MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

September 12-13, 1984
Washington Hilton Hotel

WEDNESDAY, September 12, 1984

Noon	JOINT LUNCHEON OF AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION and AAMC ADMINISTRATIVE BOARDS Hemisphere Room
1:00pm	JOINT MEETING OF AAMC COMMITTEE ON FINANCING GRADUATE MEDICAL EDUCATION and AAMC ADMINISTRATIVE BOARDS and Small Group Discussions Conservatory Room
6:00pm	COCKTAILS Thoroughbred Room
7:00pm	DINNER Thoroughbred Room

THURSDAY, September 13, 1984

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

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

September 13, 1984
Washington Hilton Hotel
Jackson Room
9:00am - 1:00pm

I.	CALL TO ORDER	
II.	CONSIDERATION OF MINUTES June 28, 1984	Page 1
III.	PAYING CAPITAL COSTS IN COTH HOSPITALS	Executive Council Agenda - Page 20
IV.	MODIFYING THE MEDICARE PAYMENT SYSTEM	Executive Council Agenda - Page 57
V.	FINANCING GRADUATE MEDICAL EDUCATION - FOLLOWUP TO SEPTEMBER 12 MEETING	--
VI.	HEALTH CARE IN THE 1990'S: TRENDS AND STRATEGIES	Page 16
VII.	JCAH REPORT ON ACADEMIC HEALTH CENTER HOSPITALS	Page 26
VIII.	MATCHING MEDICAL STUDENTS FOR ADVANCED RESIDENCY POSITIONS	Executive Council Agenda - Page 69
IX.	REPORT OF THE PROJECT PANEL ON THE GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN	Executive Council Agenda - Page 70
X.	LOW LEVEL RADIOACTIVE WASTE DISPOSAL	Executive Council Agenda - Page 73
XI.	MEMBERSHIP APPLICATIONS	
	Bayfront Medical Center St. Petersburg, Florida	Page 50
	Veterans Administration Medical Center Mountain Home, Tennessee	Page 58
XII.	OTHER BUSINESS	
XIII.	ADJOURNMENT	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
June 28, 1984

PRESENT

Haynes Rice, Chairman
Sheldon S. King, Chairman-Elect
Earl J. Frederick, Immediate Past Chairman
J. Robert Buchanan, MD
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Irwin Goldberg
William B. Kerr
Glenn R. Mitchell
Eric B. Munson
C. Thomas Smith
Thomas J. Stranova
Nancie Noie, AHA Representative

ABSENT

David A. Reed

GUESTS

Robert M. Heyssel, MD
Richard Janeway, MD
Charles Sprague, MD

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
John H. Deufel
Richard M. Knapp, PhD
Len T. Koch
Karen L. Pfordresher
John F. Sherman, PhD
Nancy E. Seline
August G. Swanson, MD
Kat S. Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MEETING
Minutes
June 28, 1984

I. CALL TO ORDER

Mr. Rice called the meeting to order at 9:00am in the Jackson Room of the Washington Hilton Hotel. Before moving to the agenda, Mr. Rice indicated that he had several items that he wished to report and have reported. He indicated that he had asked and Jerry Grossman, MD, President, New England Medical Center in Boston, had agreed to serve as Chairman of the 1985 COTH Spring Meeting Planning Committee to plan the meeting in San Francisco, May 8-10. Mr. Rice indicated he would be discussing the composition of the remainder of the Committee with the staff and Dr. Grossman over the summer. He also stated that he was pleased to note that Dr. Heyssel had been appointed to the AHA Hospital Research and Educational Trust.

On the afternoon of June 27, the AAMC Executive Committee met with the Executive Committee of the Association of Academic Health Centers. Before reporting on that meeting, Mr. Rice asked Dr. Dalston to report on the meeting of the AAHC Committee on Teaching Hospitals. Dr. Dalston reported that the meeting had been held on May 25 and that Vice Presidents Langfitt, MD; Challoner, MD; and Vanselow, MD from Pennsylvania, Florida, and Minnesota respectively were the other individuals in attendance. The Committee discussed the special nature of "principal teaching hospitals," policy issues for teaching hospitals, and teaching hospital activities of other organizations. A lengthy discussion was held concerning the COTH/AAMC paper entitled, "New Challenges for Council of Hospitals and the Department of Teaching Hospitals." Dr. Challoner also gave a report on the Commonwealth Fund Task Force on Academic Health Centers. Dr. Dalston reported that the Committee was in agreement on the following points:

- The hospital issues are central to the responsibilities of the academic health center CAO's. The AAHC should continue to to pay close attention to them;
- There is no need at this time to create a special task force, as opposed to the function of the Board Advisory Committee on Hospitals;
- The AAHC is interested in all of the approximately 125 principal teaching hospitals, even though there may be differences among them;
- The AAHC should emphasize to the CAO's the importance of inviting their hospital chiefs to AAHC meetings. Furthermore, it should try to include in its programs topics of interest to hospital directors;
- The AAHC should continue to keep COTH informed of its initiatives and interests in areas related to hospitals to reinforce the understanding that the CAO's need to be informed and involved in teaching hospital policy formulation (These underlinings are taken from the actual minutes of the meeting which the AAHC provided.);

- The AAHC should do active lobbying only on special compelling issues not addressed by other groups.

Dr. Dalston also reported that the staff had been requested to do a survey of what issues are of priority with respect to teaching hospitals and the survey should be done of CAO's and principal teaching hospital directors. He also indicated that a study concerning governance and divestature of university hospitals was in the developmental stage and that Dr. Fred Munson together with AAHC staff is preparing a proposal to be sent to a foundation.

Dr. Knapp asked whether or not the Board felt that it would be useful if the AAMC were to be a co-sponsor of the study. Following discussion, the following action was taken.

ACTION: It was moved, seconded and carried that the COTH Administrative Board recommend that the AAMC Executive Committee consider the merits of requesting AAMC sponsorship together with the Association of Academic Health Centers in the study of university hospital governance.

At this point, Mr. Rice reported on the meeting the previous afternoon between the executive commitees of the respective organizations.

He reported the following matters were discussed:

- Agenda items for the Joint Health Policy Committee of the American Association of Universities and the National Association of State Universities and Land Grant Colleges. It was agreed that the two organizations would develop a background paper on the issue of animals in research for presentation to the Joint Health Policy Committee. Another possible issue to be developed was research facility construction authority and the related issue of "pork barreling" in the Congress for university facilities.

- AAMC contract with the National Library of Medicine. It was reported that the AAMC had received a contract from the NLM to conduct a sympcsium on medical information science and medical education. It was agreed that this report did not seem to overlap or duplicate the recent AAHC report on executive management of computer resources in the academic health center.

- The Medicare Prospective Payment System. It was reported the AAMC had commissioned a paper from Judith Lave on the indirect medical education adjustment which will be ready by the end of the summer and will be shared with the AAHC and its members. There was also discussion of recent legislative action on the prospective payment system and the survey that is being done of COTH member experiences under the prospective payment system.

- o Marketing Activities. It was reported that the AAMC Management Education Program would present a seminar entitled, "Strategic Marketing: Management in a Competitive Environment" in September. Dr. Hogness reported that the AAMC had let a contract to a public relations firm to outline a plan that the AAHC could use nationally to market academic health centers.

- o Lengthening of Residency Training. The AAMC position opposing recent action by the American Board of Pathology to increase the length of training required for certification was discussed as was the general AAMC policy concerning the autonomy of specialty boards to lengthen training programs. It was agreed that the AAHC should develop its own statement on the subject but a joint statement from both the AAMC and the AAHC would be a useful action to take.

- o Medical School Class Size. It was reported that the AMA and AAMC would be supporting a conference at Duke Medical Center concerning the issue of medical school class size and physician supply.

- o Dr. Hogness announced that the AAHC planned a new project to study the pros and cons of university ownership of teaching hospitals. He reported that Dr. Fred Munson had assisted the AAHC in developing the proposal which will be presented for foundation funding.

Mr. Rice next called upon Dr. Knapp to report on a number of items. He first distributed a questionnaire that should have been attached to the item entitled, "Survey of Faculty Practice Plans" that was mailed as a separate board item on June 20. He asked that anyone that had comments on the questionnaire should call directly. Next he called attention to the item which was also mailed on June 20 entitled, "Distinguished Service Membership Nominations." He indicated that the staff was not able to identify anyone who would meet the qualifications. If anyone could identify an individual who would meet those qualifications, they should let the staff know so that action could be taken in September.

A number of individuals had indicated checkout problems from the hotel. Melissa Wubbold reported having spoken with appropriate hotel personnel and having been told that an individual checking in at the hotel need only immediately go to the hotel's Assistant Manager's desk adjacent to the checkin area and indicate his/her name, room #, planned date of departure, and the fact that the reservations desk had a credit card # on file for this individual. Having done this, a guest in the hotel need go through no formal checkout procedures upon departure, and would automatically be considered checked out based on the information given the Assistant Manager's desk at the time of their arrival.

Dr. Knapp reported the following plans had been made for the COTH General Session at the AAMC General Session in Chicago on October 29, 1984.

