association of american medical colleges

AGENDA

FOR

COUNCIL OF TEACHING HOSPITALS

ADMINISTRATIVE BOARD MEETING

April 10, 1986
8:00 a.m.
Washington Hilton Hotel
Hamilton Room

one dupont circle, n.w./washington, d.c. 20036

COTH ADMINISTRATIVE BOARD

Chairman: C. Thomas Smith
Yale New Haven Hospital

Chairman-Elect: Spencer Foreman, MD
Sinai Hospital of Baltimore

Immediate Past Chairman: Sheldon S. King
Stanford University Hospital

Secretary: John E. Ives
Shands Hospital

Robert J. Baker
University of Nebraska Hospital and Clinics

J. Robert Buchanan, MD
Massachusetts General Hospital

Gordon M. Derzon
Univeristy of Wisconsin Hospital and Clinics

Gary Gambuti
St. Luke's-Roosevelt Hospital

Larry L. Mathis
The Methodist Hospital

James J. Mongan, MD
Truman Medical Center

Eric B. Munson
North Carolina Memorial Hospital

Charles M. O'Brien, Jr.
Georgetown University Hospital

Raymond G. Schultze, MD
UCLA Hospitals and Clinics

Barabara A. Small
Veterans Administration Medical Center

William T. Robinson
AHA Representative

COTH MEETING DATES

COTH ADMINISTRATIVE BOARD MEETINGS

April 9-10, 1986	Washington Hilton Hotel Washington, DC
June 18-19, 1986	Same
September 10-11, 1986	Same

COTH SPRING MEETING

May 7-9, 1986	Franklin Plaza Hotel Philadelphia, PA
May 13-15, 1987	Fairmont Hotel Dallas, TX
May 11-13, 1988	New York Hilton Hotel New York, NY

AAMC ANNUAL MEETINGS

October 25-30, 1986	The Hilton Hotel New Orleans, LA
November 7-12, 1987	Washington Hilton Hotel Washington, DC

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

April 9-10, 1986
Washington Hilton Hotel
Washington, DC

WEDNESDAY, April 9, 1986

6:30p	COTH ADMINISTRATIVE BOARD MEETING Adams Room
	Edmund J. Mihalski Health Counsel and Deputy Staff Director Senate Committee on Finance
6:30pm	COTH ADMINISTRATIVE BOARD RECEPTION/DINNER Bancroft Room/Adams Room

THURSDAY, April 10, 1986

8:00am	COTH ADMINISTRATIVE BOARD MEETING Hamilton Room
12:00noon	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Hemisphere Room
1:00pm	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

Edmund Joseph Mihalski, C.P.A.

Edmund Mihalski currently is serving as Deputy Chief of Staff for Health Policy with the U.S. Senate Committee on Finance. As the committee's chief staff member for health, his legislative issue areas include medicare, medicaid, maternal and child health, and peer review organizations.

Prior to committee staff work in the Senate, Mr. Mihalski worked for 7 years as a senior evaluator at the U.S. General Accounting Office. While with GAO, his responsibilities centered on federal program evaluations of the medicare and medicaid programs, and the direct health care delivery systems of the Department of Defense, Public Health Service, and Veterans Administration.

He has an undergraduate degree in accounting from the University of Washington and a M.B.A. from the University of Arkansas. He is a certified public accountant.

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

April 10, 1986
WASHINGTON HILTON HOTEL
Hamilton Room
8:00am-12:00noon

I.	CALL TO ORDER	
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	Humana Hospital University, Louisville, KY	Page 31
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V.	PROPOSED MEDICARE REGULATIONS ON PAYMENTS FOR MEDICAL EDUCATION	Executive Council Agenda - Page 171
VI.	REVISION OF THE GENERAL REQUIREMENTS SECTION OF THE ESSENTIALS OF ACCREDITED RESIDENCIES	Executive Council Agenda - Page 18
VII.	CHANGES IN GME TRAINING REQUIREMENTS	Executive Council Agenda - Page 166
VIII.	COTH/AAMC AS A VEHICLE TO PROVIDE COMPETITIVE ECONOMIC SERVICES	Page 42
IX.	AAMC FINANCE COMMITTEE REPORT (Forthcoming)	
X.	MARKETING AND ADVERTISING: THE ROLE OF THE AAMC	Executive Council Agenda - Page 179
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XIII.	REPORT OF THE AD HOC COMMITTEE ON FEDERAL RESEARCH POLICY	Executive Council Agenda - Page 102
XIV.	INTERPRETING THE AAMC POLICY IN THE TREATMENT OF IRREGULARITIES IN MEDICAL SCHOOL ADMISSIONS	Executive Council Agenda - Page 164
XV.	ADJOURNMENT	

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COTH ADMINISTRATIVE BOARD MEETING
January 23, 1986

PRESENT

C. Thomas Smith, Chairman
Sheldon S. King, Immediate Past Chairman
Spencer Foreman, MD, Chairman-Elect
Robert J. Baker
J. Robert Buchanan, MD
Gordon M. Derzon
Gary Gambuti
John E. Ives
James J. Mongan, MD
Eric B. Munson
Charles M. O'Brien, Jr.,
Raymond G. Schultze, MD
Barbara A. Small
William T. Robinson, AHA Representative

ABSENT

Larry L. Mathis

GUESTS

Richard Janeway, MD
Jack Meyers, MD
Edward J. Stemmler, MD
Virginia V. Weldon, MD

STAFF

James D. Bentley, PhD
Robert Beran, PhD
Melissa Brown
Brendan J. Cassidy
John A. D. Cooper, MD
John H. Deufel
Paul R. Elliott, PhD
Joseph A. Keyes, Jr.
Richard M. Knapp, PhD
James R. Schofield, MD
Karen L. Pfordresher
Nancy E. Seline
John F. Sherman, PhD
Judith L. Teich
Kathleen Turner
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD MINUTES
Meeting Minutes
January 23, 1986

I. CALL TO ORDER

Mr. Smith called the meeting to order at 8:00am in the Adams Room of the Washington Hilton Hotel.

