include the Catholic Hospital Association.

On Page 52, I would suggest the wording in the third paragraph, last sentence, be as follows -

> At the same time, other teaching hospitals seem to believe that the organization is dominated by the large private traditional teaching hospitals.

Similarly, on Page 58, in the first paragraph at the top of the page, the phrase "primary teaching hospitals" should be changed to "traditional integrated hospitals."

Finally, on Page 62, I would suggest a fifth bullet indicating the importance of monitoring any evidence of decreasing quality of patient care.

BAYLOR
COLLEGE OF
MEDICINE

Texas Medical Center
Houston, Texas 77030

William T. Butler, M.D.
President
(713) 799-4846

March 23, 1984

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 Dick:

Enclosed is my critique and comments on the document entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." Since there is some confusion about page numbers, I have also attached the document from which I worked and I have outlined in yellow the particular statements in the document to which my notes refer.

I look forward to seeing you in Callaway Gardens. Please let me know if you have any questions in the meantime.

With personal regards,

Bill

William T. Butler, M.D.

WTB:hd

xc: John A. D. Cooper, M.D., Ph.D.
Edward J. Stemmler, M.D.
Richard H. Moy, M.D.
Joseph A. Keyes, Jr., J.D.

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

Page(s)	Statement(s) in Document	CRITIQUE AND COMMENTS
21	COTH successful in attracting major teaching hospitals as members...	- How is major teaching hospital defined? - Major is a considerable contrast to definitions on pp. 25-27. - Perhaps it reflects the term used by LCME (AAMC/AMA) in defining affiliated teaching hospitals.
25	Members defined as hospitals where chiefs of services are also chairmen of the medical school departments. Inextricable relationships is used.*	- Defining major teaching hospitals by this single indicator limits the COTH membership to 28%. - It fails to recognize the diversity as well as the pluralistic nature of major teaching hospitals. - The Methodist Hospital (TMH) meets this criteria but is not listed among the 28%. - Baylor has a variety of affiliations defined as major in education (Medical Student and GME).

26	Resident-to-bed ratios serve to classify the affiliated hospitals numbered (7) and (8).	- This is an additional definition.
		- It is not relevant to teaching and research.
		  - Bears no institutional commitment in dollars or in philosophy
		  - Has potentially damaging implications particularly regarding future funding patterns.
		- TMH is a primary Baylor teaching hospital but classified on a resident-to-bed ratio.
		  - TMH houses Baylor's Departments of Medicine, Surgery, and Physical Medicine. The Departments of Otorhinolaryngology, Ophthalmology, Neurology, and Neurosurgery are housed in

*
Inextricable: - a maze or tangle from which it is impossible to get free
- incapable of being disentangled or untied
- not capable of being freed.
(Source: WEBSTER'S NEW COLLEGIATE DICTIONARY)

Page(s)	Statement(s) in Document	CRITIQUE AND COMMENTS
26 Cont.		TMH/Baylor shared space. - 34% of Baylor's research funds are expended at TMH - 17% of Baylor's Medical Students at any time are at TMH as are 20% of the Residents - Clinical Research Fellows and Students (Baylor and other schools) on electives spend major training/eduation time in TMH. - What a major primary teaching hospital is in terms of education and research should be defined not in resident-to-bed ratios but perhaps in dollar support of education and research per teaching bed; or a determination made by the Dean taking all factors into account. - Comment: Future decreases in resident numbers would affect the resident-to-bed ratio even more adversely!
27	Redefinitions of teaching hospitals and their listing in Tables II and III.	- Above critiques and statements apply.

Page(s)	Statement(s) in Document	CRITIQUE AND COMMENTS
34	Unique characteristic of AAMC...and to reduce friction and mistrust between components of medical center leadership.	- Except at top levels in AAMC, how effective is AAMC/COTH in bringing about communication and understanding and thereby decreasing friction and mistrust? - What was Dean's input into the document? - The three groups are brought together at the top but should there be a matrix organization at operational levels?
35	CEO's of teaching hospital involvement in COTH/AAMC activities.	- Where does this interaction take place? - What is the actual extent of CEO participation and involvement?
36-37	Representation of COTH members on the Administrative Board.	- How are Administrative Board members selected? - As COTH hospitals are defined in the document and its appendix, should there be given consideration for representation on the Board by function rather than geographic location?
37	Regarding request that institutional representatives to COTH be someone other than CEO.	- It may also indicate that community hospitals may get more mileage out of their own organizations, e.g., AHA, state hospital associations, etc. than from the COTH/AAMC.
38	To overcome a difficulty—that more CEO's wish to participate than can be accommodated, the staff attend regional meetings to meet with constituents.	- I note the COTH/AAMC staff comprises three Ph.D.'s, two staff associates, and a research associate and whether or not any have had grass roots hospital administration experience I don't know. Would it be helpful to add someone to the staff who has had recent management experience in a major hospital who can increase the liaison capability that you seem to need.
39	Staff activities focus primarily in the areas of advocacy, information, education, and research.	- To what extent does the staff reflect COTH membership as well as insights of Deans and health science center presidents?

Page(s)	Statement(s) in Document	CRITIQUE AND COMMENTS
39 Cont.		- Or does staff advocacy primarily reflect staff and AAMC staff opinions?
40	Staff interaction with HCFA and with boards and committees of other hospital associations.	- To what extent do these staff discussions represent staff opinion vs. that of COTH and other constituencies such as COD?
41	Advocacy emphasis to shift to protecting the diversity of COTH membership...and to protect the teaching hospitals' share (of reimbursement).	- Concur, but don't dilute or jeopardize the role by failing to recognize the diversity of primary teaching hospitals that fulfill major roles in all phases of medical education and in basic and clinical research.
42	A number of COTH members believe they would believe they would be better served if AAMC advocated the needs of only the first three categories of teaching hospitals.	- Agree with department staff that this would be an improper course to pursue - It would be limited to 28% of major primary teaching hospitals, thus too parochial and self-serving. - It would be a serious disservice to the remaining primary teaching hospitals. It, like the residents-to-bed ratio, would have the potential to seriously penalize hospital reimbursements were the federal government to adopt these criteria. This focus would certainly exclude TMH.
45	Research recommendation.	- Great, and probably long overdue.

aamc association of american medical colleges

COTH SPRING MEETINGS

1978 - 1986

1978	St. Louis, Missouri
1979	Kansas City, Missouri
1980	Denver, Colorado
1981	Atlanta, Georgia
1982	Boston, Massachusetts
1983	New Orleans, Louisiana
1984	Baltimore, Maryland
1985	San Francisco, California (May 8-10)
1986	Philadelphia, Pennsylvania (May 7-9)

The staff recommends that consideration be given to the following cities for the 1987 COTH SPRING MEETING; other suggestions would be appreciated:

Dallas

Houston

Chicago

HOTELS • 1301 PENNSYLVANIA AVENUE, N.W. • WASHINGTON, DC 20004 • (202) 223-1231

FAIRMONT HOTEL MANAGEMENT COMPANY

March 29, 1984

Ms. Melissa Wubbold
ASSOCIATION OF AMERICAN
MEDICAL COLLEGES
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

Dear Melissa,

Our Fairmont Hotel in San Francisco greatly appreciates your time and effort in regard to your 1985 gathering. We're looking forward to a most successful conference.

Melissa, as requested, we would like to adjust the room block to read as follows:

	Day	Date	# of Rooms
**	Tuesday	May 7, 1985	200
	Wednesday	May 8, 1985	200
	Thursday	May 9, 1985	DEPARTURE

Since we're able to move your dates, we are pleased to offer the following rates which are our 1983 rates:

Main Building Court		Main Building Outside	
Single	$85-120	Single	$110-135
Double	$110-145	Double	$135-160

Tower	
Single	$135-160
Double	$160-185

**A Monday-Wednesday room block is also an option (5/6-8) if there is significant interest in having the meeting adjoin a weekend. Additionally, in the Monday-Wednesday option, the meeting rates would be guaranteed for those participants arriving over the 5/4-5 weekend.

Melissa, for your information, the current rates in San Francisco run in the range of $90-$165 single and $115-$190 double. Again, these are 1984 rates and the 1985 rates are expected to rise again. However, we will stay with the 1983 rates.