"Strategic Planning in the Teaching Hospital: Lessons from Other Industries"

SPEAKER: Thomas J. Manning
McKinsey & Co.
Chicago, Illinois

"Severity Measures: The Teaching Hospital Difference"

SPEAKER: Richard A. Berman
New York University Hospital
New York, New York

Membership dues invoices are sent out in the spring preceding the start of the subsequent fiscal year. This is a time when hospitals terminate their membership in COTH if they had been considering doing so. Appendix A contains a list of the 31 hospitals that have terminated membership since 1980. Eight hospitals have terminated membership this spring, four of which are corresponding members. (The Board should take note that Greenville Hospital System in Greenville, SC has since decided not to terminate its membership.) It was suggested that David Jepson of Intermountain Health Care Corporation should be called to ask about the reason for LDS Hospital in Salt Lake City terminating its membership in 1983.

Dr. Knapp noted that Jim Roberts of the Joint Commission on Accreditation of Hospitals (JCAH) would be visiting on July 5 to discuss JCAH Issues and it is expected that a paper is being developed that will be placed on the agenda for the September meeting of the Board. He also reported that Karen Pfordresher and Nancy Seline are exploring the issue of the impact of Medicare prospective payment rates on clinical trials.

Finally Dr. Knapp reported that he had attended a meeting in Chicago, June 13-14, of 15 hospitals with burn centers. The meeting had been organized by the chief executive and burn center director of Sherman Oaks Hospital in California, an investor-owned hospital with a 30 bed burn unit. A number of medical center hospitals were represented, including the University of Alabama, Loyola, Washington Hospital Center, and a number of non-teaching hospitals were represented as well. The group agreed to make an effort to organize and an organizing committee will be sending a request for a proposal to law firms and associations asking for proposals to provide organizational and lobbying services to what they hope to be a coalition of hospitals with burn centers. The purpose of the organization is to lobby for better payment for burn cases. It appears that the particular impetus for this meeting has resulted from the inadequate weights that have been assigned to some of the burn case DRG's. Dr. Knapp indicated that he thought that this might be the first of a number of organizations that may develop representing segments of the hospital. Hospital directors probably should be prepared for requests to pay dues from organizations like this that will develop and an assessment will need to be made as to whether or not these kinds of special interest organizations should be supported.

Mr. Rice then requested Mr. Kerr give a brief report on the development of the Metropolitan Hospital Section of the American Hospital Association. Mr. Kerr

indicated that 1,000 hospitals had signed preference forms for the section. He reported that the group was considering how best to proceed with strong support for the AHA DRG blending proposal under Medicare and in addition, pursuing the issue of indigent care. An attempt is being made to find practical solutions to the indigent care problem in addition to efforts to place it higher on the agenda of the American Hospital Association's priority list.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded and carried to approve the minutes of the April 12 COTH Administrative Board Meeting.

III. REVIEW OF 1984 COTH SPRING MEETING

Attendance at the meeting and mail received by the staff following the meeting were discussed. It was agreed that the meeting had been a successful one and thanks were expressed to the Planning Committee, particularly to Glenn Mitchell as Chairman, and to Dr. Foreman and his colleagues in Baltimore for hosting the reception. The correspondence that has been received will be shared with the 1985 COTH Spring Meeting Planning Committee in order that suggestions that have been made can be properly evaluated in the context of next year's meeting.

IV. DISCUSSION OF NEW CHALLENGES PAPER

Dr. Knapp indicated that implicit in the "New Challenges" paper were some basic issues which need attention which are related to the requirements for membership in COTH. There are three somewhat distinctive questions.

1. Should the COTH Administrative Board recommend that the Council limit its membership to that group of hospitals that would meet a very narrow definition of teaching hospitals?

It was agreed that such a direction would indicate a specific move in the direction of exclusivity. The point was made several times that the membership criteria should be related to the clarity of purpose of the organization. If the purpose is to advance and improve medical education and to identify the particular hospital problems of teaching hospitals, then clearly any organization which is interested and willing to get behind these purposes should be permitted to join. After a brief discussion, it was agreed that the COTH Administrative Board should not recommend that the Council limit its membership to a very narrow definition of primary teaching hospitals.

2. Should the COTH Administrative Board recommend that the Council require a minimum number of residents for a hospital to become a full COTH member?

Dr. Knapp indicated that there are 41 current COTH members who have less than 50 fulltime equivalent residency positions filled. A list of those hospitals was provided in the agenda and Dr. Knapp cautioned that the numbers should be treated carefully because there was some question as to the accuracy of the numbers that were reported in some cases. In particular, Mr. Stranova noted that the Veterans

Administration Medical Center in Brockton, Massachusetts had a much higher number of FTE positions since the two Veterans Administration institutions (Brockton and West Roxbury) had merged. After a relatively brief discussion, it was agreed that as long as a teaching hospital meets the literal requirements for COTH membership, it should be eligible to join. Therefore, there will be no minimum requirement for the number of residency positions occupied or filled as long as the hospital sponsors or participates in four residency programs and has an affiliation agreement and letter of recommendation from the college of medicine.

3. Should the COTH Administrative Board recommend that the Council provide full membership and participation for investor-owned teaching hospitals?

Dr. Knapp indicated that a strong case can be made that representatives of these hospitals would be a minority in the organization and to the extent their views were contrary to the current COTH/AAMC policies and those of their colleagues, their views would not prevail. Additionally, in at least two cases currently, the teaching hospital which is the principal institution in which the medical school's programs are carried out are or will shortly be ineligible for membership (Humana Hospital University in Louisville and St. Joseph's Hospital in Omaha). Before discussion moved ahead, the Chairman suggested the group be reminded that on page 76 of the Executive Council agenda, a brief report was set forth outlining the results of a survey that had been conducted of the Council of Deans concerning the relationship of investor-owned organizations with medical schools. Seventy deans returned the questionnaire of which 40 reported that there had been a contact regarding affiliation relationships with an investor-owned organization. Twelve schools are presently affiliated with a hospital owned or managed by a for-profit corporation. While the current interaction with investor-owned organizations is clearly a minority set of activities, it is also clear that there is a great deal of discussion and negotiation going on with investor-owned organizations. Since this was a discussion item on the Executive Council agenda, the Chairman suggested that this discussion be integrated with the current agenda item concerning membership of investor-owned hospitals in the Council of Teaching Hospitals. The following points were made:

- The arguments for participation of investor-owned hospitals in COTH are logical and to some degree persuasive. However, there are a number of practical and emotional problems which need to be considered;

- If an organization supports our goals and is interested in participating, perhaps then it should be given the opportunity to do so;

- Inviting such organizations to participate would be one more step toward their legitimacy as an acceptable and productive component of the health care industry;

- Inviting them to participate could be a very devisive move at this point since there is not a clear consensus in the COTH constituency;

- If they are not invited to participate, the possibility of two organizations representing teaching hospitals could possibly develop. This matter should be kept in mind.

After lengthy discussion, it was agreed that no action should be taken and a proposed bylaw change should not be prepared for discussion at the September Administrative Board and Executive Council meetings. The staff was directed to be sure that a debate similar to that which was engaged at the COTH Spring Meeting take place at the COTH Annual Business Meeting in Chicago on October 29.

V. INTERIM REPORT OF THE AAMC AD HOC COMMITTEE ON CAPITAL PAYMENTS FOR HOSPITALS

The Board reviewed and discussed the Interim Report from the AAMC ad hoc Committee on Capital Payments for Hospitals, chaired by Mr. Frank. In its deliberations, the Board noted the signficance of a hospital's present position in the capital cycle as the key problem in identifying a capital option acceptable to all AAMC members. In addition, a number of major points were raised in the discussion:

- o The difficulty of using a regulatory capital policy as a transition to a more competitive system (Mr. Goldberg);
- o The financial impact on hospitals of using depreciation and interest versus debt service payments in "grandfathering" past projects (Mr. Frank);
- o The hypothesized importance of biomedical research activity on hospital capital needs (Dr. Dalston).

After extensive discussion the following action was taken:

ACTION: It was moved, seconded, and carried that the COTH Administrative Board recommend that the Executive Council adopt capital option #1 (choice of depreciation and interest or percentage add-on) as its preference with the American Hospital Association's June 4 Finance Council Proposal (combining floor payments and a 10 year blend) as a reasonable secondary position.

VI. GRADUATE MEDICAL EDUCATION ISSUES

Dr. Cooper joined the Board for this discussion. Before preceding to the issue, he distributed a letter announcing his retirement on June 30, 1986. (A copy of this letter is included as Appendix B to the minutes of this meeting.)

Dr. Cooper noted that during the past decade and a half, the Associations's stability has been substantially increased and its financial position has been strengthened, permitting more flexibility in undertaking new and timely initiatives. He added that the Association has no peer in higher education and has been of great assistance in studies and policy development at both the national and institutional levels; and has become a more effective spokesman for the academic medical centers to the Federal Government. He concluded that he felt that in the 15 years since he had assumed the position of first fulltime President of the Association he had achieved his own goals and objectives and

felt the announcement of his retirement at this time would enable a search process to begin and ensure a smooth transition to the next phase of the Association's development.

Following Dr. Cooper's announcement, Dr. Buchanan paid Dr. Cooper the following tribute.