II. CONSIDERATION OF THE MINUTES

ACTION: It was moved, seconded, and carried to approve the minutes of the September 12 and October 28, 1985 COTH Administrative Board meetings.

III. TAX REFORM AND DEFICIT REDUCTION LEGISLATION

Drs. John Sherman and John Cooper were introduced for a special presentation on recent developments in the areas of tax reform legislation, the Gramm-Rudman budget deficit legislation, and the Medicare portions of the pending reconciliation act. Dr. Sherman opened his presentation by noting that each Board member had received supplemental agenda items on these topics at the meeting. Dr. Sherman expressed his regret that the agenda items had not been distributed in advance but noted staff had only completed a draft of them the previous afternoon. He also noted that the written materials were early drafts for Board members only and that they should not be distributed to the membership until they had been revised. In his final introductory comments, Dr. Sherman noted that the Board's discussion of these matters was primarily to receive the Board's initial reaction. In the afternoon, the Executive Council would have time for additional debate and discussion on these items.

Dr. Sherman introduced the topic of the tax reform legislation which had passed the House of Representatives at the end of the 1985 session of Congress. Noting that the Administration continues to advocate a "revenue neutral" tax revision, Dr. Sherman emphasized that the efforts of the House Ways and Means Committee to maintain the deduction for state and local taxes required them to find a large number of smaller revenue items. Among the items of special concern to AAMC constituents were proposed restrictions on the amount and use of tax-exempt financings and retirement and pension fund changes.

Following Dr. Sherman's summary of the status of tax-exempt financing, the Board discussed the three major options available to the AAMC: opposing any change in current tax-exempt financing, modifying the House-passed provisions to reduce the restrictions, and supporting the House provisions. All three options are preferable to the Administration's proposal to eliminate tax-exempt financing.

In the discussion, Drs. Foreman and Schultze noted that the proposal did not alter tax-exempt financing for public institutions. As a result, public constitutional corporations, such as the University of California were receiving conflicting information on whether or not they would still be able to obtain tax-exempt financing. Dr. Foreman also emphasized the importance of tax-exempt financing in maintaining a competitive capital formation position for hospitals which cannot issue stock. Dr. Buchanan recommended that the Board support the option of modifying the House-passed provision to remove the dollar issue limits

while accepting the restrictions on use. Several Board members supported this position. The Board concluded its discussion with a consensus that the AAMC should work to maintain access to tax-exempt financing for the exempt purposes of the organization and that the AAMC should not oppose reasonable restrictions on the arbitrage of funds.

Dr. Sherman summarized the retirement and pension provisions of the tax bill giving special attention to proposals to limit contributions to tax deferred annuities, deferred compensation and the proposal to tax TIAA/CREF assets. The Board discussed these matters extensively. All discussants were strongly opposed to these provisions, especially because they placed non-profit organizations at a disadvantage with taxable corporations in recruiting and compensating employees. In a consensus, the Board encouraged the AAMC to strongly oppose these provisions, to work with other organizations in a cooperative effort to oppose the provisions, and to base the AAMC's opposition on the inequities the provisions would create for the retirement plans of university and hospital personnel. Lastly, the Board urged AAMC staff to to prepare an explanation of the pension and retirement provisions that would clear up some of the confusion created by a recent TIAA mailing.

Turning to the Gramm-Rudman-Hollings Act (G-R-H), Dr. Sherman provided a briefing on the 1986 and 1987 impacts of the act on AAMC members. Both Medicare and NIH impacts were described. It was emphasized that the staff suggested the position of removing Medicare Part A benefits from the G-R-H sequester process would further decrease NIH funds. This presents the AAMC with an internal conflict in the interests of its members. Finally, Dr. Sherman described the five year impacts of G-R-H and noted the consequences were unacceptable to Association interests unless increased revenues could reduce the necessity for cutting expenditures.

The Board readily agreed that the long-term impacts of using expenditure cuts to balance the budget were unacceptable. Board members felt the necessary expenditure reductions would destory important national efforts such as biomedical research. Mr. Smith raised the prospect of increasing Federal revenues. Dr. Weldon supported the need for increased revenues but expressed concern about the recommendation that the AAMC take a leadership role in advocating increased taxes. Dr. Stemmler urged that the AAMC argue primarily for the appropriations and necessity of maintaining expenditures and Dr. Schultze noted this would ultimately require the AAMC to accept and support increased Federal tax revenues. Mr. O'Brien supported the position that advocating a continuation of present programs carried with it accepting increased taxes. The Board concluded its discussion by agreeing the AAMC should primarily advocate maintaining programs such as NIH and Medicare, should support but not lead a move to increase Federal revenues; and should prepare an easily understood "primer" explaining G-R-H to the membership.