Melissa, also, we're pleased to offer a one-bedroom suite over and above our regular complimentary policy of one per fifty.

Thanks again for all your time and help. We greatly appreciate your consideration, and please let me know if you have any other questions.

Sincerely,

FAIRMONT HOTELS

Marc Fletcher
Regional Director of Sales

MF/cc

cc: Brent Mundt, Sales Manager
Fairmont Hotel & Tower, San Francisco

association of american medical colleges

AAMC ANNUAL MEETING
COTH GENERAL SESSION THEMES

1972	EXTERNAL FISCAL CONTROLS ON THE TEACHING HOSPITAL
1973	THE ECONOMIC STABILIZATION PROGRAM AND OTHER HEALTH INDUSTRY CONTROLS
1974	NEW MANAGEMENT AND GOVERNANCE RESPONSIBILITIES FOR TEACHING HOSPITALS
1975	RECENT CHANGES IN THE HEALTH CARE DELIVERY SYSTEM: IMPLICATIONS FOR THE TEACHING HOSPITAL
1976	CLINICAL CASE MIX DETERMINANTS OF HOSPITAL COSTS
1977	PHYSICIAN RESPONSIBILITY AND ACCOUNTABILITY FOR CONTROLLING THE DEMAND FOR HOSPITAL SERVICES
1978	MULTIPLE HOSPITAL SYSTEMS AND THE TEACHING HOSPITAL
1979	CONFLICT: CONTINUING ADVANCEMENT IN MEDICAL TECHNOLOGY AND THE QUEST FOR COST CONTAINMENT
1980	THE HIGH COST PATIENT: IMPLICATIONS FOR PUBLIC POLICY AND THE TEACHING HOSPITAL
1981	IMPLEMENTING COMPETITION IN A REGULATED HEALTH CARE SYSTEM
1982	HEALTH CARE COALITIONS: TRUSTEES IN A NEW ROLE OR BUSINESS AS USUAL
1983	ETHICAL DILEMMAS AND ECONOMIC REALITIES

The staff would appreciate some discussion and guidance in selecting a topic and speaker(s) for the COTH portion of the November, 1984 AAMC Annual Meeting.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

1984 ANNUAL MEETING PLENARY SESSIONS

International Ballroom
Conrad Hilton Hotel
Chicago, IL

Monday, October 29

9:00 am — Medical Education and the University

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

9:30 am — The Role of the Teaching Hospital in Professional Education

Mitchell T. Rabkin, M.D.
President, Beth Israel Hospital

10:00 am — Break

10:30 am — Reflections on Medical Education

Brian J. Awbrey, M.D.
Resident in Orthopaedics
University of North Carolina

11:00 am — Faculty Perspectives on Clinical Education

Lloyd H. Smith, Jr., M.D.
Chairman, Department of Medicine
University of California, San Francisco

Dr. Smith will present the Alan Gregg Memorial Lecture

Tuesday, October 30

9:30 am — Presentation of the AAMC Award for Distinguished Research and the Flexner Award

10:00 am — Education in Our Society

Ernest L. Boyer, Ph.D.
President, The Carnegie Foundation for the Advancement of Teaching

10:30 am — The Public's Expectations on Physician Training

Ann Landers
Syndicated Columnist

11:00 am — AAMC Chairman's Address

Robert M. Heyssel, M.D.
President, The Johns Hopkins Hospital

aamc association of american medical colleges

February 28, 1984

The Honorable Robert Dole
Chairman, Finance Committee
United States Senate
Washington, D.C. 20510

Dear Senator Dole:

The Association of American Medical Colleges, whose teaching hospital members care for one-fourth of the short-stay hospital admissions of both Medicare and Medicaid beneficiaries, wishes to restate its strong opposition to three proposals which we understand the Finance Committee will be considering. The AAMC:

- opposes eliminating the 1% new technology factor from the Medicare prospective payment system,
- opposes proposals to replace the required market-basket adjustment for hospital payments with a fixed and arbitrary inflation percentage, and
- opposes any arbitrary cut in the federal matching share for state-administered Medicaid programs.

Recent changes in hospital payments under the Medicare and Medicaid programs are requiring hospitals to make substantial changes in their operations. To further reduce payments will compound the problems hospitals face and necessitate short-term expense reductions without full awareness of their long-term consequences. More importantly, if the Congress fails to comply with the payment commitments made in P.L. 98-21, many administrators will view the Federal Government as unreliable, and begin replacing cost containment with cost shifting. To avoid these adverse outcomes, the AAMC urges the Senate Finance Committee to retain the 1% technology, the market basket inflation adjustment, and the present Medicaid matching formula.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.
President

cc: Members, Senate Finance Committee

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

aamc association of american medical colleges

February 28, 1984

The Honorable Dan Rostenkowski
Chairman, Ways and Means Committee
United States House of Respresentatives
Washington, D.C. 20515

Dear Mr. Rostenkowski:

The Association of American Medical Colleges, whose teaching hospital members care for one-fourth of the Medicare beneficiaries admitted to short-stay hospitals, strongly urges the Congress to lengthen the phase-in period for Medicare's prospective payment system. Under present statute, the first year phase-in is based on a blend (1) of 75% inflation-adjusted hospital costs and (2) of 25% standardized regional costs. The AAMC strongly recommends a second year of this 75/25 blend be added and urges support of H.R. 4093 which would require this change.

Medicare's prospective payment system is a dramatic change in the hospital environment requiring an equally substantial change in the nation's hospitals. With prospective payment introduced in less than half of the hospitals and with less than six months of data, it is clear that numerous problems are developing with the implementation of this new system. Substantial questions of equity, fairness, and reasonableness have arisen. Rather than ignore these problems and compound them by changing to a 50/50 blend on October 1, the AAMC believes the 75/25 blend should be maintained for a second year and HCFA should be required to submit an analysis on February 1, 1985 which describes the impact of prospective payment on the revenues of different types of hospitals.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.
President

cc: Members, House Ways and Means Committee

One Dupont Circle, N.W. 48 ...n, D.C. 20036 / (202) 828-0400

- D R A F T -

aamc association of american medical colleges

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

(202) 828-0460

March 28, 1984

The Honorable William Natcher
Chairman, Subcommittee on Labor,
Health and Human Resources
Appropriations Committee
U. S. House of Representatives
Washington, DC 20515

Dear Mr. Natcher:

Your subcommittee will soon consider an appropriation for the Office of Technology Assessment's Prospective Payment Assessment Commission. On behalf of the membership of the Association of American Medical Colleges, I wish to convey our full support for adequate funding of this Commission. I believe that the staff of the Pro-PAC, as the Commission has come to be called, has estimated that it will need just over $3.1 million for FY 1985. This figure appears to be a reasonable, perhaps even a conservative estimate, of what this Commission will need in order to adequately perform the difficult duties with which it is charged.

While most of us in the health care sector have focused our attention on the problems experienced during the initial implementation of the Prospective Payment System, we realize the important questions for assuring the long-term success of this system are:

- At what rate should the DRG prices be increased in each year in order to reflect changes in inflation, productivity, technology, and quality?

- How should the DRG payment rates be changed to reflect improvements in both the practice of medicine and our ability to identify patient characteristics that influence the care rendered?

It is these two questions for which the Pro-PAC is responsible. It is vital that your committee continue to provide adequate funding for its functions.

Sincerely,

John A. D. Cooper, M.D.

One Dupont Circle 49 shington, D.C. 20036

association of american medical colleges

TOWARD AN UNDERSTANDING OF CAPITAL COSTS IN COTH HOSPITALS

James D. Bentley, Ph.D.
Associate Director
Department of Teaching Hospitals

March 27, 1984

BACKGROUND

When Congress adopted the Medicare prospective payment system, capital costs of hospitals were excluded from the prospective payment and continued on a cost reimbursement basis. This exclusion does not necessarily reflect a Congressional commitment to continuing cost reimbursement for capital: it does reflect the presently inadequate, conflicting, and occasionally surprising information on capital costs of hospitals. One of the initial surprises in the government's analysis of hospital capital costs in the Medicare program was the finding, by the Office of the Assistant Secretary for Planning and Evaluation (ASPE), that capital costs in hospitals belonging to the Council of Teaching Hospitals (COTH) averaged 5.01% of total expenses while capital costs in non-COTH hospitals averaged 7.17%. Of equal significance was the ASPE finding that COTH members were consistently more heavily concentrated in the low capital cost categories, Table 1. These findings were in conflict with the "conventional wisdom" that major teaching hospitals have atypically high capital costs because of their roles in developing new technologies and initiating new diagnostic and treatment services.