> I guess I am one of the few around, and there are a few, who have been active off and on in this organization since the early days of John's presidency and remember the Association as it was before John Cooper. I think, John, we owe you an incredible debt for what you have made of this Association and what you have done with it on our behalf. It is a tribute to a professional career, and I think if the membership doesn't recognize it, that's in itself a great tribute to you and the grace with which you have performed the magic of organization building and influencing public policy on behalf of our institutions, whether they be medical schools - I can speak from that perspective - or teaching hospitals - and I can speak from that perspective. It's really remarkable. It is without doubt the most influential association that deals with issues of concern to academic health centers, and probably has influenced the way in which specialty medicine is practiced more than any other group I know of. I salute you for this, and I would like to say that I understand your philosophy about not being buried here. My father used to say that he wanted to flame out, not rust out, and I'm with you!

On behalf of the Board, the Chairman stated that there was a clear sense that Doctor Buchanan's remarks reflected the appreciation, thanks, and best wishes of the COTH Administrative Board.

Following a brief recess, the meeting resumed and the Chairman then asked Doctor Cooper to proceed with the discussion of the item entitled Graduate Medical Education Issues. The ensuing discussion noted changes in the method of paying for hospital services and controversy surrounding the appropriate method of financing graduate medical education, increasing the AAMC's concerns over the continued availability of funding for residency training programs. So that the AAMC can play a principal role in future discussions about this financing, the Board was asked to consider the establishment of a task force to examine the issues. Additionally, it was suggested that in September a joint meeting of the Boards would be held to hear from selected speakers working on GME financing issues.

ACTION: It was moved, seconded, and carried that the the COTH Administrative Board recommend the establishment of a task force on graduate medical education financing and that a joint session of the Administrative Boards be held in September to review the issues.

VII. FACULTY SALARIES FROM NIH GRANTS AND CONTRACTS

Not long before the Board meeting, three medical schools were questioned about the calculation of the amount of faculty salary that might be charged to grants

and contracts. Disagreement has centered on what constitutes the "base salary" for a faculty member. The Board was asked to discuss if the AAMC should become involved in this issue, and if so, how? Through data collection, an attempt to determine how base salaries should be determined, or through AAMC staff or committee involvement in this issue?

ACTION: It was moved, seconded, and carried that the COTH Administrative Board recommend that the AAMC begin discreetly gathering data in case further action was necessary, but that no other action should be taken at this time.

IX. PATENT REFORM/GENERIC DRUG LEGISLATION

Dr. Sherman described an amendment to the Drug Price Competition Act (H.R. 3605) which would shorten the FDA review process for generic forms of drugs approved after 1962. This bill would also allow patent extension on certain products subject to FDA approval. Patents could be extended for a period equal to half the time required for safety and effectiveness testing and FDA market approval, with extension not exceeding five years or the effective patent life exceeding fourteen years.

Although intended as a compromise action, neither the major pharmaceutical nor the generic drug companies are satisfied and further amendments may be suggested, although the bill's sponsor, Representative Waxman (D-CA) said none will be accepted. A compromise bill was introduced by Senator Hatch to the Labor and Human Resources Committee, and hearings were scheduled for June 28th.

X. NIH PROPOSED POLICY CHANGES

The National Institutes of Health has recently proposed revisions to animal welfare policy that update and refine procedures for review of the use of animals in research. The proposed policy would 1) strengthen the accountability at facilities by designating a responsible "senior official" at each institution; 2) insure that institutions implement requirements and recommendations in the "Guide for the Care and Use of Laboratory Animals," and accept its principles; 3) reduce compliance options from three to two with additional requirements for nonaccredited facilities; 4) change the composition and name of the animal care committees, stipulating that a person not affiliated with the institution, a scientist, a person who is not a scientist and a veterinarian compose the new animal research committee (ARC); 5) require the ARC's to review and approve research applications involving animal use; and 6) create additional record keeping responsibilities.

The Board suggested that copies of these amendments be sent to member hospitals for their review in order to determine whether or not such a policy would be administratively reasonable and feasible.

Other NIH Activities:

Many individuals in the political and medical community agree that many research laboratories are outdated and that this impedes research. A survey evaluating the status of such laboratories is required to be completed by the Department of Defense, with a report due in the Spring of 1985. Although an interagency committee has been established to design the survey, it is not clear how the survey will be conducted, or who will conduct it. Assumedly, the results of such a survey could form the basis to build support for a grant program for matching construction funds.

On a related point, circular A-21's rate component includes a determination of user charge and depreciation plus recovery of interest on loans (initiated in 1982) that can be used in lieu of matching funds to finance research construction. Mr. Deufel presented information from a telephone survey indicating there is some interest in using this A-21 option in the future. The Board was asked whether they would endorse advocating a dedicated authority for the construction of research facilities under a matching grant program. Such a system could provide a wider distribution of research funds than the use of the indirect cost option in A-21 previously discussed, which is historically research-dependent.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board endorse a matching grant program to support construction of research facilities.

XI. REPORT OF THE PROJECT PANEL ON THE GENERAL PROFESSIONAL EDUCATION OF THE PHYSICIAN AND COLLEGE PREPARATION FOR MEDICINE

The COTH Board was requested to formally review the Project Panel Report and determine whether or not the Board could endorse this report at the Board meeting in September. Discussion of the report raised questions about how the recommendations will or will not effect curriculum, tenure, and accreditation decisions. The report emphasizes the need for excellence of teaching, but as yet, the Board noted, medical schools still emphasize the need to publish rather than proven excellence in teaching when making decisions regarding the granting of tenure.

Dr. Swanson responded to questions relating to promotion criteria as well as the assumption in the report that all medical school faculty are good teachers. Dr. Swanson agreed that if excellence in teaching is not recognized by medical school leadership the suggested changes in the report will be unsuccessful. The Board questioned the statement in the report that stated teaching hospitals must provide resources for clerkship clinical settings (p. 52-53, Executive Council agenda). Dr. Swanson stated that it was not the intention of the report to imply that hospitals would have to pay for medical education.

Dr. Swanson informed the Board that only minor changes can be made to the report at this time, that the panel will not meet again, but that comments will be considered.

ACTION: It was moved, seconded, and carried that the COTH Administrative Board representatives to the AAMC

Executive Council review the Board discussion at the Council meeting.

XII. MEMBERSHIP APPLICATIONS

Following brief discussion of the membership application submitted by the Women's Hospital of Las Vegas and accompanying letter from Dean Robert Daugherty, Jr., the following action was taken.

ACTION: It was moved, seconded, and carried to approve WOMEN'S HOSPITAL, Las Vegas, Nevada for corresponding membership.

Per discussion of the paper entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals" concerning membership criteria, the Board agreed that staff should review the status of all hospitals designated as corresponding members. As a result of this discussion the following action was taken on two institutions submitted for change in membership status.

ACTION: It was moved, seconded, and carried to approve (1) ST. ELIZABETH'S MEDICAL CENTER, Dayton, Ohio for full membership (from corresponding); (2) GERMANTOWN HOSPITAL AND MEDICAL CENTER, Philadelphia, Pennsylvania for full membership (from corresponding).

XIII. ADJOURNMENT

With no new business, the meeting was adjourned at 1:00pm.

INSTITUTIONS HAVING DROPPED MEMBERSHIP IN THE COUNCIL OF TEACHING HOSPITALS, 1980-84

1. Rancho Los Amigos Hospital, Downey, CA - 1980
2. McLean Hospital, Belmont, MA - 1980
3. Gorgas Hospital, Ancon, Canal Zone - 1980
4. Children's Hospital of Philadelphia, Philadelphia, PA - 1980
5. Greater SE Community Hospital (Corresponding) Washington, DC - 1980
6. Health Sciences Center Hospital, Lubbock, TX - 1980
7. Beckley Appalachian Regional Hospital (Corresponding), Beckley, WV - 1981
8. St. Thomas Hospital, Nashville, TN - 1981
9. Lutheran Medical Center, Brooklyn, NY - 1981
10. The Queen's Medical Center, Honolulu, HI - 1982
11. Veterans Administration Medical Center, Salt Lake City, UT - 1982
12. Prince George's General Hospital, Cheverly, MD - 1982
13. Abbott-Northwestern Hospital (Corresponding), Minneapolis, MN - 1982
14. Methodist Hospital of Illinois (Corresponding), Peoria, IL - 1982
15. Ball Memorial Hospital, Muncie, IN - 1982
16. Martin Luther King Jr. General Hospital, Los Angeles, CA - 1982
17. Mayaguez Medical Center, Mayaguez, PR - 1982
18. Schwabb Rehabilitation Center, Chicago, IL - 1982
19. The Jewish Hospital and Medical Center of Brooklyn, Brooklyn, NY - 1983
20. University of Louisville Hospital, Louisville, KY - 1983
21. Veterans Administration Medical Center, Kansas City, MO - 1983
22. LDS Hospital, Salt Lake City, UT - 1983
23. Orthopedic Hospital, Los Angeles, CA - 1983
24. Greenville Hospital System, Greenville, SC - 1984
25. The Community Hospital of Springfield, Springfield, OH - 1984 (Corresponding)

26. Worcester City Hospital, Worcester, MA - 1984

27. Veterans Administration Medical Center, Clarksburg, WV - 1984

28. Jewish Hospital, Louisville, KY - 1984.

29. Memorial Hospital (Corresponding), Chattanooga, TN - 1984

30. Little Company of Mary Hospital (Corresponding), Evergreen Park, IL - 1984

31. Community Hospital of Indianapolis, Inc. (Corresponding), Indianapolis, IN - 1984

aamc association of american medical colleges

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

(202) 828-0460

June 27, 1984

Dear Friends:

In 1969, when I was considering the Executive Council's invitation to become the first full-time President of the Association of American Medical Colleges, my friends counseled me against considering the leadership of an organization whose governance structure was being expanded to include faculty and hospital administrators in addition to the deans. They cautioned that the job would be impossible because the three groups were natural enemies of each other. It is obvious that I did not share their anxieties and believe that subsequent events have justified the wisdom of my judgment. The broadened constituency has worked together constructively and, as a result, the Association has become an exciting, vigorous organization effectively serving the entire academic medicine community.