IV. LCME INVOLVEMENT IN THE ACCREDITATION OF FOREIGN MEDICAL SCHOOLS

Mr. Joe Keyes, Director of the Department of Institutional Development, and James Schofield, MD, Director of the Division of Accreditation, discussed the involvement of the Liaison Committee on Medical Education (LCME) in the accreditation of foreign medical schools. Mr. Keyes stated that the American Medical Association's (AMA) Council of Medical Education and the Council on Legislation recommended endorsement of HR 3485, a bill introduced by Representative Claude Pepper (D-FL) that would provide for a system of accreditation of courses of study in medicine offered by medical schools located

outside the United States. This recommendation was not acted upon by the AMA board because of reservations related to legal liability and expense.

Dr. Schofield presented a brief history of the evolution of the LCME and its current responsibilities for the Board. He described this bill as a response to Mr. Pepper's perception that there are too many foreign medical graduates (FMG's) in the United States that are inadequately trained.

Dr. Buchanan, currently chairman of the LCME, described the enormity of the task of accrediting medical schools world wide, a task that could weaken the existing LCME by dispersion of its energy. Mr. King questioned whether attempting to develop standards and procedures for such accreditation is a valid exercise given the questionable need for physicians trained outside the United States and the current perception of "physician supply." He also stated that to develop standards applicable to foreign cultures would require detailed, specifically measurable standards similar to the general thrust of JCAH standards. Mr. King said he believes a move in that direction would be a mistake. Dr. Bentley stated that, for some in Congress, placing barriers to the opportunities of foreigners is contrary to the ideal of the United States as a "melting pot." Dr. Foreman suggested that an entirely new process would have to be adopted if such accreditation were attempted, because the range of the educational experiences provided by these medical schools is incredible.

ACTION: It was moved, seconded, and carried to approve the recommendation against LCME involvement in the accreditation of foreign medical schools.

The board also approved the recommendation that the Executive Council:

1/ reaffirm its position that Medicare funds should not be used to pay for graduate medical education expenses incurred on behalf of graduates of foreign medical schools;

2/ reaffirm support of an amendment to the Higher Educational Renewal Act which would require that an institution, in order to be considered "comparable" for purposes of student eligibility for guaranteed student loans, be required to enroll at least 75% of its student body from the citizenry of the country in which it is located;

3/ reaffirm its support for the development of a satisfactory examination of clinical competence with graduates of non-LCME accredited schols being required to pass as a condition of eligibility for entry into accredited graduate medical education programs;

4/ as an interim measure, at the very least support a policy requiring that graduates of foreign schools be required to pass both parts of the FMGEM's examination at the same administration.

Having considered those items which needed attention early in the agenda because of the scheduling needs of those who would be required to present them, Mr. Smith

gave a particular word of welcome to the five new Administrative Board members. He indicated that Larry Mathis, President, Methodist Hospital, Houston, was unable to be present. He then indicated that after a few announcements and observations, he would be asking each Board member to take a moment or two to outline their career path and the characteristics of the hospital they lead.

The Chairman then called attention to a number of meetings throughout the year that he would like to highlight and call to the attention of the Board members:

- On February 16-17, Scottsdale, AZ, the AAMC and the Association of Academic Health Centers (AAHC) are sponsoring a conference the purpose of which is to provide an interim report on the study of "the pro's and con's of separation of university-owned hospitals from the university." Dr. Fred Munson, who is the project director, will be giving a report of the study thus far and case studies will be presented with regard to governance at the universities of Alabama and Florida, and Northwestern University. He indicated that Board member John Ives would be making a presentation at that meeting.

- On February 26-28, Orlando, FL, the AAMC along with the AHA and AMA is sponsoring a conference on "Vertical Integration in Health Care: Implications for Medical Education and Practice." John Ives is a member of the planning committee for that effort.

- The AAMC is sponsoring four programs entitled, "Academic Medical Centers and the Challenges Posed by Alternative Delivery Systems." These meetings are to be held in Chicago, Atlanta, Philadelphia, and San Diego. Dr. Foreman, COTH Chairman-Elect, will be giving the keynote address at each of these, and John Ives will be speaking at the seminars in Atlanta and Philadelphia.

- The staff is working on a revival of the Executive Development Seminar that used to be provided for COTH Chief Executive Officers, the most recent one having been held for COTH members in the fall of 1983. There has been sufficient change in the membership and the staff believes it would useful to offer another conference. One is being developed for October 9-14, 1986.

- The 1986 COTH SPRING MEETING is to be held in Philadelphia, May 7-9, beginning Wednesday evening, May 7, and adjourning by noon on Friday, May 9.

- It was also suggested that members mark their calendars to note the AAMC Annual Meeting this year is in New Orleans, October 25-30.

At this point, the Chairman announced the following committee appointments. The COTH Nominating Committee is by tradition composed of the COTH Immediate Past Chairman, the current COTH Chairman, and an appointed member at-large. Therefore, the Committee this year will be chaired by Sheldon King and will further be comprised of Mr. Smith and David A. Reed, President, Samaritan Health Service, Phoenix, as the member at-large.

Paul F. Griner, MD, General Director, Strong Memorial Hospital, Rochester, NY, has been appointed to the Flexner Award Committee, and in addition, will serve as a newly appointed COTH member to the Journal of Medical Education editorial

board. John Ives is a member of this board as well as Don Kassebaum, MD, who up until recently was CEO of the University Hospital at the University of Oregon. Bill Kerr, Director of Hospitals and Clinics, University of California, San Francisco; and Jerry Grossman, MD, President, New England Medical Center, Boston will replace David Everhart, President, Northwestern Memorial Group, who has been the COTH representative on the Management Education Program Committee.