Other ASPE analyses tended to corroborate the unexpected COTH/non-COTH differences in capital costs. As shown in Table 2, lower capital costs were also found in hospitals with CT scanners, pediatric/neonatal intensive care units, open heart surgery services, and Medicare case mix indices greater than 1.1. Each of these findings was contrary to the "conventional wisdom" on capital costs which held that higher capital costs would be present in clinically advanced and intensive hospitals.

ISSUE

An analysis of hospital capital costs under Medicare has produced the unexpected finding that COTH hospitals, as a group, have lower capital costs than other short-stay, non-Federal hospitals. A number of possible explanations could account for this difference:

- #1: COTH hospitals have lower capital costs as a percentage of expenses and per unit of output than non-COTH hospitals; or

  COTH hospitals have higher capital costs per unit of output than non-COTH hospitals but the higher operating costs of COTH hospitals result in capital costs being a small percentage of total expenses in COTH than non-COTH hospitals, and

- #2: COTH hospitals have older plant and equipment than non-COTH hospitals. As a result, COTH hospitals have relatively lower capital costs because construction and financing costs have increased rapidly across the past decade.

Using available data sources, this paper compares capital costs in COTH and non-COTH hospitals in order to help focus present discussions of capital costs.

ANALYSIS

Expenses

QUESTION: Do the relatively lower capital costs in COTH members mean that COTH hospitals use less capital per unit of workload performed?

Table 3 shows depreciation and interest expenses as a percentage of total hospital expenses for COTH and non-COTH hospitals. It should be noted that the interest expense percentage includes both interest paid on capital indebtedness and interest paid on working capital because the AHA's Annual Survey of Hospitals does not differentiate them. COTH members, as a group, report a lower percentage of expenses for both depreciation and depreciation plus interest. This is consistent with the ASPE finding.

In Table 4, depreciation and interest expenses for COTH and non-COTH hospitals are computed on a unit of workload basis using adjusted census days, adjusted patient days and adjusted admissions. In each case, the "adjusted data" provides a comprehensive measure of hospital workload by increasing actual inpatient workload by a hospital specific factor designed to convert outpatient services into inpatient workload equivalents. In both depreciation and interest expenses categories, COTH hospitals report significantly higher expenses per workload unit. This finding of higher capital costs per unit of workload but lower costs as a percentage of expenses is also supported when depreciation expenses for COTH and non-COTH hospitals are compared by census region, Tables 5 and 6. Thus, at the first level of analysis, it appears that COTH members have significantly higher capital costs per unit of workload than non-COTH hospitals.

Age of Plant

QUESTION: Do COTH hospitals have older or newer capital (equipment and facilities) than non-COTH hospitals?

In the past decade, construction and financing expenses have increased rapidly. As a result, hospitals having older plant and equipment have depreciation expenses based on lower construction costs and financing costs based on lower interest rates. Table 7 shows the standard financial ratio "average age of plant" in COTH and non-COTH hospitals. The average age of COTH hospitals is 7.4 years while non-COTH hospitals average 6.7 years. COTH hospitals are 12% older, on average, than non-COTH hospitals. Average age of plant is shown by census region in Table 8. In seven of the nine regions, COTH hospitals have older plant and equipment than non-COTH hospitals.

DISCUSSION

The data analysis clarifies somewhat the capital costs of teaching hospitals. Without fully explaining capital costs, the data suggest two independent factors are acting to influence the relative capital costs of teaching hospitals.

First, COTH members do have greater absolute capital expenditures per unit of workload. At the same time, COTH members have relatively smaller capital costs when capital costs are compared to total hospital expenses, at least for periods in the early 1980's.

This first finding has significant implications in evaluating capital payment proposals from the perspective of COTH members. Using historical data as an indicator of future relationships, the acceptability of a uniform capital "add-on" to the DRG payment system depends on COTH members receiving greater than average operating payments under the scheme. If the present resident-to-bed adjustment or a future severity of illness adjustment provides COTH members with payments per admission substantially greater than those in non-COTH hospitals, a uniform percentage increase for capital will more than adequately compensate COTH members as a group. If, however, prospective payment requires COTH members to accept operating cost and capital payments equal to non-COTH hospitals, COTH hospitals will not be able to maintain their greater capital intensity. This is illustrated in Table 9. If payments for operating costs in COTH hospitals drop either to the national or non-COTH averages, historical capital costs in COTH hospitals become relatively greater than capital costs in non-COTH hospitals.

Second, the capital stock of COTH hospitals is, on average older than that of community hospitals generally. This implies that either COTH

hospitals are relatively under capitalized or that non-COTH hospitals are relatively over-capitalized. In either case, if COTH hospitals are to offer competitive plant and equipment, COTH hospitals are more likely to undertake major capital projects in the near term, a development which would raise capital costs in COTH hospitals. This expectation is supported by Table 10 showing that COTH members, which have 18% of adjusted admissions, had 27% of the construction in progress in 1982. This increased capital spending is consistent with the finding of higher average plant age in COTH hospitals and suggests historical data, such as the 1981 Medicare data used by ASPE, may not accurately represent current capital expense patterns.

The current above average capital spending in COTH hospitals is further demonstrated in Table 11 where 1982 total capital expenditures for COTH and non-COTH hospitals are compared by census region and nationally. COTH members consistently report higher 1982 capital expenditures per adjusted admission than non-COTH members. This expenditure pattern suggests that COTH hospitals view themselves as undercapitalized and are modernizing to alter this perception. As a result, relative capital costs in COTH hospitals can be expected to at least approximate those in non-COTH hospitals in the next few years.

This paper was not developed to provide a conclusive discussion of capital costs in COTH and non-COTH hospitals. Four conclusions, however, are clear:

- o historical data which compares capital costs to total expenses have been misinterpreted by some to imply that COTH hospitals have lower absolute capital costs than non-COTH hospitals
- o capital costs per unit of workload performed are higher in COTH than non-COTH hospitals
- o COTH hospitals have older plants than non-COTH hospitals, and

- recently increased capital spending by COTH hospitals may alter statistical relationships that existed in data collected in the 1970's and early 1980's.

Given those conclusions and the "lumpy" capital cycle of major facility projects, COTH hospitals must give particular attention to the impacts of proposed capital payment policies on hospitals which have recently constructed or are planning in the next few years to begin construction of major plant replacements. Special care must be taken to ensure that incorrectly interpreted or past trends are not used to restrict the financial viability and competitive attractiveness of major teaching hospitals.

Table 1

Percentage Distribution of Capital Costs as a Percentage of Total Expenses by Membership in the Council of Teaching Hospitals, FY 1981

Percentage of Capital Costs	Percentage of Hospitals	
	COTH	Non-COTH
Less than 4%	37%	25%
4% to 6.57%	39	34
6.58% to 9.99%	17	23
10.0% to 14.99%	6	13
15% to 19.99%	1	4
20% or more	1	2
TOTAL	101%	101%

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 2

Capital Costs as a Percentage of Total Costs
by Selected Hospital Characteristics, FY 1981

Hospital Characteristic	Number of Hospitals	Mean Percentage of Expenses for Capital Costs
CT Scanner		
Yes	1108	6.47%
No	3867	6.75
Pediatric/Neonatal ICU		
Yes	1215	6.09
No	3760	7.09
Open Heart Surgery		
Yes	463	6.09
No	4512	6.85
Medicare Case Mix Index		
Less than .9	862	5.64
0.9 - 1.0	1517	6.72
1.0 - 1.1	1631	7.16
More than 1.1	814	6.07

Source: Office of the Assistant Secretary for Planning and Evaluation, DHHS.

Table 3

Depreciation and Interest as a Percentage of Total Expenses for COTH and Non-COTH Hospitals, 1982

Expense Type	Percent of Total Expenses	
	COTH Members	Non-COTH
Depreciation	3.7%	4.2%
Interest	2.7	2.7
Depreciation and Interest	6.4	6.9

Source: AHA Annual Survey, 1982 data.