The basic charge given me by the Executive Council was to implement the recommendations of the Coggeshall report on Planning for Medical Progress Through Education, to strengthen the Association, and to develop programs that would respond to the growing number of opportunities and the changing environment for academic medical centers. I also established personal goals for myself and for the Association.

As I review the accomplishments of the past 15 years, I feel that we have made great progress in responding to the Council's charge and that I have achieved my own goals and objectives. For this reason, I have requested, and the Executive Council has agreed, that I retire as President of the Association on June 30, 1986. I have offered to be available in any way the new President or the Executive Council believe would be helpful in the transition to new leadership and have chosen to announce my retirement now so that the search process can begin and plans can be drawn up for the next phase of the Association's development. I look forward to continuing my work with you over the next two years as I continue to fulfill my responsiblities as President.

During the past decade and a half, the Association's stability has been substantially increased. Its financial position has been strengthened and now permits more flexibility in undertaking new and timely initiatives to respond to the changing environment of the medical schools and teaching hospitals. An outstanding staff, recognized nationally for its excellence and deeply committed to the organization's work, has been recruited. Working with the constituency, the staff has broadened the scope and depth of the Association's programs in response to new opportunities and new needs. A data base with easily retrieved information on the organization, operation, programs and component bodies of our medical schools and teaching hospitals has been developed. It has no peer in higher education and has been of great assistance in studies and policy development at both the national and institutional levels.

One Dupont Circle, N.W. Washington, D.C. 20036

The Association and its members have become more effective spokesmen for the academic medical centers to the Federal Government. It has not hesitated to seek legal remedies when other approaches to protecting the rights of its members and programs have not been successful. The increased level of interaction and cooperation with other organizations having similar purposes and interests has widened its influence in the medical community.

My years at the AAMC have been exciting, challenging and rewarding, due largely to the tremendous support, counsel and advice that I have received from the staff and my many friends both within and outside of the membership. I hope that this same support is available to my successor so that the vitality and strength of the Association can continue to grow and develop. We must not dwell on past accomplishments if we want to maintain the preeminence of American academic medicine among the nations of the world in the face of growing threats to the principles that have made this country's medicine great and to the integrity of the academy in which we have found a congenial home.

I deeply appreciate the opportunity you have given me to engage in so worthy a cause and your confidence in our efforts to work toward common goals.

Sincerely,

John A. D. Cooper

John A. D. Cooper, M.D.

HEALTH CARE IN THE 1990'S: TRENDS AND STRATEGIES

The report entitled, "Health Care in the 1990's: Trends and Strategies," sponsored by the American College of Hospital Administrators and completed in conjunction with Arthur Andersen & Co. has received substantial publicity. The table of contents and first chapter have been reproduced for your review. Dr. Cooper is formally listed as an advisor to the study. He served as a respondent to the delphi questionnaire, and reviewed the initial questionnaire as set forth in the letter of February 17, 1984.

A number of board members have suggested it might be productive for the Board to have a brief discussion of the report.

association of american medical colleges

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

February 17, 1984

202: 828-0460

Robert D. Clyde
Partner
Arthur Andersen & Co.
1201 Elm Street, Suite 2200
Dallas, Texas 75270

Dear Mr. Clyde:

I have had a chance to go over the delphi questionnaire and to discuss it with members of my staff. I have some suggestions for additional questions that I would like you to consider. I recognize that the questionnaire is already lengthy. However, I think it has not covered some areas in which information would be very valuable.

Although the questionnaire does ask for views about numbers of physicians and specialists, it does not go on to obtain views on the impact that the numbers will have on medical care. For example: Will the increasing number of physicians bring about closure of more hospital medical staffs? What effect will the increasing demand for appointments have on the selection of medical staff? Will present medical staff attempt to restrict the addition of new staff because of increased competition they would provide.

Although the questionnaire does cover issues relating to research and development, I believe some important questions are not asked: Is the amount of support being devoted to biomedical research the right amount, too much, or too little? What are predictions about future levels of support? What are the views of the respondents about the amount of research and development in the health area which will be supported by Federal agencies and other organizations? What will be the attitude about research which brings about changes in medical care which are cost enhancing and not cost saving?

It will also be interesting to know what the respondents predict about house officer training in teaching hospitals. Will there continue to be support for this activity from payments made for medical care?

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Is it possible that the types of residency programs supported will be more in keeping with perceived national needs rather than hospital care needs in the institution providing the training?

I am not clear about the meaning of the statement in the covering letter regarding study objectives. For example, it says that, "The objective of the Delphi study is to project future trends in the health care industry and the strategies most likely to achieve success during the next decade. The results of the study will provide health care executives and governing boards a valuable strategic planning tool." For whom will the trends and strategies most likely achieve success? For the public?, the patient?, the physician?, hospital administrators?, boards of trustees? I guess that each one answering the questionnaire will decide for whom they are predicting success, but I just think that the statement is not very specific in its meaning.

Overall, I think it is an excellent document that will provide some very valuable information.

I look forward to continuing my participation in the effort.

Sincerely,

John A. D. Cooper, M.D.

P.S. On page 5 of the section on Regulations, I do not know what the 8th item, under Services Covered, means.

JCAH REPORT ON ACADEMIC HEALTH CENTER HOSPITALS

In order to better understand academic health center hospitals and hopefully improve the accreditation process, the JCAH has completed the following report. The COTH Administrative Board is requested to review the report so that reactions, observations and suggestions can be sent to Jim Roberts, MD.

JCAH

June 7, 1984

M E M O R A N D U M

To: Accreditation Committee

From: James S. Roberts, M.D. JSR

Subject: Academic Health Center Hospitals
Accreditation Committee Meeting, June 15, 1984
Agenda Item II-E

Background

Academic health center hospitals are a relatively small (approximately 3%) but important group of the hospitals surveyed by the JCAH. Periodically the Commission receives complaints from such institutions relative to its standards, surveyors and survey processes. Additionally, members of the Accreditation Committee have often raised concerns about the survey processes and findings from surveys of such institutions.

To better understand and define these issues, JCAH staff undertook a study reviewing accreditation data and interviewing key administrative, medical, nursing and quality assurance personnel at five of these institutions. This paper outlines the nature of the study, its findings and recommendations.

Definitional Issues

There are approximately 1549 hospitals with residency programs and there is great variation within this group as to the degree to which teaching is a predominent mission. Because virtually all of the concern being voiced about the JCAH has come from those teaching hospitals which are components of academic health centers, it is this group which we chose to study. These institutions have a high proportion of geographically full-time faculty, residency programs which cover most physician specialities, and often have programs for teaching medical, nursing and other health care students. They are committed to research and have close, if not controlling ties with medical schools.

While probably not totally inclusive we identified a universe of 157 hospitals associated with such centers and thus eligible for this study. They were selected from the membership of the Association of Academic Health Centers with the addition of several other institutions known by staff to be academic health center hospitals but not appearing in the membership of the Association. Of this 157, 34 hospitals were surveyed in 1982 constituting a 22% sample of the total universe. It is this group of 34 hospitals which is included in the data presented below.

Accreditation Data

Using data from the Aggregate Survey Data file for 1982 a review was conducted of the accreditation decisions and survey findings in these 34 academic health center hospitals.

In all cases the hospitals were accredited. Table I indicates that 15 out of 34 or 44% of these hospitals received three year accreditation without contingencies. As indicated in the table this compares favorably with the total universe of hospitals. However, the difference is not statistically significant.

Table I

		Accreditation Decision		
	#	% Acc. Without Cont.	% Acc. with Cont.	%NA
Academic Health Center Hospitals	34	44	56	0
All Hospitals	1361	40	58	2

To explore the survey findings in more detail, analyses were made of the most frequent contingencies (Appendix I), most frequent recommendations (Appendix II) and the reasons for contingencies in academic health center hospitals as compared to all hospitals (Appendix III). Finally, Appendix IV compares the reasons for contingencies in academic health center hospitals when the building problems often found in such institutions are removed from the analysis.

The analysis by contingencies in Appendix I indicates that the major areas of compliance difficulty for academic health center hospitals are in Medical Records, Building and Grounds and Quality Assurance. Delinquent medical records was the problem causing the highest percentage of contingencies (23.5%). Of note is the fact that 18 of the 37 listed problems related to building and grounds standards--reflecting the tendency of university hospitals to be housed in older facilities.

When the SRF items are analyzed by the total number of recommendations (Appendix II), there are changes in the ranking of items seen in Appendix I, plus the addition of new items. The regular review and evaluation of the quality of care in special care units, a quality assurance item, has the highest percentage of total recommendations (51%). The medical records item ranked first by contingencies is now ranked second, but additional medical record items become more prominent. In addition, new items from

Central Services, Pharmaceutical Services and Medical Staff appear in the rank order indicating three more areas in which a substantial number of recommendations are received, even though none of them contributed to any contingencies. Building and Grounds items are less prominent.