The Chairman indicated that he hoped to get through the agenda a bit early so that there would be time available to discuss possible topics for Board consideration as well as speakers Board members would like to hear on the Wednesday evening sessions that traditionally are held prior to the Thursday morning Board meetings. At this point, the Chairman asked each member of the Board to take a moment to outline their career path and the characteristics of the hospital they lead. Following these introductions, Dr. Knapp announced that Karen Pfordresher will be leaving the staff of the Department of Teaching Hospitals effective February 1. She will become Director of Admissions at the Georgetown University College of Medicine. Dr. Knapp thanked her for her excellent work over the past two years and the Chairman asked that the minutes express the thanks of the COTH membership and the Administrative Board's best wishes on her new position. On February 1, Judy Teich will join the Department of Teaching Hospitals staff. She has a masters degree in social work from New York University, and worked as a clinical social worker for 8 years in the departments of psychiatry in several teaching hospitals in New York City. She moved to Washington in 1980 to do a residency in mental health research/program evaluation at St. Elizabeth's Hospital. She subsequently worked as a program evaluator and implemented a computerized management information system for a county-wide mental health center in Virginia. Ms. Teich was first employed with the AAMC in September 1984 as database administrator for student and application information management systems. The members of the Board welcomed her to the staff of the Department of Teaching Hospitals.

V. COORDINATED MEDICAL STUDENT LOAN PROGRAM

Several AAMC staff were available for discussion of whether or not to proceed with the development of the Coordinated Medical Student Loan Program, which would require entering into contracts with an appropriate lending institution and the Higher Education Assistance Foundation. Mr. Deufel, Director of Administration and Finance, AAMC Department of Business Affairs, reported on the possible benefits and costs of the program, describing the AAMC's role as the marketing arm of the operation as well as the processor of the data received.

ACTION: It was moved, seconded, and carried unanimously to recommend that AAMC staff proceed with contract negotiation and procurement activities.

VI. MEMBERSHIP

Following discussion and appropriate consideration, the following action was taken:

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

ST. VINCENT HEALTH CENTER, Erie, Pennsylvania for corresponding membership; and

UCLA NEUROPSYCHIATRIC HOSPITAL, Los Angeles, California, for full membership.

Dr. Knapp distributed a list of institutions that have terminated membership in the Council of Teaching Hospitals over the past six years. He pointed out that the University of Louisville terminated its membership in 1983 at which time the University no longer operated the hospital, management being assumed by an investor-owned group and subsequently leased by the Humana Corporation. A membership application has been sent to the chief executive officer of the Humana Hospital University since the bylaws have been changed to permit investor-owned hospital membership. Board members were reminded that there are three COTH members that are currently owned by investor-owned corporations:

St. Joseph Hospital, Omaha, NE
Presbyterian-St. Luke's Medical Center, Denver, CO
Wesley Medical Center, Wichita, KS

The Board was also reminded that when Rochester Methodist Hospital in Rochester, MN, terminated its membership in 1985, Dr. Knapp was asked to call the CEO of that institution and he did so. The hospital has not reconsidered its membership. Several members asked if there was any reason they should not talk to individuals at some of these institutions to see if there wasn't reason for reconsideration of COTH membership. Specific examples included Children's Hospital of Philadelphia, Queen's Medical Center in Honolulu, LDS Hospital in Salt Lake City, and the Veterans Administration Medical Centers in Des Moines and Salt Lake City.

VII. NOMINATING COMMITTEE REPORT

The Nominating Committee chairman, Mr. King, reported that he and Dr. Knapp would be appearing before the American Hospital Association Nominating Committee on the morning of February 4. This practice was begun in 1984 with the purpose of educating the members of the AHA Nominating Committee to the size and scope of the COTH membership, and hopefully to assure participation on the AHA Board of Trustees of a greater percentage of "medical center" hospital executives. Mr. King indicated his approach would be set forth in the following manner:

- Outline the statistics on COTH members as a percentage of all hospitals (we have 5.6% of the hospitals, 17.5% of the admissions, 30.4% of the outpatient visits, etc.).

- Set forth the number of COTH members on the AHA Board. Of the fifteen members of the American Hospital Association Board whose terms expire in 1987, 88 and 89, five are members of the AAMC Council of Teaching Hospitals (one in 87 and 89 respectively, and three whose terms expire in 1988 - these three will be reduced to two when Bob Johnson leaves as chief executive officer of the DC General Hospital).

- Distinguish between all COTH members and "medical center" hospitals, defined as those institutions in which the majority of medical school departmental chairmen are also chiefs of service in the hospital.

- Point out that there are no medical center hospitals currently represented on the AHA Board.

- o Recommend Bob Heyssel, MD, President, The Johns Hopkins Hospital; Mitch Rabkin, MD, President, Beth Israel Hospital; and Rob Muilenberg; Executive Director, University of Washington Hospitals, as specific candidates that would be supported by COTH. Drs. Heyssel and Rabkin have been recommended in the past; Mr. Muilenberg would be a first-time recommendation. Mr. King reminded the Board that Mr. Muilenberg is currently Chairman-Elect of the AHA Metropolitan Hospital Section.

VIII. SPRING MEETING PLANNING COMMITTEE REPORT

Mr. Gambuti, Chairman of the COTH SPRING MEETING Planning Committee, called the attention of the Administrative Board to the final draft program which had been distributed for review. He indicated that all speakers had been confirmed and was pleased to report that the reception at the Franklin Institute was being hosted courtesy of the Delaware Valley COTH member institutions. He reported that the Wednesday evening dinner and program had been designed in recognition of Dr. Cooper. Russell Nelson, MD, former chief executive of the Johns Hopkins Hospital, was the first COTH representative to be appointed AAMC Chairman in 1971-72, and is a close personal friend of Dr. Cooper's. Dr. Nelson will be making an appropriate presentation to be followed by Mark Russell, noted political humorist of whom Dr. Cooper is a big fan. It was also reported that a symbolic gift for presentation to Dr. Cooper has been ordered.