Table 4

Depreciation and Interest Expenses per Adjusted Census Day, Adjusted Patient Day, and Adjusted Admission in COTH and Non-COTH Hospitals, 1982

Workload Unit	Expenses per Workload Unit			
	Depreciation		Interest	
	COTH	Non-COTH	COTH	Non-COTH
Per Adjusted Census Day*	$8,596	$4,003	$4,345	$2,902
Per Adjusted Patient Day	23.50	10.90	11.91	7.95
Per Adjusted Admission	203.90	80.90	103.09	58.69

Source: AHA Annual Survey, 1982 data.

* A census day is equal to one bed occupied for 365 days. It is computed by dividing total patient days by 365.

Table 5

1982 Depreciation Expenses as a Percentage of
Total Expenditures in Short-Stay, Non-Federal Hospitals
by Membership in COTH and Census Region

Region	Depreciation as a Percentage of Total Expenses	
	COTH	Non-COTH
New England	3.5%	3.6%
Middle Atlantic	3.7	3.9
South Atlantic	3.8	4.3
East North Central	4.3	4.4
East South Central	4.3	4.4
West North Central	2.7	4.6
West South Central	3.9	4.3
Mountain	4.3	4.2
Pacific	2.9	3.9
National	3.7%	4.2%

Source: AHA Hospital Survey, 1982 data.

Table 6

Depreciation Expenses per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	1982 Depreciation Expense Per Adjusted Admission	
	COTH	Non-COTH
New England	$135.22	$ 86.94
Middle Atlantic	137.24	91.90
South Atlantic	133.45	88.02
East North Central	166.44	103.42
East South Central	128.87	77.13
West North Central	130.12	99.77
West South Central	122.68	81.93
Mountain	133.11	91.89
Pacific	128.57	111.08
National	$140.23	$ 92.93

Source: AHA Hospital Survey, 1982 data.

Table 7

Average Age of Plant in Short-Stay,Non-Federal Hospitals by Membership in COTH, 1982

Type of Hospital	Average Age of Plant*
COTH Hospitals	7.4 years
Non-COTH Hospitals	6.7 years

*Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Hospital Survey

Table 8

Average Plant Age in Short Stay
Non-Federal Hospitals by
by Membership in COTH And Census
Region, 1982

Region	Average Age of Plant* COTH Hospitals	Non-COTH Hospitals
New England	8.74	8.16
Middle Atlantic	8.00	7.53
South Atlantic	7.04	6.19
East North Central	6.81	7.17
East South Central	7.32	6.22
West North Central	7.51	7.21
West South Central	6.74	6.01
Mountain	5.80	6.05
Pacific	7.74	5.99

*Average Age of Plant = $\frac{\text{Accumulated Depreciation}}{\text{1982 Annual Depreciation}}$

Source: AHA Annual Hospital Survey

Table 9

Estimating COTH Capital Costs With Price Competitive Total Expenses

Assumption: All capital costs in COTH and non-COTH hospitals are necessary.

Step 1: Estimate patient care capital costs per admission in COTH hospitals.

COTH Total Expenses per Adjusted Admission	$3778
Medicare Estimate of Capital Costs	5.01%
Capital Costs per Adjusted Admission in COTH Hospitals	$192.68

Step 2: Estimate capital percentage in COTH hospitals if total expense per admission was limited to the national average expense per admission.

National Average Total Expenses per Adjusted Admission	$2498
COTH Capital Costs from Step 1	192.68
COTH Capital as a Percentage of National Average Total Expenses per Adjusted Admission	7.71%

Step 3: Estimate capital percentage in COTH hospitals if Total Expenses per adjusted admission was limited to the average of non-COTH hospitals.

Non-COTH Total Expenses per Adjusted Admission	$2208
COTH Capital Costs from Step 1	192.68
COTH Capital as a Percentage of Non-COTH Total Expenses per Adjusted Admission	8.73%

SUMMARY:

Current Medicare Capital Costs as a Percent of Expenses

COTH Hospitals	5.01%
Non-COTH Hospitals	7.17%

COTH Capital as a Percent of "Competitive" Total Expenses

Using National Average	7.71%
Using Non-COTH Average	8.73%

Table 10

1982 Construction in Progress in Short-Stay, Non-Federal Hospitals by Membership in COTH

	Construction in Progress	
Type of Hospital	Amount	Percent of Total
COTH Member	$1,603,593.494	27%
Non-COTH	2,818,714,864	73%
Total	$4,422,308,358	100%

Source: AHA Hospital Survey

Table 11

1982 Total Capital Expenditures per Adjusted Admission in Short-Stay, Non-Federal Hospitals by Membership in COTH and Census Region

Region	82 Capital Expenditures Per Adjusted Admission	
	COTH	Non-COTH
New England	$307.44	$170.71
Middle Atlantic	368.39	274.83
South Atlantic	349.91	258.55
East North Central	505.27	255.66
East South Central	649.29	247.71
West North Central	637.46	237.17
West South Central	351.64	230.73
Mountain	520.81	248.97
Pacific	366.07	278.86
National	$421.50	$254.50

Source: AHA Hospital Survey, 1982 data.

association of american medical colleges

Date: March 23, 1984

COTH GENERAL MEMBERSHIP MEMORANDUM

No. 84-3

Subject: COTH PROSPECTIVE PAYMENT IMPACT SURVEY

As the first year of the Medicare prospective payment system progresses, there is increasing interest in the impact of this development on different types of hospitals. Because teaching hospitals have multiple products and societal contributions resulting in relatively high per diem costs, there is particular interest in how the new system is affecting members of the Council of Teaching Hospitals (COTH). To date, the AMMC staff and the Administrative Board officers have had only anecdotal information to use in describing the impact. The enclosed questionnaire has been developed to provide a comprehensive understanding of the impact of Medicare's prospective payment system on COTH hospitals. Findings from questionnaire responses will be used to prepare testimony on proposed changes in the Medicare system, to develop research questions for HCFA's technical advisory panel on prospective payment, to specify areas of investigation for work by the Prospective Payment Assessment Commission, and to prepare a paper for the 1984 COTH Spring Meeting. To accomplish these objectives, completed questionnaires are needed from all COTH general hospitals. We recognize that your hospital presently operates under a waivered state system rather than the Medicare system. However, because a comprehensive understanding of the impact of prospective payment is needed, I strongly urge you to have your staff complete the questionnaire to the best of their capabilities and return it by April 20, 1984. Please mail the completed questionnaire to:

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

We recognize that the financial and case mix date shown in Sections II, III and IV of the questionnaire are highly sensitive. Therefore, the data in those sections will be presented in categorical or aggregate rather than individual hospital forms and individual hospitals information will be held in confidence. In order to continue our discussions with HCFA on the computation of the indirect "medical education" adjustment paid under prospective payment, we request the right to present HCFA with bed capacity and full-time-equivalent resident data on individual hospitals. If your staff has questions about confidentiality or about questions on this survey, please have them contact Jim Bentley or Nancy Seline at (202) 828-0493

Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

association of american medical colleges

COTH PROSPECTIVE PAYMENT IMPACT SURVEY
MARCH, 1984

Medicare's prospective payment system has dramatically modified hospital payment for the only national payer. In order to evaluate proposed changes in the system and to protect the interests of teaching hospitals, the AAMC needs accurate information on the impact of this new payment system on its teaching hospital members. Please assist us by completing and returning this questionnaire by April 20, 1984. If you have any questions about the meaning of a questionnaire item, please call Jim Bentley or Nancy Seline at (202)828-0493.

Sincerely,
Richard M. Knapp, Ph.D.
Director
Department of Teaching Hospitals

I. HOSPITAL IDENTIFICATION

1. Hospital Name: _____
2. Hospital Address: _____
   _____
   _____
3. The hospital's Medicare cost reporting year begins on _____
4. Please list the provider and subprovider numbers reported as part of the hospital's Medicare Cost Report:

Unit Status	Type of Unit	Provider/Subprovider Numbers
Provider	Hospital	_____
Subprovider	_____	_____
Subprovider	_____	_____
Subprovider	_____	_____
Subprovider	_____	_____

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

II. ESTIMATED MEDICARE REVENUE AND EXPENSE UNDER TEFRA

Note: The TEFRA year is the Medicare cost reporting year beginning between October 1, 1982 and September 30, 1983.