It is also of interest to compare academic health center hospitals with all hospitals (Appendix III). The top 20 items with the highest percentage of contingencies for all hospitals were all Quality Assurance items. However, for the academic health center hospitals only half (10/20) of the top twenty items were Quality Assurance items. The remainder consisted of one Medical Records item, ranked first, and nine Building and Grounds items.

The problem areas of quality assurance that were common to both groups of hospitals (6/20) involved the review of antibiotic usage, special care units and anesthesia services; documentation in meeting minutes of the recommendations and actions resulting from review of patient care; documentation in medical staff executive committee meeting minutes that recommendations from all medical staff groups are received and acted upon; and surgical case review when no specimen was removed.

The remaining quality assurance item (4/20) particular to academic health center hospitals consisted of hospital-sponsored ambulatory care concerns; documentation that the review of the quality of hospital-sponsored ambulatory care is performed at least twice annually, involves the use of medical records and pre-established criteria, and includes action taken on the findings of review and evaluation; and documentation of review of surgical patients who require hospitalization following ambulatory surgery. These items were not in the top twenty items with contingencies for all hospitals. The higher percentage of contingencies in the area of ambulatory care may be explained if academic health center hospitals more often have organized ambulatory care units. Exploration of this possibility was beyond the scope of this study.

If the Building and Grounds items are removed from the rank ordering of academic health center hospital contingency items (Appendix IV), the top twenty would then consist of 19 Quality Assurance items in addition to the delinquent medical records item. With this ranking, the academic health center hospitals and all hospitals have eleven top contingency items in common. In addition to the six items discussed previously, both hospital groups have compliance difficulty with:

1. Documentation of review of appropriateness of ER patient care
2. Documentation of action and follow-up on surgical case review findings
3. Documentation of review of the quality of radiologic services
4. Medical staff review of blood transfusions
5. Drug utilization review

Areas in which all hospitals exhibit compliance difficulty which are not shared by academic health center hospitals (9/20) include: the delineation of clinical privileges; review of respiratory and nuclear medicine services; actions taken on the findings of antibiotic usage review of ER care using medical records and pre-established criteria on a monthly basis; and three items evaluating the rehabilitation services.

These analyses indicate that, with the exception of more difficulties with their buildings, academic health center hospitals have problems generally similar to those in all other hospitals in that they cluster in the quality assurance area.

Interview Results

As noted earlier, JCAH staff visited several large academic teaching institutions to conduct informal discussions concerning JCAH standards, survey processes and surveyors. The institutions visited were:

-Thomas Jefferson Medical Center; Philadephia, Pennsylvania

-Massachusetts General Hospital; Boston, Massachusetts

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

-University of Indiana Medical Center; Indianapolis, Indiana

-Duke University Medical Center; Durham, North Carolina

These institutions were chosen because they had recently been surveyed, they are major teaching centers and, in most cases, JCAH staff had easy access to one of the leaders and could thus be assured of open discussions.

The visits to these five centers were exceedingly valuable. In all cases we met with the key leaders of the institution and had frank, to-the-point discussions. There was support for a serious review of JCAH's interactions with academic teaching hospitals and gratitude for the opportunity to directly express opinions and make suggestions.

For the most part, there was consensus that it was very important to have an effective voluntary, private-sector, professionally sponsored hospital accreditation program. Some participants seemed to believe that the primary value of the JCAH was to serve as an alternative to government regulation. Others felt that external, private-sector assessment had its own intrinsic value and thus favored making the JCAH as effective and influential as possible. All expressed the view that the JCAH could do much better in its dealings with academic health center hospitals. Outlined below are the specific areas suggested for change as well as a discussion of an important philosophical issue which surfaced during the visits.

Areas of Suggested Change

1. JCAH should review its standards to eliminate those which prompt unnecessary paperwork. Stated differently, JCAH should be concerned only with items that have important effects on quality.

2. Standards should focus more on patient outcomes and less on structure and procedures.

3. Surveyors are a key to success. They must gain a better understanding of the structures and functions of academic health center hospitals. Using surveyors having past or, if possible, current experience in such settings would be exceedingly helpful.

4. More attention needs to be given to the central role played by Department Chairmen in academic teaching centers.

5. The governing bodies of such hospitals are often distant organizationally, functionally and sometimes geographically from the hospital. JCAH needs to accommodate to this reality.

6. Because of the high caliber of the practitioners in such institutions and the "fish bowl" nature of the scrutiny placed on everyone's practice, competence is constantly under review. Thus formalized systems to assess competence, as sought by JCAH in its privilege delineation processes, are duplicative and unnecessary.

7. There is a need to reflect the fact that care in such centers is provided in the context of intensive dedication to teaching and research. Because this devotion to teaching and research represents a commitment to patient care quality, the JCAH should tap into these processes to judge their effectiveness in monitoring and improving the quality of care rather than require a parallel system of quality assurance.

For the most part these issues have been raised by others--they are concerns which are not completely unique to teaching hospitals. With the exception of the last issue, these concerns are being addressed implicitly in the revisions of the AMH, the series of changes being explored in the 1984 series of modified surveys, and in work on improving standards and survey processes for privilege delineation.

Item 7 however, is unique and represents, in the view of staff, a problem JCAH should specifically address. As stated by those interviewed, the problem is that teaching and research responsibilities are conducted in ways which involve ongoing assessment of individual and aggregate performance concerning quality of care. Mechanisms cited include morning residents

rounds, attending rounds, morbidity and mortality conferences, CPCs, etc. It is argued that together these processes represent an effective monitoring of the quality of care and that a parallel system of formalized quality assurance is unnecessary. Countering this argument is the question of whether these endeavors are so focused upon teaching that they concentrate on the unusual and illustrative case rather than the full spectrum of care provided. That is, do they truly constitute systematic quality assurance? The scope of this study did not allow conclusions to be drawn except to say this is a key issue for further work.

Philosophical Issue

Major U.S. academic health center hospitals are generally considered to provide the best health care available in the world. Their staffs consist of individuals highly knowledgeable and skilled in their fields and surrounded by the latest in technologically-advanced equipment and the most skilled support personnel. These institutions pride themselves on the quality of their work and enjoy the well-deserved respect of the general public.

Given this, several of those interviewed questioned whether any external organization could effectively evaluate their institutions. While many stated that the criticisms of voluntary hospital accreditation would be eliminated if the above noted actions were taken, JCAH staff was left with the nagging concern that many others held the belief that academic health center hospitals would never be significantly aided by external assessment related to quality of care. This was best stated by one participant who said that voluntary accreditation was a useful way to keep government out of hospitals but was not helpful in improving care in his hospital. He felt that the internal, formal and informal mechanisms noted above, and not compliance with external standards, would improve care. While not conveyed by all institutions or by all those interviewed, such a philosophy was often evident in the discussion and, we believe, would have been more prominent if we had discussed these issues with the next lower level of leadership and the practitioners in these institutions.

While some might consider such opinions as academic arrogance, staff does not take this view. Rather, we believe that these statements represent the honest beliefs of individuals clearly committed to quality patient care. In considering them, one is hard pressed to deny that our major academic health center hospitals represent the cutting edge in medical knowledge. They are the final point of referral for difficult patient problems and thus are acknowledged by the public and health care practitioners as being the best. Yet there are examples of teaching institutions which have had significant problems with quality of care and JCAH accreditation. It is also important to observe that, while the mix varies, virtually all teaching institutions care for patients whose problems range from the mundane to the most complex. As noted above, one

wonders if the commitment to teaching and research at times focuses attention on the unusual and complex at the expense of the routine.

It has not been possible in this study to sort out fact from impressions on this important issue. Staff believes, however, that this basic questioning of the value of external assessment of quality in academic health center hospitals should not be ignored. Rather, in conjunction with leaders of these institutions, JCAH should study this problem with the specific objective of finding reasonable methods to strengthen the impact of JCAH on the quality of care.

Conclusions

For some time there has been discontent with JCAH among academic teaching center hospitals and questioning by some Commisssioners of the validity and usefulness of present JCAH standards and surveys related to such institutions. The study outlined above represents a first attempt to address this important problem.

Its results, though not conclusive in all aspects, do provide additional impetus to the current effort to revise the AMH. Additionally, the series of pilot tests undertaken in 1983 and continuing this year are designed to modify the survey process in a way which addressess several of the problems identified by this study.

However, as noted above, there are two critical findings which are not currently being addressed by the Commission. They relate to the basic question of the value of external assessment related to quality care and to whether the teaching and research processes represent adequate compliance with JCAH's requirements for hospital-wide, systematic quality assurance. Pursuit of these questions is important, but should only be undertaken if there is firm commitment by JCAH and the leaders of this field to the value of well designed external review and programs of systematic quality assurance in such institutions. That is, JCAH would need to reconfirm the importance of having such mechanisms to all hospitals, and the leaders of the academic health center hospital field would need to support this concept. Without such support, it would be wasteful of limited resources to devote the considerable time necessary to find mechanisms to improve the value and relevance of our work to such hospitals.

Thus, staff concludes the following:

1. It is important and useful for all types of health care organizations to conduct systematic quality assurance and undergo periodic external assessment.