IX. AAMC STAFF ACTIVITIES

Dr. Knapp indicated as set forth in Item XII in the agenda book, for the past two years the COTH Administrative Board has explored the implications of the growing number of hospital organizations (e.g., networks, consortia, alliances such as VHA, AHS, UHC, and CJH) on COTH and the AAMC. For the most part, the discussion had focused on exploring the role and function of COTH/AAMC with regard to matters of education, information and data collection, research, service, and advocacy as these new organizations initiate activities in these areas. In January 1983, the AAMC Executive Council set forth a policy that determined that except in very unusual circumstances, the AAMC would not engage in economic advantage or service activities (such as group purchasing).

As these alliances and consortia have begun to mature, they are beginning to develop and market various types of insurance products. These products are designed as "patient acquisition strategies" to provide market share advantages to their sponsors. This is a type of service activity, but one which is somewhat different than group purchasing, insurance pools, and other activities which lead to economic advantage but don't directly deal with specific competition for patients.

The question before the Administrative Board is, "What role can the AAMC staff members play if asked to participate in the development of insurance products of any one of the alliances or consortia?" Jim Bentley has been asked to participate as a member of the National Health Care and Insurance Delivery Council of the University Hospital Consortium. Mr. Baker outlined the activities of that Council as exploring the various options of networking for academic medical centers and the type of insurance products that might be useful to academic medical centers. He indicated that he feels strongly that the AAMC and the Association of Academic Health Centers (AAHC) have a role in the development of these linkages and a vital role in exploring the networking possibilities. Mr. Derzon, who is chairman of that council, indicated that the initial effort of the council is an analytical one and is not yet at the point where he would call

it a product development activity, although he didn't foreclose the possibility that this might in fact develop. Mr. Ives made the point that 1/3 of the core membership of the Council of Teaching Hospitals - that is the so-called "medical center" hospitals - are members of the consortium, and viewed this as a high priority agenda item. He further indicated that seven members of the University Hospital Consortium are members of the COTH Administrative Board, and that there was a relationship between the consortium and staff of the Department of Teaching Hospitals which was based on trust and competence. Drs. Foreman and Buchanan questioned whether the Association staff should be involved in the basic economic interests of COTH members. They indicated that it would be a mistake for the staff to be identified as "advocates" of any one of the various groups that are beginning to emerge. To tap the staff for one organization and not to make this same service available to all could lead to some difficult problems. In addition, if the staff were made available to all such organizations, there would be problems of conflict of interests and also the question of whether or not this was a wise way for the staff to spend its time. If the AAMC has a policy, as it does, with regard to the consulting time of its staff members, it could be possible that a staff member might work with one of these groups as a paid consultant. However, even this arrangement should be approached cautiously. Mr. Munson indicated that he thought there might be a difference between open and full communication as an observer with the activities of these newly emerging organizations versus membership on a specific committee of one of these organizations. He felt that it is important to the AAMC that its staff stay up-to-date on key issues of member concerns, and felt that open communication was necessary to achieve this. Mr. Baker indicated that he felt that the basic question was, "What role does the AAMC play in the emerging service arrangements in the newly competitive environment?" The chairman suggested that in a more limited sense, a policy with regard to the AAMC's activities in service arenas had been articulated in the past, and there was no reason why it couldn't be revisited. He suggested that the staff review the appropriate history of this policy matter and set forth a new agenda item incorporating the foregoing discussion, and make it a major agenda item for the April 10 COTH Administrative Board meeting. Mr. Baker suggested that the distinction between narrow service activities such as group purchasing be distinguished from the newly emerging networking arrangements as the agenda item is developed for discussion.

X. MALPRACTICE INSURANCE LEGISLATION

The growing reluctance of traditional insurance companies to write malpractice liability policies and the rapidly increasing costs for such coverage have precipitated a crisis. Some hospitals and universities have resorted to creating their own insurance pools or tried other innovative methods of constraining costs. Some physicians have stopped offering some services for which they are particularly vulnerable to litigation in order to limit the cost of their liability insurance. In an effort to address this crisis, the AMA drafted legislation which was introduced by Senator Hatch (R-UT). The bill is designed to encourage states to reform their tort laws to limit awards for non-economic damages, establish a fee schedule for attorneys, permit installment payments for awards in excess of $100,000, allocate money to state agencies responsible for disciplining health professionals, and improve risk management programs for health care providers. The AAMC has been asked by the AMA to support this bill, and the COTH Administrative Board was asked to discuss what position the AAMC should take and whether there were any liability issues that were unique to teaching hospitals.

Mr. Robinson noted that malpractice insurance was just one of the many types of liability insurance for which there was a crisis in America. He noted that cities, school systems, and other public entities were unable to get general liability coverage, and therefore, there were a variety of parties advocating tort reforms and other means of addressing this crisis. The Board identified several aspects which may pose particular liability problems for teaching hospitals, including: (1) the presence of medical students and residents; (2) the conduct of research and provision of tertiary care and other unique services which result in more high risk patients being treated in teaching hospitals and in the use of unconventional treatments; (3) more technical resources are available; (4) and the hospitals' and universities' relationships to the faculty. With regard to specific aspects of the bill, some Board members expressed concern that the proposed bill specified a fee schedule for attorneys. They felt that those payments should be left to the client and attorney to negotiate.