5. Please list TOTAL MEDICARE INPATIENT EXPENSES as submitted on the hospital's cost report under TEFRA:

   a. Operating Costs (before payment limitation) (do not include pass throughs) $ _____

   b. Medical Education Pass Through _____

   c. Nursing Education Pass Through _____

   d. Capital Cost Pass Through _____

   e. Other Adjustments and Pass Throughs _____

   f. Total Medicare Inpatient Costs (5f = 5a+5b+5c+5d+5e) _____

6. Please estimate the hospital's TOTAL MEDICARE INPATIENT REVENUE for the TEFRA year:

   a. Total Medicare Inpatient Revenue $ _____

   b. If the estimated Medicare Inpatient Revenue shown in 6.a exceeds total Medicare Inpatient costs shown in 5.f, please show the "bonus" payment expected under TEFRA: $ _____

   c. If the estimated Medicare Inpatient Revenue shown in 6.a is less than total Medical Inpatient Costs shown in 5.f, please show the payment penalty and check the type of limit exceeded

      Payment Penalty $ _____

      _____ exceeded Section 223 limit

      _____ exceed target rate limit

III. ESTIMATED MEDICARE REVENUE AND EXPENSES UNDER PROSPECTIVE PAYMENT

Note: The first prospective payment year begins with the hospital cost reporting year beginning on or after October 1, 1983. We recognize that no member hospital has completed this year and that many have not even started the year. Therefore, please complete this section using the best estimated information for questions.

7. Please estimate anticipated Total Medicare Inpatient Revenue for the first prospective payment year:

Type of Medicare Inpatient Revenue	Total Estimated Revenue
a. Total DRG per case payments (based on both hospital specific and regional components, excluding outlier and pass through payments)	$ _____
b. Total Outlier Payments	_____
c. "Indirect Medical Education" Payments	_____
d. Direct Medical Education Pass Through	_____
e. Capital Costs Pass Through	_____
f. Payments for Distinct Part Units	_____
g. Total Estimated Medicare Inpatient Revenue (7g = 7a+7b+7c+7d+7e+7f)	$ _____

8. Total estimated Medicare Inpatient costs which will be shown on hospital's cost report $ _____

9. If a Medicare patient is treated at your hospital and assigned to a DRG with a weight of 1.0 , please show the components of the DRG case payment you would expect to receive

75% Hospital's own base component	$ _____
25% Regional average component, wage adjusted	$ _____
100% Per case payment if DRG has weight of 1.0	$ _____

IV. PATIENT MIX INFORMATION

10. Please list the number of Hospital Discharges by payer:

	Total Discharges All Payers	Total Medicare Discharges	Total Medicaid Discharges
FY 1982	_____	_____	_____
FY 1983	_____	_____	_____
FY 1984 (estimated)	_____	_____	_____

11. Please list your hospital's DRG case mix index for Medicare payments:

Year	Published by Medicare	Calculated by Hospital (if available)
1980	_____	_____
1981	_____	_____
1982		_____
1983		_____
1984 (estimated)		_____

12. Please estimate the percentage of Medicare Admissions and bed days which will be provided to patients in your hospital's 25 most frequent Medicare DRGs

25 most frequent Medicare DRGs = _____ % of Medicare Admissions

25 most frequent Medicare DRGs = _____ % of Medicare patient days

13. Does your hospital have the capability to estimate costs the hospital incurs in producing individual DRGs? (Check as appropriate)

_____ yes, using software program developed by hospital staff

_____ yes, using software developed by and purchased from external source: Name of firm: _____

_____ yes, using software developed and owned by external source: Name of firm: _____

_____ yes, other (please describe _____
_____

_____ no

14. Please list the number and name of the five Medicare DRGs which your hospital produces at the greatest total net gain. (Total net gain = net gain per case times number of cases)

DRG #	DRG Name

15. Please list the number and name of the five Medicare DRGs which your hospital produces at the greatest total net loss: (Total net loss = net loss per case times number of cases)

DRG #	

V. HOSPITAL BED CAPACITY

16. Total hospital beds currently set up and staffed _____

17. Please report the number of beds in distinct part unit exempt from Medicare Prospective Payment

Unit Type	Number of Beds
Alcohol/Drug Dependency	
Psychiatric	
Rehabilitation	

VI. FULL-TIME-EQUIVALENT RESIDENTS IN TRAINING

18. Total Full-Time-Equivalent Residents reported to Medicare Intermediary on the HCFA Form 1008 _____

19. Does the number of residents shown in 18 include fellows?

_____ yes, number of fellows included is _____

_____ no

20. Please list the number of full-time-equivalent residents training in the hospital by the name of organization issuing the resident's stipend check.

Organization Issuing Check	Number of FTE Residents
Hospital itself	_____
Other hospitals (please list names)	
_____	_____
_____	_____
_____	_____
Medical School/University (please list names)	
_____	_____
_____	_____
_____	_____
Governmental unit (please list names)	
_____	_____
_____	_____
_____	_____
All other (please list names)	
_____	_____
_____	_____
_____	_____

21. Please report the number of full-time-equivalent residents assigned to distinct part units excluded from Medicare Prospective Payment: _____

Thank you for completing this survey. Please return it by April 20, 1984 to:

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

POST SCRIPT

If you have any other data or anecdotal information regarding the implications of the new Prospective Payment System that you feel would be of assistance to us in dealing with Congress or the Department of Health and Human Services, please use this space to provide us with that information:

DISCUSSION ITEM FOR THE JOINT COMMISSION
ON ACCREDITATION FOR HOSPITALS

On January 12, James S. Roberts, MD, Vice President for Accreditation wrote Dr. Cooper as follows:

> Each of the Professional and Technical Advisory Committees (PTACs) provides a valuable service to JCAH's accreditation programs by identifying and offering advice on issues related to health care, standards and the survey process. A major objective of the JCAH is to ensure that matters of significant concern to the health care field are addressed. We believe that one of the best methods to achieve this goal is through the activities of the PTACs.
>
> In light of this, I would appreciate receiving your ideas for topics of discussion at future PTAC meetings, as well as your suggestions on how we might best approach issues of importance to your organization. Although it may not be possible to address all of the items that are identified, your thoughts will be of great assistance as we plan the direction of our activities for the next few years.

In a February 6 memorandum, COTH Administrative Board members were asked for suggestions in response to Dr. Roberts' letter. Enclosed are copies of these responses on the subject from Messrs. Goldberg, Kerr, and King. Since this is a long-term JCAH matter, and we have the time to do so, I think we should take Mr. Kerr's advice and discuss the matter before communitcating with the JCAH.

As an additional item to consider, we may wish to call attention to the substantial changes in Medicare payment for services in the clinical laboratory and the resulting incentives with regard to physician staffing in the clinical laboratory. Given these events, it may be appropriate to suggest a "closer look" at the physician staffing in the clinical laboratory when accreditation visits are made.

THE MONTEFIORE HOSPITAL
PITTSBURGH, PENNSYLVANIA

OFFICE OF THE DIRECTOR

March 1, 1984

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

Dear Dr. Knapp:

This letter is in response to your request for topics of future review and discussion by the JCAH Professional and Technical Advisory Committee.

I am advised by our Pathologist-in-Chief, who also heads up an inspection team for the College of American Pathologists, that there has been a significant decline in the level of autopsies in JCAH approved Hospitals since the standard was dropped, which governed the number of autopsies performed. Consequently, the quality of autopsy services, in what otherwise would be high quality and reputable institutions around the country, has suffered.

In an effort to strengthen the quality of autopsy services, we are suggesting that the JCAH Professional and Technical Advisory Committee review the role of the autopsy as a qualitative standard and reinstitute the quantitative standard for accreditation in both teaching and community hospitals. Specific consideration of the quality control function, cost-related aspects and continuing education role of the autopsy should also be discussed.

Many thanks.

Sincerely,

Irwin Goldberg
Executive Director

dlu

of the Director
pitals and Clinics
Francisco, CA 94143

University of California, San Francisco . . . A Health Sciences Campus

February 29, 1984

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

Dear Dick:

Thanks for your recent note concerning the JCAH's request for ideas on future standards and surveys. I am pleased that we have this opportunity for input and hope that we can get some discussion going on some of the following:

1. Differentiation between small community hospitals and large teaching centers.

   a. Recognition of teaching rounds, case conferences, subspecialty and section/division meetings as part of overall case/quality monitoring, moving away from the one month, one meeting concept.

   b. Clarification of separation of house staff from the credentialling process.