2. JCAH must devote specific attention to the "areas of suggested changes" noted earlier in this report. Of particular importance is the need to find mechanisms to tap into teaching and research processes to judge the effectiveness of these activities in monitoring and improving the quality of care.

3. It would be appropriate to review the results of this study with leaders of the Council of Teaching Hospitals and the Association of Academic Health Centers. Such a review should include consideration of how best to pursue necessary changes.

*** Recommendation

Staff recommends Accreditation Committee approval of this study's findings and conclusions and the Committee's endorsement of same to the Board of Commissioners.

SURVEY REPORT FORM ITEMS WITH THE GREATEST PERCENTAGE OF CONTINGENCIES - 1982

Rank Order Of Contingencies	Questions	% With Contingencies
1.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations? (n=34)	23.5
2.0	For all buildings designed in or before 1973 and for buildings designed after 1973 that are less than 2 stories in height, are chutes or other vertical openings protected with partitions having at least 1-hour resistive rating? (n=23)	21.7
4.0	*Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit? (n-31)	19.0
4.0	Do service doors in laundry chutes have at least a Class B fire-resistive rating? (n=21)	19.0
4.0	Is there documentation of a systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery? (n=21)	19.0
6.0	Are all doors in required 2-hour rated fire separations provided with positive latching? (n=22)	18.2

* SRF items that are also in the top twenty items with contingencies in the National Survey, 1982.

Rank Order Of Contingencies	Questions	% with Contingencies
7.5	Are all duct penetrations of smokestop partitions protected by approved smoke dampers? (n=29)	17.2
7.5	Are the dampers in duct penetrations of smokestop partitions closed upon activation of a smoke detector within the duct system? (n=29)	17.2
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services is performed at least twice annually? (n=31)	16.1
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services includes action taken on the findings of review and evaluation? (n=31)	16.1
11.0	If corridor doors contain louvers or transoms, are they closed and made smoke tight by permanent noncombustible construction? (n=26)	15.4

Rank Order Of Contingencies	Questions	% With Contingencies
12.5	When corridor enclosures involve the use of vision panels, are the panels set in approved steel frames? (n=33)	15.2
12.5	* When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed? (n=33)	15.2
15.5	On each floor, do smokestop partitions limit the maximum area of each smoke compartment to no more than 22,500 square feet of which the upper limit of either length or width is 150 feet? (n=34)	14.7
15.5	* Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups? (n=34)	14.7
15.5	* Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and action instituted, resulting from the review of the care and treatment of patients served by the hospital? (n=34)	14.7
15.5	* Is an ongoing review of antibiotic use documented? (n=34)	14.7

Rank Order Of Contingencies	Questions	% With Contingencies
18.5	Are all corridors separated from institutional sleeping and treatment rooms and other use areas by partitions that are constructed to resist the passage of smoke? (n=31)	12.9
18.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services involves the use of the medical record and pre-established criteria? (n=31)	12.9
20.0	* Is the quarterly review and evaluation of the quality and appropriateness of anesthesia care documented? (n=32)	12.5
23.5	When corridor enclosures involve the use of vision panels, are the panels of fixed wired glass? (n=33)	12.1
23.5	When corridor enclosures involve the use of vision panels, are the panels not in excess of 1296 square inches? (n=33)	12.1
23.5	Are doors in smokestop partitions fitted adequately to prevent the spread of smoke? (n=33)	12.1
23.5	* Does the medical staff review blood transfusions for proper utilization (eg., use of whole versus component blood)? (n=33)	12.1

Rank Order Of Contingencies	Questions	% With Contingencies
23.5	Is surgical case review (tissue committee function) performed on a monthly basis? (n=33)	12.1
23.5	* When surgical case review (tissue committee function) is performed, is there written evidence of any required action and follow-up on the findings? (n=33)	12.1
32.0	Are corridor doors fitted with latching that ensures maintenance of a tight closure? (n=34)	11.8
32.0	Are corridor doors at least 1 3/4 inch solid bonded wood core or equivalent? (n=34)	11.8
32.0	Are doors in partitions separating hazardous areas kept closed? (n=34)	11.8
32.0	Are smokestop partitions continuous from outside wall to outside wall? (n=34)	11.8

Rank Order Of Contingencies	Questions	% With Contingencies
32.0	Are smokestop partitions continuous from slab to the floor or roof slab above, through any concealed spaces such as those above suspended ceilings and interstitial spaces? (n=34)	11.8
32.0	Are all aisles and corridors kept uncluttered? (n=34)	11.8
32.0	For the purpose of reviewing and evaluating the care and treatment of patients served by the hospital, is there a monthly meeting of the medical staff in the nondepartmentalized hospital, or the departmental or major clinical service staffs in a departmentalized hospital? (n=34)	11.8
32.0	Have criteria been established for an ongoing review of antibiotic use? (n=34)	11.8
32.0	*Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic services provided is performed? (n=34)	11.8

Rank Order Of Contingencies	Questions	% With Contingencies
32.0	* Is there evidence that drug utilization and effectiveness in the hospital is reviewed? (n=34)	11.8
32.0	Does the director of the pharmaceutical service participate in those aspects of the hospital's quality assurance program that relate to drug utilization and effectiveness? (n=34)	11.8

LA/edc

Appendix II

SURVEY REPORT FORM ITEMS WITH THE GREATEST PERCENTAGE OF TOTAL RECOMMENDATIONS - 1982

ık Order Total commendations	Questions	% With Recommendations
1.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit? (n=31)	51.3
2.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations? (n=34)	44.1
3.0	When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed? (n=33)	42.4
4.0	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and action instituted, resulting from the review of the care and treatment of patients served by the hospital? (n=34)	41.2
5.0	Does the clinical resume contain pertinent instructions for further care (such as physical activity limitations, medications, diet)? (n=34)	41.2
6.0	Is the unit dose drug distribution system in use throughout the hospital? (n=34)	35.2

ınk Order : Total :commendations	Questions	% With Recommendations
7.0	Does the emergency medical record include condition of patient on release? (n=31)	32.2
8.5	Are all duct penetrations of smokestop partitions protected by approved smoke dampers? (n=29)	31.0
8.5	Are the dampers in duct penetrations of smoke-stop partitions closed upon activation of a smoke detector within the duct system? (n=29)	31.0
11.0	Are laboratories protected by at least 1-hour fire-resistive construction and an approved automatic fire extinguishing system or at least 2-hour fire resistive construction? (n=33)	30.3
11.0	Does the design and work flow pattern provide for separation of soiled or contaminated supplies from those which are clean and sterile? (n=33)	30.3
11.0	Is the review and evaluation of the quality and appropriateness of rehabilitative services performed with participation of both medical staff and rehabilitation personnel? (n=33)	30.3

ank Order f Total ecommendations	Questions	% With Recommendations
17.5	Are all toilet and bathing areas used by patients equipped with an emergency call system? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their qualifications? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their status? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their clinical duties? (n=34)	29.4
17.5	Do the medical staff bylaws, rules and regulations include for specified professional personnel delineation relative to their responsibilities? (n=34)	29.4
17.5	Do the medical staff bylaws require revision in some areas? (n=34)	29.4

Rank Order Of Total Recommendations	Questions	% With Recommendations
17.5	Is the pharmacy and the therapeutics function of the medical staff being performed? (n=34)	29.4
17.5	Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups? (n=34)	29.4
17.5	Is an ongoing review of antibiotic use documented? (n=34)	29.4
17.5	Have criteria been established for an ongoing review of antibiotic use? (n=34)	29.4

A/edc

Appendix III

University Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
1.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations?	23.5
2.0	For all buildings designed in or before 1973 and for buildings designed after 1973 that are less than 2 stories in height, are chutes or other vertical openings protected with partitions having at least 1-hour resistive rating?	21.7
4.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	19.0
4.0	Do service doors in laundry chutes have at least a Class B fire-resistive rating?	19.0
4.0	Is there documentation of a systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery?	19.0
6.0	Are all doors in required 2-hour rated fire separations provided with positive latching?	18.2
7.5	Are all duct penetrations of smokestop partitions protected by approved smoke dampers?	17.2
7.5	Are the dampers in duct penetrations of smokestop partitions closed upon activation of a smoke detector within the duct system?	17.2
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services is performed at least twice annually?	16.1
9.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services includes action taken on the findings of review and evaluation?	16.1
11.0	If corridor doors contain louvers or transoms, are they closed and made smoke tight by permanent noncombustible construction?	15.4
		15.1

All Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
1.0	Is there an ongoing review of antibiotic usage documented?	24.9
2.5	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions, and actions instituted resulting from the review of the care of patients served by the hospital?	24.8
2.5	Have there been actions (antibiotic) taken on the findings of the reviews made?	24.8
4.0	Is a regular (quarterly) review and evalua- of the quality, safety, and appropriateness of care performed and documented for each special care unit?	22.4
5.0	Is the quarterly review and evaluation of the quality or appropriateness of anesthesia care documented?	18.7
6.0	When surgical case review is performed, does it include all cases in which no specimen was removed?	18.2
7.0	Is the review and evaluation of the quality and appropriateness of rehabilitative services performed with participation of both medical staff and rehabilitation personnel?	17.8
8.0	Is there documentation of the timely review and evaluation of the appropriateness of emergency patient care?	17.2
9.0	Is the quality and appropriateness of respiratory care services evaluated regularly (quarterly)?	16.4
10.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed at least quarterly?	15.9
11.5	Is there a reasonably comprehensive delineation of clinical privileges for each member of the medical staff?	15.7
11.5	Is there written evidence of any required action (surgical case) and follow-up on the findings?	15.7
13.5	Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic	15.1

University Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
12.5	When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed?	15.1
15.5	On each floor, do smokestop partitions limit the maximum area of each smoke compartment to no more than 22,500 square feet of which the upper limit of either length or width is 150 feet?	14.7
15.5	Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	14.7
15.5	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and actions instituted, resulting from the review of the care and treatment of patients served by the hospital?	14.7
15.5	Is an ongoing review of antibiotic use documented?	14.7
18.5	Are all corridors separated from institutional sleeping and treatment rooms and other use areas by partitions that are constructed to resist the passage of smoke?	12.9
18.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services involves the use of the medical record and pre-established criteria?	12.9
20.0	Is the quarterly review and evaluation of the quality and appropriateness of anesthesia care documented?	12.5

All Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
13.5	Does the review and evaluation (of ER medical records) involve the use of the medical record and pre-established criteria?	15.1
15.0	Is a review and evaluation of emergency care performed at least monthly?	14.7
16.0	Does the medical staff review blood transfusions for proper utilization?	14.4
17.0	Do the medical staff executive committee meeting minutes document that this committee receives and acts on the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	13.9
18.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed using predetermined criteria?	12.8
19.0	Is the review and evaluation of the quality, safety and appropriateness of the nuclear medicine service documented?	12.7
20.0	Is there evidence that drug utilization in the hospital is reviewed?	10.9

University Hospitals Without Building and Grounds SRF Items

Rank Order Of Contingencies	Questions	% Contingencies
1.0	What is the total number of delinquent medical records based on the time frame defined in the medical staff rules and regulations?	24
2.5	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	19
2.5	Is there documentation of a systematic review and evaluation of surgical patients who require hospitalization following ambulatory surgery?	19
4.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services is performed at least twice annually?	16
4.5	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services includes action taken on the findings of review and evaluation?	16
6.0	When surgical case review (tissue committee function) is performed, does it include all cases in which no specimen was removed?	15
8.0	Do the medical staff executive committee meeting minutes document that this committee receives and acts upon the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	15
8.0	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions and actions instituted, resulting from the review of the care and treatment of patients served by the hospital?	15
8.0	Is an ongoing review of antibiotic use documented?	15
10.0	Is it documented that review and evaluation of the quality and appropriateness of hospital-sponsored ambulatory care services involves the use of the medical	13

All Hospitals

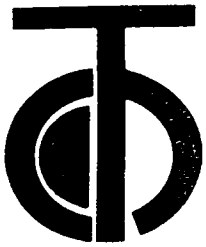
Rank Order Of Contingencies	Questions	% Contingencies
1.0	Is there an ongoing review of antibiotic usage documented?	25
2.5	Do the minutes of the monthly medical staff or department/major clinical service meetings document the recommendations, conclusions, and actions instituted resulting from the review of the care of patients served by the hospital?	25
2.5	Have there been actions (antibiotic) taken on the findings of the reviews made?	25
4.0	Is a regular (quarterly) review and evaluation of the quality, safety, and appropriateness of care performed and documented for each special care unit?	22
5.0	Is the quarterly review and evaluation of the quality or appropriateness of anesthesia care documented?	19
6.0	When surgical case review is performed, does it include all cases in which no specimen was removed?	18
7.0	Is the review and evaluation of the quality and appropriateness of rehabilitative services performed with participation of both medical staff and rehabilitation personnel?	18
8.0	Is there documentation of the timely review and evaluation of the appropriateness of emergency patient care?	17
9.0	Is the quality and appropriateness of respiratory care services evaluated regularly (quarterly)?	16
10.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed at least quarterly?	16
11.5	Is there a reasonably comprehensive delineation of clinical privileges for each member of the medical staff?	16
11.5	Is there written evidence of any required action (surgical case) and follow-up on the findings?	16
13.5	Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic	15

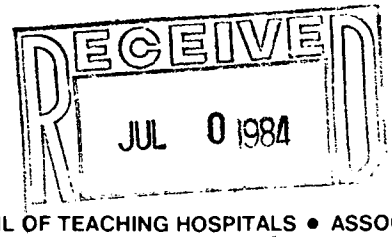
University Hospitals Without Building and Grounds SRF Items

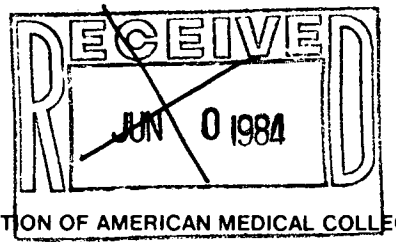
Rank Order Of Contingencies	Questions	% Contingencies
11.0	Is the quarterly review and evaluation of the quality and appropriateness of anesthesia care documented?	13
13.0	Does the medical staff review blood transfusions for proper utilization?	12
13.0	Is surgical case review (tissue committee function) performed on a monthly basis?	12
13.0	When surgical case review (tissue committee function) is performed, is there written evidence of any required action and follow-up on the findings?	12
17.0	For the purpose of reviewing and evaluating the care and treatment of patients served by the hospital, is there a monthly meeting of the medical staff in the nondepartmentalized hospital, or the departmental or major clinical service staffs in a departmentalized hospital?	12
17.0	Have criteria been established for an ongoing review of antibiotic use?	12
17.0	Is there documentation that a regular review and evaluation of the quality and appropriateness of the radiologic services provided is performed?	12
17.0	Is there evidence that drug utilization and effectiveness in the hospital is reviewed?	12
17.0	Does the director of the pharmaceutical service participate in those aspects of the hospital's quality assurance program that relate to drug utilization and effectiveness?	12
20.0	Is there documentation of the timely review and evaluation of the quality and appropriateness of emergency patient care?	10

All Hospitals

Rank Order Of Contingencies	Questions	% Contingencies
13.5	Does the review and evaluation (of ER medical records) involve the use of the medical record and pre-established criteria?	15
15.0	Is a review and evaluation of emergency care performed at least monthly?	15
16.0	Does the medical staff review blood transfusions for proper utilization?	14
17.0	Do the medical staff executive committee meeting minutes document that this committee receives and acts on the reports and recommendations of all other medical staff committees, departments, services, and assigned activity groups?	14
18.0	Is the review and evaluation of the quality and appropriateness of rehabilitation services performed using predetermined criteria?	13
19.0	Is the review and evaluation of the quality, safety and appropriateness of the nuclear medicine service documented?	13
20.0	Is there evidence that drug utilization in the hospital is reviewed?	11







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: BAYFRONT MEDICAL CENTER

Hospital Address: (Street) 701 SIXTH STREET SOUTH

(City) ST. PETERSBURG, (State) FL (Zip) 33701

(Area Code)/Telephone Number: (812) 893-6183

Name of Hospital's Chief Executive Officer: T. L. JACOBSEN

Title of Hospital's Chief Executive Officer: PRESIDENT

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year) FY83

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	518	Admissions:	14,778
Average Daily Census:	315	Visits: Emergency Room:	34,778
Total Live Births:	2943	Visits: Outpatient or Clinic:	57,618

B. Financial Data

Total Operating Expenses: $ 51,734,976.

Total Payroll Expenses: $ 27,510,681.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 555,592.00
Supervising Faculty: $ 277,632.00

C. Staffing Data

Number of Personnel: Full-Time: 1400
Part-Time: 150

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 374*
With Medical School Faculty Appointments: 70

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

NONE

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery			
Ob-Gyn			
Pediatrics			
Family Practice	Student number not limited	40	Elective
Psychiatry			
Other: ER	Not Limited	6	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				
Ob-Gyn	8	7	1	1954
Pediatrics				
Family Practice	21	20	1	1972
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: College of Medicine, Univ. of South Florida

Dean of Affiliated Medical School: Andor Szentivanyi, M.D.

Information Submitted by: (Name) Charles E. Aucremann, M.D.

(Title) Director, Medical Education

Signature of Hospital's Chief Executive Officer:

T. L. JACOBSEN, PRESIDENT (Date) 7/10/84

**

Total Medical Staff of Bayfront Medical Center is 374.

There are the following categories:

Active	212
Associate	28
Honorary	26
Provisional	47
Consulting	32
Teaching	5
Adjunctive	24
Total	374

BAYFRONT MEDICAL CENTER

The Medical Education Program at Bayfront Medical Center (then Mound Park Hospital) was started in 1951 with an approved one year rotating internship. An Ob/Gyn residency and approved one year programs in medicine and surgery were added during the next two years. Although no approval mechanism was available for General Practice, a two year General Practice Residency was developed and proved popular with physicians leaving the military service in the nineteen fifties. The one year medicine program was discontinued about 1961 and the one year surgery program phased out in 1975.

With the approval of Family Practice in 1969, it was felt by the hospital and the staff interested in medical education, that this was the most appropriate program for this community hospital. With the guidance of Dr. Walter Wiggins, the then Director of Medical Education, a planning committee was appointed, and a variety of consultants from the American Academy of Family Practice and the A.M.A. visited the institution. Dr. Don Smith, the founding Dean of the developing College of Medicine, University of South Florida was a member of the planning committee and when the Family Practice Residency was accredited in 1972, (the fourth program in Florida), an affiliation agreement was promptly signed between the Hospital and the University. For several years, the Bayfront Residency was the only Family Practice program for the university.