ACTION: It was moved, seconded, and carried after discussion to recommend the AAMC be generally supportive of the AMA bill to encourage tort reforms, but that the Association should not specifically endorse the Hatch bill. It also recommended that staff continue to follow this issue and gather information.

XI. REPORT OF THE STEERING COMMITTEE ON THE EVALUATION OF MEDICAL INFORMATION SCIENCE AND MEDICAL EDUCATION

Jack Myers, University Professor of Medicine at the University of Pittsburgh and chairman of the Steering Committee on the Evaluation of Medical Information Science in Medical Education, presented that Committee's report to the Board. Dr. Myers described medical informatics as a relatively new field which began in 1970 and has become basic to the understanding and practice of medicine. Dr. Myers reiterated the recommendations contained in the report that call for including medical informatics as an integral part of the medical curriculum with an identifiable locus of such activity in the academic medical center.

ACTION: It was moved, seconded, and carried unanimously to accept the report of the Steering Committee, commenting on the excellent quality of the report itself.

XII. AD HOC COMMITTEE ON GRADUATE MEDICAL EDUCATION

AAMC Chairman, Virginia Weldon, MD, joined the Administrative Board for a discussion of this issue. She indicated that at its September 1985 meeting, the Executive Council authorized the appointment of an ad hoc committee charged to consider the problems created by the residency selection process at the transition from medical school to residency. This issue was discussed at the December AAMC Officers' Retreat, and during the course of that discussion at the Retreat, it became apparent that problems at the transition cannot be isolated from overall graduate medical education issues. Therefore, it was determined that an ad hoc committee should be considered to review the Association's past positions relative to graduate medical education. Dr. Buchanan indicated that whenever financing graduate medical education is discussed all of the collateral issues to it come to the surface. Further, there is so much attention to graduate medical education, it's relation to undergraduate medical education does not get appropriate attention. The chairman also recalled that at the September Executive Council meeting, the Council of Deans recommended that the charge to the committee should be as follows:

- o It shall study the present process by which admission is granted to graduate medical education programs. Based on this study it will recommend changes in the process.

- o The committee will consider the effects of the curricula of the medical schools caused by present GME selection processes with particular emphasis on effects regarding the general professional education of the physician.

- o The committee will also consider present practices regarding the counseling of medical students for entry into graduate medical education.

Based on the discussion and the recollection of the Deans' recommendations in September, it was agreed that while all aspects of this issue are important and related, the focus of the committee's activities should be on the transition between undergraduate medical education and the initial portion of graduate medical education.

XIII. INFORMATION ITEMS

Dr. Knapp called attention to the December 13 letter from Don Arnwine, Chairman, Voluntary Hospitals of America (VHA) outlining the fact that the VHA Board had indicated that there would be issues arising at the national level on which it should take an advocacy position. Dr. Knapp indicated that he had communicated with Mr. Arnwine on these matters and would do his best to work with him and his staff as policy positions were developed by both organizations. With regard to the matter of "Corporate Comments on Teaching Hospital Use," Dr. Knapp indicated that he had received from Gaylen Young, Director, Office of Health Coalitions and Private Sector Initiatives of the American Hospital Association, copies of a number of publications developed by health care coalitions. The section cited in the original Quaker Oats publication has been revised and the offending language, as viewed by some individuals, has been deleted. In its place, actual prices charged by specific hospitals in the Chicago area have been added. Dr. Knapp indicated he had reviewed all of the publications that Ms. Young had sent for review, and identified those passages which made specific reference to teaching hospitals or the special functions and objectives of teaching hospitals. None of them can be construed to be negative in nature. He indicated that he was in the process of organizing them and outlining them in writing so that they could be forwarded to the COTH membership for information.

At this point, Dr. Bentley distributed a copy of the AAMC position paper on Medicare payments for capital expenditures. A copy of this position is attached to these minutes as Appendix A. The chairman suggested that it would be wise for each member to become familiar with the issue since it will become very controversial. Dr. Mongan suggested that it would be very helpful if the staff could at least obtain anecdotal data if not systematic data on the effects different policy options would have on specific institutions. He recalled that one of the problems in opposing the move toward full implementation of the transition to national rates was the absence of good data early in the policy debate.

XIV. POSSIBLE ITEMS FOR FUTURE COTH ADMINISTRATIVE BOARD DISCUSSION

The chairman asked what issues the Administrative Board would like to discuss at forthcoming Board meetings. The following suggestions were made:

- Commercial aspects of intellectual properties (e.g.; royalties, licensure agreements, and proprietary rights).

- The malpractice survey being undertaken by the Government Accounting Office (GAO).

- Unfunded residency positions. The questionnaire for the 1985 COTH Housestaff Survey included the following question, "Do you offer any positions for volunteer (unpaid) residents who do not receive funding from any source including patient fees?"

  An analysis of the responses to this survey was distributed for the Board's information. A copy of this analysis is included in these minutes as Appendix B.

- Specialty board increases in the time and other requirements to be eligible to sit for board examination.

- Joint ventures with proprietary hospitals.

- The role of faculty practice plan leaders and executives in the AAMC.

Speakers who were suggested as possibilities for the informal gathering on Wednesday evening were Stan Jones, Carol McCarthy, and John Cogan, who many Board members felt was an excellent speaker and had spoken to the Board when he was associate director of OMB. Now that he is in a new position, it was suggested he might be asked back for a view from the outside. It was pointed out that he is now at the Rand Corporation in California, but that Don Moran is a similar individual who is currently employed by a consulting company here in Washington. Mr. Moran was suggested as a possible speaker as well.