2. Refinement of standards for hospital-based ambulatory surgery.

3. Reduction of paper-work documentation requirements, in light of developing computerized information systems.

4. Recognition of multi-hospital systems (e.g. central teaching hospital and affiliates, shared services, medical and house staff, potential of combined rounds, and case conferences).

I wonder if these issues, and those suggested by others, shouldn't first be discussed within our group before passing them on to the JCAH. Please pardon my tardy response. Recent issues at SFGH have complicated an already tight schedule.

Sincerely,

William B. Kerr, Director
Hospitals and Clinics

STANFORD UNIVERSITY HOSPITAL
STANFORD UNIVERSITY MEDICAL CENTER STANFORD, CALIFORNIA 94305 • (415) 497-5222

Sheldon S. King
Executive Vice President and Director
Stanford University Hospital
Associate Vice President for Medical Affairs
Stanford University

February 22, 1984

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

Dear Dick:

SUBJECT: **Request for Advice from the Joint Commission on Accreditation of Hospital**

Enclosed are the individual requested comments.

1. JCAH standards have been established in an environment where financial concerns were secondary. Therefore, it is likely that some were adopted without a careful cost-benefit analysis. As the nation is clearly reluctant to fund health care at any cost, the standards should be re-evaluated in light of the economic burdens they impose.

2. a. Better assessment on quality-demand department statistics, survival rates-develop standards to allow comparison between institutions, regions, etc.
   b. Since the JCAH visit is so crucial to the hospital and it is the one time everything comes under scrutiny, I would use the time to upgrade really important areas-be really tough on incident reporting, follow up in events that endanger patients

3. Dispensing with such "nits" as lack of dental exam.
   Clarifying better the expectations of quality in a medical record note.
   Require physician's participation and attendance or something less drastic to make medical staff concerned along with hospitals. Now there seems to be low image of JCAH among most physicians and hospitals get dinged for lack of physician cooperation.

4. Improve the medical records requirements by being more realistic about items e.g. certain parts of physical exams are not mandatory on every patient. e.g. rectal and or pelvic exams depend on age and admission frequency.

Sincerely,

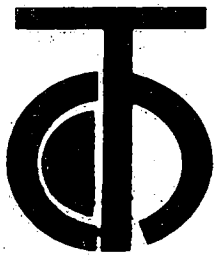
Sheldon S. King
Executive Vice President and
Director

attachment

MEMBERSHIP APPLICATIONS

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

HOSPITAL	STAFF RECOMMENDATION
John Peter Smith Hospital Ft. Worth, TX	Corresponding
The Medical Center Columbus, GA	Corresponding
Memorial Medical Center Savannah, GA	Full
St. Elizabeth Medical Center Dayton, OH	To be discussed
St. Mary's Hospital and Medical Center San Francisco, CA	Full



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: John Peter Smith Hospital

Hospital Address: (Street) 1500 South Main

(City) Fort Worth (State) Texas (Zip) 76104

(Area Code)/Telephone Number: (817) 921-3481

Name of Hospital's Chief Executive Officer: M.T. Philpot

Title of Hospital's Chief Executive Officer: Administrator

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	420	Admissions:	19,639
Average Daily Census:	244	Visits: Emergency Room:	59,984
Total Live Births:	4,686	Visits: Outpatient or Clinic:	121,364

B. Financial Data

Total Operating Expenses: $ 43,231,664

Total Payroll Expenses: $ 18,446,152

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 3,137,967
Supervising Faculty: $ XXXXXXXXX

C. Staffing Data

Number of Personnel: Full-Time: 1158
Part-Time: 154

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 238
With Medical School Faculty Appointments: 62

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

Medicine	OB/Gyn	Family Practice	Pediatrics
Surgery	Orthopedics	Psychiatry	

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	48	13	
Surgery	24	4	
Ob-Gyn	24	16	
Pediatrics	24	2	
Family Practice	24	18	
Psychiatry	24	0	
Other: E.R.	84	44	
Oral Surgery	24	10	
Anesthesiology	12	1	
Orthopedics	48	25	

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		7-1-81
Medicine				
Surgery				
Ob-Gyn	12	12		7-1-72
Pediatrics				
Family Practice	60	60		7-1-69
Psychiatry				
Other: Orthopedics	15	15		7-1-72

[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.

SEE ATTACHMENT 1

V. SUPPORTING DOCUMENTS

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

SEE ATTACHMENT 2

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

Name of Affiliated Medical School: University of Texas Southwestern

Dean of Affiliated Medical School: Kern Wildenthal, M.D.

SEE ATTACHMENT 3

Information Submitted by: (Name) W.O. Hargrove, M.D.

(Title) Medical Director

Signature of Hospital's Chief Executive Officer:

M.T. Staff (Date) 1/31/94

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT DALLAS
SOUTHWESTERN MEDICAL SCHOOL

KERN WILDENTHAL, M.D., Ph.D.
DEAN

5323 HARRY HINES BOULEVARD
DALLAS, TEXAS 75235
(214) 688-2022

January 13, 1984

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

Dear Sirs:

This letter is written to support the application of John Peter Smith Hospital in Fort Worth, Texas, for membership on the Council of Teaching Hospitals. Since 1961 that hospital has been fully affiliated with the University of Texas Southwestern Medical School. The affiliation agreement between the hospital and the Board of Regents of the University of Texas provides that the appointment of the Medical Director of the hospital is subject to approval of the Dean of the school, and the Medical Director holds a joint appointment from the school as Assistant Dean for Clinical Affairs.

Clinical clerkships for the school's senior students are available in various disciplines at the hospital, where students are supervised by the hospital's Teaching Staff, who are required to hold clinical faculty appointments at the school. The school's largest and very competitive resident training program in Family Practice is based at the hospital, and three full-time faculty members from the school's Department of Family Practice and Community Medicine are assigned to the hospital. The hospital's Transitional first year program is an excellent preparation for entry at the second post graduate year level to programs in Anesthesiology, Neurology, and Psychiatry based at the school.

As well as serving as an important educational resource for the school, over the years the hospital has made significant financial commitments to faculty support in several clinical departments of the school. The President of the Health Science Center, Dr. Charles Sprague, joins me in urging favorable action on the application of John Peter Smith Hospital.

Sincerely yours,

Kern Wildenthal, M.D., Ph.D.

KW:ms

XC: Dr. Sprague

IV. SUPPLEMENTARY INFORMATION

John Peter Smith Hospital, a component of the Tarrant County Hospital District, is a general, acute-care, public tax-supported hospital. The governing body is the Board of Managers, who are appointed by the elected officials comprising the Tarrant County Commissioners Court. The Court also approves the District's budget and sets its ad valorem tax rate each year. The District was created in 1959 by voters of Tarrant County, and since 1961 it has been fully affiliated with the University of Texas Southwestern Medical School in Dallas, Texas.

The Medical and Dental Staff of the Tarrant County Hospital District is composed of:

1. Teaching Staff, who are full-time or part-time practitioners appointed by the Board of Managers with approval of the Dean of the University of Texas Southwestern Medical School and on recommendation of the Executive Committee of the Staff to be responsible for post-doctoral medical education, medical administrative matters and clinical care of medically-indigent patients, whose care is sponsored by the District. Full-time hospital-based Teaching Staff now serve as Medical Director and Directors of the Departments of Medicine, Surgery, Obstetrics Gynecology, Pediatrics, Psychiatry, Orthopedic Surgery, Radiology, Pathology, Anesthesiology and Family Practice and the Divisions of Nephrology, Hematology Oncology, Pulmonary Medicine, Emergency Medicine and Dentistry. Other full-time, hospital-based Teaching Staff serve as Assistant/Associate Directors in most of those components. The Teaching Staff hold clinical faculty appointments at Southwestern Medical School. Their services are secured to the District by contracts with professional associations, which in turn employ or contract with the individual practitioners.

2. Consulting Staff, who are community practitioners in various sub-specialties and whose services on a part-time basis are contracted for by the professional associations referenced above.