Bayfront Medical Center is primarily a medically oriented hospital, and the medical service for the Family Practice Residency is the strongest rotation. The University affiliated Ob/Gyn Residency, with a major participation of University based faculty, provides an unusually good Ob/Gyn rotation and support for Family Practice residents, and the adjacent All Childrens Hospital which has a University affiliated pediatric residency, provides a unique and outstanding pediatric experience for Family Practice.

The Family Practice Center is one block from the parent Hospital, with 10,000 square feet of space for seven resident teams to have an office and assigned examining rooms. The residents and faculty care for over 14,000 patient visits annually with 324 hospital admissions.

The first resident completed the program in 1975 and with the class of 1984, forty eight Family Practice residents will have completed the program. All previous graduates are Board Certified and seven are in variable levels of Family Practice residency education. The program has eight family practice faculty and forty part time consultants and specialty faculty who receive a teaching honorarium for their participation.

The Ob/Gyn residency has eight residents in the four year program with a full time Director and participation of three full time University Faculty, as well as local part time physicians. Bayfront Medical Center is a level three perinatal center with a major high risk program and obstetrical admissions of 3467 annually.

In addition to the Family Practice and Ob/Gyn residencies, Bayfront Medical Center has two pathology residents rotating each year from the University of South Florida pathology program, and one or two anesthesia residents from the University. Negotiations are underway for a senior surgery resident from USF to spend one year at Bayfront Medical Center.

For over forty years, Bayfront Medical Center has been the only Pinellas County Hospital with a Medical Education Program. With the development of the College of Medicine, the hospital program has increased in its academic participation. Plans are underway for an increased local development of the University medical program in Pinellas County. Bayfront Medical Center, All Children's Hospital, and the V.A. Hospital at Bay Pines will be the primary focus for this effort.

UNIVERSITY OF SOUTH FLORIDA
TAMPA • ST. PETERSBURG • FORT MYERS • SARASOTA

MEDICAL CENTER
OFFICE OF THE ASSISTANT DIRECTOR
DEPUTY DEAN OF THE COLLEGE OF MEDICINE
BOX 5
12901 NORTH 30TH STREET
TAMPA, FLORIDA 33612

813: 974-3216

May 23, 1984

Dr. Charles Aucremann
Family Practice Department
Bayfront Medical Center
701 - 6th Street South
St. Petersburg, Florida 33701

Dear Dr. Aucremann:

This letter will confirm that the Bayfront Medical Center is indeed an affiliated hospital within the University of South Florida Affiliated Program. The hospital serves as a vital training ground for the affiliated Family Medicine residency as well as serving affiliated experiences in Pathology and Anesthesiology and student experiences in OB/GYN and Surgery as well as Family Medicine. We appreciate very much the role which Bayfront Medical Center has played and support wholeheartedly its application to become a member of the Council of Teaching Hospitals.

If you need further information, please let me know.

Sincerely yours,

James A. Hallock, M.D.
Assistant Director, Medical Center
Deputy Dean, College of Medicine

JAH/cjt

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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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: Veterans Administration Medical Center

Hospital Address: (~~Street~~) (Johnson City)

(City) Mountain Home (State) Tennessee (Zip) 37684

(Area Code)/Telephone Number: (615) 926-1171

Name of Hospital's Chief Executive Officer: BERNARD D. PRICE

Title of Hospital's Chief Executive Officer: Medical Center Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 510

Average Daily Census: 395

Total Live Births: 0

Admissions: 7,500

Visits: Emergency Room: and Outpatient or Clinic: 55,000 (combined)

B. Financial Data

Total Operating Expenses: $ 14,192,979

Total Payroll Expenses: $ 28,093,558

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 663,989
Supervising Faculty: $ not available

C. Staffing Data

Number of Personnel: Full-Time: 1,102 (perm) and 32 (temp)
Part-Time: 110 (perm)

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 22 FT 29 PT (4 FT Dentists)
With Medical School Faculty Appointments: 48

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

Chief of Staff	Radiology	Dental	
Laboratory	Rehabilitative Medicine		

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships		Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	Jr.	6	24	Req.
	Sr.	5	21	Req.
	Sr.	Variable *	31	Elec.
Surgery	Jr.	12	58	Req.
	Sr.	5	12	Req.
	Sr.	Variable *	4	Elec.
Ob-Gyn		-	-	-
Pediatrics		-	-	-
Family Practice		-	-	-
Psychiatry	Jr.	6	25	Req.
	Sr.	Variable *	2	Elec.
Other: Radiology		Variable *	4	Elec.
Orthopedic Anatomy		Variable *	2	Elec.

* Varies with student demand nt and faculty resources

B. Graduate Medical Education (as of July, 1984)

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	30	13	16	7/1/77
Surgery	8	8	0	5/20/80
Ob-Gyn				
Pediatrics				
Family Practice	5	3	2	Johnson City Ctr 9/79 Kingsport Ctr 10/75 ~~Bristol Ctr 7/76~~
Psychiatry				
Other: Pathology	2	1	1	5/24/83

[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: Quillen-Dishner College of Medicine at East Tennessee State University

Dean of Affiliated Medical School: Herschel L. Douglas, M.D.

Information Submitted by: (Name) BERNARD D. PRICE

(Title) Medical Center Director

Signature of Hospital's Chief Executive Officer:

B. D. Price (Date) 8-9-84

BERNARD D. PRICE, Medical Center Director

SUPPLEMENTARY INFORMATION FOR COTH APPLICATION

The hospital's organized medical education is under the auspices of both the Office of the Associate Chief of Staff for Education, as well as an Education Committee. The latter committee consists of chiefs of services and/or their designees, and reviews all pertinent needs assessments on a regular basis for the various services in the hospital at large.

The Associate Chief of Staff for Education is also the representative for the regional Medical Education Centers of the Veterans Administration. This facility is a member of the Southeastern Region, and the various needs assessments as defined through the Education Committee are forwarded to the Regional Medical Education Center at which time, annually, the Associate Chief of Staff for Education appears and represents the facility for discussion purposes. Appropriate funding is then forwarded for various programs for management, the various medical and surgical services, and Nursing Service, and other ancilliary services.

In addition, the Associate Chief of Staff for Education functions as the Assistant Dean for Continuing Medical Education, as well as Director of Medical Education for this facility for the affiliated medical school, the Quillen-Dishner College of Medicine of East Tennessee State University.

Therefore, category I credit is available because of the appropriate evaluation and regular monitoring of various functions, such as the Tumor Board, some of the guest lecturers for medical/surgical grand rounds, as well as comprehensive medical/surgical review sessions.

The research programs are under the auspices of a Research Committee, and headed by Research Coordinator and chairman of the Committee.

Various grants from the Veterans Administration as well as private grants through the affiliated Medical School are coordinated by this Committee for research on veterans. All appropriate protocols are reviewed by the Institutional Review Board as well.

Unique hospital characteristics of this facility are a large acute and chronic geriatric population due to a resident domiciliary on the facility. As a result of this fact, a mini-residency in geriatrics for the entire Veterans Administration in the Southeastern Region has been developed and has been implemented, as well as an elective for house staff and students in geriatrics and gerontology.

Floyd B. Goffin, MD

FLOYD B. GOFFIN, M.D.
Associate Chief of Staff/Education

East Tennessee State University
Dean's Office • Box 23320A • Johnson City, Tennessee 37614-0002 • (615) 928-6426, Ext. 315

July 27, 1984

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

Dear Sir:

This letter is to lend my strong support to the application of the Veterans Administration Medical Center of Mountain Home, Tennessee, for membership in the Council of Teaching Hospitals of the Association of American Medical Colleges. The affiliation of the Veterans Administration Medical Center at Mountain Home is critical to the operation of the Quillen-Dishner College of Medicine at East Tennessee State University.

We are a medical school which was developed under the Veterans Administration Medical School Assistance and Health Manpower Training Act of 1972 (PL 92-541 - Teague-Cranston Bill). This Veterans Administration Hospital played a central role in the development and, subsequently, the implementation of the curricular programs of the College of Medicine.

The Veterans Administration Medical Center at Mountain Home is utilized in all four years of the medical students' educational program. Freshman and Sophomore students obtain their initial experiences in clinical skills at the hospital. The hospital offers required Junior year clerkships in Medicine, Surgery, and Psychiatry. They also offer required Senior clerkships in Internal Medicine and Surgery. Several elective clerkships in the elective Senior portion of the curriculum are also offered by the hospital. All medical students in the College of Medicine spend a significant amount of time at the hospital.

The College of Medicine also sponsors residency programs in Internal Medicine, Family Practice, Surgery, and Pathology. The Surgery, Internal Medicine, and Pathology programs utilize the Veterans Administration Medical Center for a major portion of their teaching programs. Residents in Family Practice utilize the Veterans Administration Hospital for rotations through the areas of Internal Medicine, Surgery, Pathology, and Psychiatry.

The Veterans Administration Hospital at Mountain Home clearly is central to the functioning of the Quillen-Dishner College of Medicine. A major portion of our teaching program is conducted at the Center. I support their application for membership in the Council of Teaching Hospitals.

Sincerely,

Herschel L. Douglas, M.D.
Dean

HLD:ksb

Enclosures