XV. ADJOURNMENT

Mr. Smith adjourned the meeting at 12:30pm.

MEDICARE PAYMENT OF CAPITAL COSTS:

AN AAMC POLICY POSITION

Background

In adopting the Medicare prospective payment system, Congress expressed a strong interest in eliminating retrospective cost reimbursement for capital expenses.

- Congress indicated capital projects initiated on or after March 1, 1983 may be paid differently from projects initiated before that date;
- Congress required HHS to complete a major study of alternative methods of paying for capital; and
- Congress provided that if retrospective cost payments continued beyond September 30, 1986, no payment shall be made for major new capital expenses unless the project is approved by a Section 1122 planing agency.

Since the Congressional action, a number of organizations have developed proposals for paying capital costs, including the American Hospital Association, the Healthcare Financial Management Association, the Healthcare Financing Study Group, and the National Committee for Quality Health Care. Given the developments of these and other proposals, it is apparent that there is no clear consensus among hospitals for a single method of paying for capital under Medicare. While the AAMC could take the lack of hospital consensus as a sign that no strong statement on this issue should be made, the high capital costs of teaching hospitals and their dependence on capital for tertiary care services and new technologies require the AAMC to be an active participant in this debate.

Two empirical reports on capital costs have major implications for teaching hospitals. One is the American Hospital Association's April 16, 1984 paper, "Capital-Related Cost Variation Across Hospitals," which has three major conclusions:

- o capital costs as a percentage of operating expenses vary substantially across hospitals even when hospitals are grouped by region, bed size, ownership, case mix, medical education activity, location and age of plant;

- o because of the variation in capital costs, capital payments based on peer groups create as many "winners" and "losers" as capital payments based on a single national rate; and

- o because of the variation in capital costs, a transition mechanism from cost reimbursement for capital to prospective payment for capital is crucial.

Second, AAMC staff prepared a separate report reviewing the capital costs of COTH members. The analysis, "Toward an Understanding of Capital Costs in COTH Hospitals," resulted in three major findings:

- o while capital costs of COTH members are a smaller percentage of total expenses than they are of non-member hospitals, COTH members do have greater absolute capital costs per unit of workload (i.e., per day or per admission);

- o the physical facilities of COTH hospitals are 12% older than those of non-COTH hospitals; and

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

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

Policy Positions

Using this information and the recommendations of the AAMC's Ad Hoc Committe on Capital Payments for Hospitals, the AAMC Executive Council adopted the following six principles as a recommended policy on Medicare payment of capital costs.

I. THE AAMC SUPPORTS REPLACING INSTITUTIONALLY SPECIFIC, COST BASED RETROSPECTIVE PAYMENTS FOR CAPITAL WITH PROSPECTIVELY SPECIFIED CAPITAL PAYMENTS.

The Part A Medicare trust fund, which is used to make payments for inpatient services, is headed for insolvency. Continuing the present open-ended cost passthrough for capital seems unlikely because it is philosophically inconsistent with prospective payment, is perceived to stimulate capital expansion and an over-investment in capital goods, and is likely to be under-funded or capped as Congress weighs service benefits for current beneficiaries against facility investments for future beneficiaries.

II. THE AAMC SUPPORTS SEPARATING CAPITAL COSTS INTO TWO COMPONENTS -- (1) MOVABLE EQUIPMENT AND (2) FIXED EQUIPMENT AND PLANT.

This separation, which has historically been maintained in accounting records, recognizes that expenditures for movable equipment are constantly made by hospitals and that the useful life of the items purhased is generally rather short. Expenditures for fixed equipment and plant, on the other hand, tend to aggregate into more infrequent major projects which have a relatively long useful life. Given these different characteristics, a transition period is not necessary for movable equipment but is necessary for fixed equipment and plant.

III. THE AAMC SUPPORTS INCORPORATING CAPITAL PAYMENTS FOR MOVABLE EQUIPMENT INTO PROSPECTIVE PAYMENT USING A PERCENTAGE "ADD ON" TO PER CASE PAYMENTS.

Because movable equipment purchases are a regular and ongoing component of hospital operations, no transition period or phase-in is required in order to include movable equipment in the per case price. Incorporating movable equipment into the prospective price would encourage managers to consider the relative advantages of capital and labor intensive alternatives. With both payroll costs and movable equipment incorporated into a single payment rate, a hospital would have the flexibility to select the labor-equipment mix most suitable to its particular circumstances.

IV. THE AAMC SUPPORTS A PERCENTAGE ADD-ON TO PER CASE PRICES FOR CAPITAL COSTS OF FIXED EQUIPMENT AND PLANT THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT PROVIDED THAT THE ADD-ON IS BASED UPON A PER CASE PRICE WHICH APPROPRIATELY COMPENSATES TERTIARY CARE/TEACHING HOSPITALS FOR THEIR DISTINCTIVE COSTS.

In enacting the Medicare prospective payment system, Congress recognized that the operating costs of teaching hospitals are higher than those of non-teaching hospitals and included a resident-to-bed adjustment in the DRG payments to recognize this difference.

> This adjustment is provided in the light of doubts ... About the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents ... The adjustment for indirect medical education costs is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals. (Senate Report 98-23, p. 52)

Thus, the patient care costs of teaching hospitals are met by combining the basic DRG payment with the resident-to-bed adjustment. The AAMC believes capital payments made to teaching hospitals should be computed as a percentage add-on to the combined DRG and resident-to-bed payments. A single percentage add-on for all hospitals has been selected because no analysis to date has identified a more equitable approach.