3. Teaching Consulting Staff, who are full-time faculty members at Southwestern Medical School.

4. Courtesy Staff, who are community practitioners with usually past but not present participation at the hospital and who choose to request biennial reappointment.

The hospital is fully accredited by the Joint Commission on Accreditation of Hospitals. Although licensed to operate 450 beds, since 1976 only 315 beds/bassinets have been open. A large Family Practice program headed by full-time faculty of Southwestern Medical School is sponsored by the hospital as well as smaller programs in Orthopedic Surgery, Obstetrics Gynecology and Transitional first year, the last being jointly sponsored by the departments of Anesthesiology, Neurology and Psychiatry at Southwestern Medical School. Also, residents in Ophthalmology at Boston City Hospital; in General Surgery at Baylor University Medical Center; and in Urology, Otolaryngology and Oral Surgery at Parkland Memorial Hospital in Dallas are assigned to this hospital. All post-doctoral programs are fully accredited by the Accreditation Council on Graduate Medical Education.

Senior medical students are offered elective clinical clerkships at the hospital on various clinical services. No stipend is paid to clinical clerks, and each must secure the approval of the Dean of his medical or dental college. Only students at schools accredited by the Liason Committee on Medical Education or by the American Dental Association are eligible for appointment.

The hospital does not provide financial support for research; however, a number of members of the Teaching Staff have over the years participated in research projects approved by the Staff Clinical Research Committee and the Administrator. Funding for these projects has come from sources other than Hospital District ad valorem taxes.

As a historical note, the hospital was founded in 1906 as City County Hospital in affiliation with Fort Worth Medical College. The latter institution subsequently moved from Fort Worth and became Baylor Medical School. In 1959 the hospital's name was changed to John Peter Smith Hospital to recognize an early community leader, who in 1876 donated the property on which the hospital now stands. A full-time, hospital-based Director of Medical Education was first appointed in 1960, and from 1966 to date more Teaching Staff have been appointed in various disciplines.

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

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	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:

Mary T. Bradshaw (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.

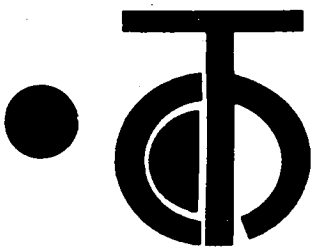
Sincerely,

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: Memorial Medical Center

Hospital Address: (Street) 4700 Waters Avenue

(City) Savannah (State) Georgia (Zip) 31405

(Area Code)/Telephone Number: (912) 356-8000

Name of Hospital's Chief Executive Officer: Kenneth W. Wood

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

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	465	Admissions:	15,098
Average Daily Census:	346 *	Visits: Emergency Room:	52,401
Total Live Births:	2,097	Visits: Outpatient or Clinic:	47,428

* represents 87% occupancy based on 399 staffed beds. Bed total temporarily decreased due to building/renovation program.

B. Financial Data

Total Operating Expenses: $ 60,851,964

Total Payroll Expenses: $ 34,683,226

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,360,775
Supervising Faculty: $ 947,639

C. Staffing Data

Number of Personnel: Full-Time: 1493
Part-Time: 292

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 213
With Medical School Faculty Appointments: 50 (list appended)

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

Surgery | Internal Medicine | Pediatrics | Ob/Gyn
Family Practice | | | |
Neonatology | Cardiology | Endocrinology | Psychiatry

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	46	41	26 required 15 elective
Surgery	40	22	16 required 6 elective
Ob-Gyn	45	35	34 required 1 elective
Pediatrics	45	30	27 required 3 elective
Family Practice	12	4	2 required 2 elective
Psychiatry			
Other:			
Radiology	12	5	elective
Endocrinology	1	1	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	15	15		
Surgery	14	13		
Ob-Gyn	5	4	1	
Pediatrics				
Family Practice	12	11		
Psychiatry				
Other: Radiology	4	4		
Urology	3	3		

[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) Carl L. Rosengart, M.D.

(Title) Vice President, Medical Education

Signature of Hospital's Chief Executive Officer:

Kenneth W. Wood (Date) 1/26/84

Kenneth W. Wood

MCG

Medical College of Georgia
Augusta, Georgia 30912
School of Medicine
Office of the Dean and Medical Director
(404) 828-2231

December 14, 1983

Gentlemen:

The Memorial Medical Center of Chatham County in Savannah has been an integral part of the School of Medicine of the Medical College of Georgia since the inception of our off-campus program for core clerkships in 1974.

Core clerkships in Obstetrics, Internal Medicine and Surgery were developed in 1975, and in Pediatrics in 1977. These have all continued uninterruptedly to the present time. A required clerkship in Family Practice was established this summer, so the Memorial Medical Center is also receiving students in Family Practice at this time.

During fiscal year 1982-83, 80 junior medical students took required core clerkships in Savannah: 22 in Pediatrics, 23 in Ob-Gyn, 12 in Surgery and 23 in Medicine. During 1983-84, we anticipate that 135 students will take core clerkships there: 31 in Pediatrics, 32 in Ob-Gyn, 32 in Surgery, 18 in Medicine and 22 in Family Practice. (This would not represent 135 individual students, as some may take more than one clerkship there.)

The program has been directed throughout the entire period by Dr. Carl Rosengart, Director of Medical Education at the Memorial Medical Center. Dr. Rosengart is a faculty member in Neurology and Educational Research and Development, and is our Assistant Dean for the program. He has most effectively helped to bridge the very real gap that exists between any parent school and its off-campus program.

Our off-campus programs broaden the educational experience of our students by introducing them to a different medical setting, with different teachers and different patients. We consider this a most important part of the education of the physician.

Yours sincerely,

F. Goodale

Fairfield Goodale, M.D.
Dean and Medical Director

FG:lk

The Chatham County Commissioners established the "Chatham County Hospital Authority" and Memorial Medical Center in 1952 in order to create a "modern hospital" in the Savannah-Chatham area that would provide the specialty and subspecialty facilities that did not exist at the time. It was also intended that the Medical Center would provide complete care for all indigent patients, as well as "create a medical educational environment".

In the ensuing years, Memorial Medical Center fulfilled these obligations and met its goals. It has become a 465 bed facility that is the tertiary care center for a region consisting of 24 counties in southeast Georgia and 2 counties in South Carolina. It serves the entire southeastern coast of Georgia. Memorial Medical Center is capable of providing the broadest scope of sophisticated diagnostic and therapeutic services.

It is the only institution in this entire region with a significant commitment to medical education: it is the only institution in the region with an affiliation with a medical school, the only institution with residency training programs, and the only institution approved for Category I credits in Continuing Medical Education.

Memorial Medical Center developed its first affiliation with the Medical College of Georgia in January, 1971 (enclosed). This affilation addressed the further enhancement of residency training at both institutions, and also created the basis for elective student rotations. I have also included a more recent agreement for enhancing the Radiology Residency Training Program.

In May, 1974, a major affiliation agreement with the Medical College of Georgia was established delegating Memorial as an "extended clinical campus facility" or "The Medical College of Georgia in Savannah". This affiliation agreement specifically addressed the rotation of third year students in four required clinical core areas. At the present time, Memorial Medical Center provides core rotations in Internal Medicine, General Surgery, Obstetrics and Gynecology, and Pediatrics. It has been doing this for ten years. In addition, for the past year, Memorial has also provided clinical rotations for Family Practice since the Medical College of Georgia created that as a core subject. In addition, at any given time, there are up to ten senior elective students present at Memorial Medical Center. Through this affiliation agreement for the training of medical students, all of our hospital-based teaching physicians have received full academic appointments at the Medical College of Georgia. The Medical College funds part of their salaries, part of the salaries of their secretaries, and also pays the hospital a per diem rate for each student. In addition, the community-based physicians active in the teaching program have been awarded clinical appointments (enclosed).

Memorial Medical Center currently supports six approved free-standing residency training programs in Internal Medicine, General Surgery, Family Practice, Obstetrics and Gynecology, Radiology, and Urology. At the present time, there are 55 residents. Although the programs are free-standing, they

are markedly enhanced by the presence of medical students and the faculty exchange resulting from the current medical college affiliation.

On October 29, 1975, Memorial Medical Center became the first and only institution within a twenty-four county radius to be approved by the AMA for Category I Continuing Medical Education Credits. It has remained accredited since then. All Category I CME in the region eminates from MMC.

As can be seen, Memorial Medical Center, is southeast Georgia's area health and education center. It is the only extension of the state's medical school in the entire coastal region. No other educational facilities exist within approximately a 125 mile radius. MMC must serve all the educational needs of students, residents, and practicing physicians.

MMC has actively and aggressively supported a close affiliation with the Medical College of Georgia for the past ten years and is currently seeking to strengthen these ties.

MEMORIAL MEDICAL CENTER

CLINICAL APPOINTMENTS - MEDICAL COLLEGE OF GEORGIA

Family Practice

Full Time -	Richard S. Graft, M.D.	Associate Professor of Family Practice
	Charles R. Peluso, M.D.	Associate Professor of Family Practice

Obstetrics & Gynecology

Full Time -	Edwin S. Bronstein, M.D.	Professor of Obstetrics & Gynecology
Part Time -	Arthur L. Haskins, M.D.	Clinical Professor
	John H. Angell, M.D.	Assistant Clinical Professor
	Darnell L. Brawner, M.D.	Assistant Clinical Professor
	Louis P. Leopold, M.D.	Assistant Clinical Professor
	Suresh I. Persad, M.D.	Clinical Instructor
	Speir N. Ramsey, M.D.	Clinical Instructor
	James D. Smith, M.D.	Clinical Instructor
	John L. Dekle, M.D.	Clinical Instructor

Surgery

Part Time -	Robert D. Gongaware, M.D.	Associate Professor of Surgery
	Carl R. Boyd, M.D.	Assistant Professor of Surgery
	Ronald Isaacson, M.D.	Assistant Clinical Professor
	Julian K. Quattlebaum, M.D.	Assistant Clinical Professor
	James W. Jackson, M.D.	Assistant Clinical Professor
	Lawrence J. Lynch, M.D.	Assistant Clinical Professor
	Thomas R. Freeman, M.D.	Assistant Clinical Professor
	William S. Hitch, M.D.	Assistant Clinical Professor
	Leslie L. Wilkes, M.D.	Assistant Clinical Professor (orthopedic
	Robert A. Wynn, M.D.	Assistant Professor surgery)
	David H. Smith, M.D.	Associate Clinical Professor
	E. Dan DeLoach, M.D.	Associate Clinical Professor

Psychiatry

Full Time -	William H. Sisson, M.D.	Associate Professor of Psychiatry

Endocrinology

Full Time -	Kaveh Ehsanipoor, M.D.	Assistant Clinical Professor

Urology

Part Time -	Peter L. Scardino, M.D.	Professor of Surgery/Urology
	Irving Victor, M.D.	Clinical Associate Professor
	Stephen Michigan, M.D.	Clinical Assistant Professor

Pediatrics

Full Time -	Martin H. Greenberg, M.D.	Professor of Pediatrics
	Thomas W. McKee, M.D.	Clinical Instructor
	Joseph V. Morrison, Jr., M.D.	Clinical Assistant Professor

Emergency Medicine

Full Time -	Lester M. Haddad, M.D.	Assistant Clinical Professor

Pathology

Full Time -	Jane B. Jennings, M.D.	Assistant Clinical Professor

Outpatient Department

Part Time -	Theodora L. Gongaware, M.D.	Associate Professor of Medicine

Psychology

	Charles McAleer, Ph.D.	Associate Clinical Professor Department of Psychiatry

Radiology

Full Time -	Gerald E. Caplan, M.D.	Clinical Associate Professor
	William A. Miller, M.D.	Clinical Associate Professor
	Burton D. Goodwin, M.D.	Clinical Assistant Professor
	Sandford V. Berens, M.D.	Clinical Assistant Professor
	Robert F. Long, M.D.	Clinical Assistant Professor
	Michael P. Carter, M.D.	Clinical Assistant Professor
	Glynn A. Bergeron, M.D.	Clinical Assistant Professor

Neonatology

Part Time -	Roberta M. Smith, M.D.	Assistant Professor of Pediatrics

Internal Medicine

Full Time -	James T. Waller, M.D.	Professor of Internal Medicine
	Danae M. Jeffery, M.D.	Assistant Professor of Internal Medicine
Part Time -	Murray C. Arkin, M.D.	Associate Clinical Professor
	C. Walker Beeson, M.D.	Associate Clinical Professor
	Lamont E. Danzig, M.D.	Associate Clinical Professor
	Keith Dimond, M.D.	Associate Clinical Professor
	Robert D. DiBenedetto, M.D.	Professor of Medicine
	Lloyd S. Goodman, M.D.	Associate Clinical Professor
	O. Emerson Ham, Jr., M.D.	Associate Clinical Professor
	Melvin Haysman, M.D.	Associate Clinical Professor
	Michael Nash, M.D.	Associate Clinical Professor
	Benjamin Pike, M.D.	Associate Clinical Professor
	Paul Jurgensen, M.D.	Associate Clinical Professor
	Roland S, Summers, M.D.	Associate Clinical Professor
	John West, M.D.	Associate Clinical Professor
	Rudolph Colmers, M.D.	Associate Clinical Professor
	J. Donny Gilley, M.D.	Clinical Instructor
	William I. Waller, M.D.	Clinical Instructor

Carl L. Rosengart, M.D.	Associate Professor of Neurology
Director of Medical Education	Assistant Dean
	Professor of Education, Research and Development

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery	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:

_____ (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

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. Mary's Hospital and Medical Center

Hospital Address: (Street) 450 Stanyan Street

(City) San Francisco (State) California (Zip) 94117

(Area Code)/Telephone Number: (415) 668-1000

Name of Hospital's Chief Executive Officer: Mr. James Metcalfe

Title of Hospital's Chief Executive Officer: Administrator

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 515

Average Daily Census: 313

Total Live Births: 711

Admissions: 11,615

Visits: Emergency Room: 12,483

Visits: Outpatient or Clinic: 114,565

B. Financial Data

Total Operating Expenses: $ 74,756,800

Total Payroll Expenses: $ 40,364,800

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ _____
Supervising Faculty: $ _____ } $2,440,227

C. Staffing Data

Number of Personnel: Full-Time: _____
Part-Time: _____ } 1679 Full-Time Equivalent Personnel

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 203
With Medical School Faculty Appointments: 76

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

Pediatrics	Psychiatry	Radiology	
Surgery	Pathology	Radiation Onc.	

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	6	15	Elective
Surgery	2	4	Elective
Ob-Gyn	1	3	Elective
Pediatrics	1	4	Elective
Family Practice	-	-	-
Psychiatry	2	6	Elective
Other: Radiology	1	4	Elective
Radiation Oncology	1	1	Elective
Community Medicine	1	3	Elective
Orthopedics	1	2	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	8	7	1	1921
Medicine	31	28	3	1946
Surgery	14	14	-	1943
Ob-Gyn	-	-	-	-
Pediatrics	-	-	-	-
Family Practice	-	-	-	-
Psychiatry	23	18	5	1962
Other: Rad Onc	3	3	-	1975
Diag Rad	5	5	-	1963
Orthopedics	12	12	-	1962

[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: UCSF

Dean of Affiliated Medical School: Rudi Schmid, M.D.

Information Submitted by: (Name) Charles H. Lithgow, M.D.

(Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

James E. Mitchell (Date) 1-18-89

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OFFICE OF THE DEAN
SCHOOL OF MEDICINE

513 PARNASSUS – S-224
SAN FRANCISCO, CALIFORNIA 94143

January 3, 1984

Mr. Richard M. Knapp, PhD
Director
Department of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, NW
Washington, DC 20036

Dear Dr. Knapp:

I am writing in support of the application of St. Mary's Hospital and Medical Center for membership in the AAMC's Council of Teaching Hospitals.

St. Mary's plays an important role in our graduate teaching programs and training house staff. Many members of St. Mary's medical staff are members of our clinical faculty and provide basic teaching for residents with an emphasis in pulmonary medicine and cardiology. Our medical students also benefit from elective courses taken at this Center.

I would be happy to provide any further information you may require.

Sincerely,

Rudi Schmid

Rudi Schmid, MD
Dean

RS:vm

✓cc: Charles H. Lithgow, MD, Director
Department of Medical Education
St. Mary's Hospital and Medical Center
450 Stanyan Street
San Francisco, CA 94117

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