V. THE AAMC SUPPORTS A LONG-TERM, HOSPITAL-SPECIFIC TRANSITION FROM THE CAPITAL PASSTHROUGH TO PROSPECTIVE PAYMENTS FOR PLANT AND FIXED EQUIPMENT.

In considering capital costs for plant and fixed equipment, it must be recognized that different hospitals are at various points in their capital cycles: some have new plants with high construction and financing costs; others have old plants and low costs but need to rebuild. Given this variability, the transition period should be long enough to recognize current obligations and make

adjustments for plant additions approved by health planning agencies and alterations/modernizations required by life safety codes and licensing and accreditation agencies.

VI. THE AAMC SUPPORTS A TRANSITION PERIOD WHICH ALLOWS EACH HOSPITAL ITS CHOICE OF (1) COST REIMBURSEMENT FOR DEPRECIATION AND INTEREST ON ADJUSTED BASE PERIOD CAPITAL OR (2) A PROSPECTIVE PERCENTAGE ADD-ON THAT IS NO LESS THAN MEDICARE'S CURRENT PERCENTAGE OF HOSPITAL PAYMENTS FOR FACILITIES AND FIXED EQUIPMENT.

Under prospective payments, change is the order of the day. Hospitals are examining long-standing operational practices and altering those found inconsistent with the incentives and requirements imposed by the new payment system. While changes in daily operating practices may be difficult, the everyday nature of these activities provides numerous opportunities for changing practices. The construction and financing of major facilities offer less flexibility: planning the project and obtaining all necessary approvals is a multi-year effort, the asset itself has a long useful life, and the permanent financing often is for 15 to 30 years. As a result of these long term dimensions of major facility changes, the AAMC believes a change in capital payments must include adjustments honoring (1) the depreciation and interest orginally anticipated for ongoing construction and recent plant additions; (2) new projects in the final planning stages; and (3) expectations of bondholders, lenders and donors.

Under this transition policy, a hospital could elect to be paid on a cost reimbursement basis (depreciation and interest) for (1) existing capital, (2) capital projects under active construction, and (3) capital projects for which a certificate of need was sought prior to a given date. These "base period" capital costs would be increased only for mandatory life safety or accreditation requirements approved by a planning agency. Capital payments would not be

increased for facility modernizations, expansions, or replacements undertaken after the base period. At any time during the allowed transition period, a hospital receiving depreciation and interest payments could elect to change and receive the prospective capital add-on to DRG payments. Once a hospital elected the prospective add-on, it could not subsequently receive payments based on depreciation and interest.

The AAMC recognizes that hospitals with above average capital costs will probably select the depreciation and interest option initially while hospitals with below average capital costs will select the percentage add-on from the beginning. This pattern of choice, which increases Medicare expenditures from 1 to 2%, will help ensure the continued viability of hospitals with recent or ongoing construction projects and maintain access to the capital market for hospitals generally. The small increase in expenditures is a reasonable price to pay for converting hospitals from a capital system based on recovery of past expenditure to one based on capital formulation and the prudent investment of capital assets.

AAMC AD HOC COMMITTEE ON CAPITAL PAYMENTS FOR HOSPITALS

Committee Appointments

Robert E. Frank, Chairman
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Department of Radiology
University of Florida
College of Medicine
JHMHC Box J-215
Gainesville, Florida 32610

Leon Zucker
Vice President for Finance
Jackson Memorial Hospital
1611 NW 12th Avenue
Miami, Florida 33136

INSTITUTIONS OFFERING POSITIONS TO "VOLUNTEER" OR UNPAID RESIDENTS

The questionnaire for the 1985 Survey of Housestaff Stipends, Benefits, and Funding attempted to determine the prevalance of unpaid, or "volunteer" residents in member institutions by asking the following:

12. "Do you offer any positions for 'volunteer' (unpaid) residents who do not receive funding from any source including patient fees?

_____ Yes _____ Number of on-duty 1984-85 _____ No".

The number of positive responses to this question was higher than anticipated, with 64 institutions responding that they offered such non-funded positions, and within those institutions 173 non-funded residents were reported to have been on-duty in 1984-85.

Subsequent Audit

In order to verify these statistics, the Department of Teaching Hospitals staff contacted the sixteen hospitals (of the 64) which reported the highest number of unfunded positions in 1984-85. Their responses varied. Although the question requested information on residency positions, many hospitals included clinical or research fellows in their count. Some institutions included residents funded from a source external to the institution, i.e., the military, a foreign country or the public health service. Some institutions that correctly responded to the question stated that many of their unfunded positions were in "competitive areas", such as opthalmology. Some institutions stated that they would offer more such positions if state legislatures continue to control increases in the absolute number of residents, especially if such state controls occur concurrently with federal actions to curtail support of direct medical education costs.

Explanations from contacted institutions are summarized below:

Hospital	Positions Filled 1984-85	Number FMGs	Explanation
1.	2	0	-All positions in a single accredited program in pediatric allergy that currently has no funding. -Offer residents opportunity of clinic work for income. -In the future, the number of these

			positions will grow due to state legislature control of increases in absolute number of residencies and because of cost-containment initiatives.
2.	5	4	-Four FMGs filled, these positions while working towards state licensure. -One position was filled by a married resident who did not require a stipend. -Positions are covered by malpractice and function as all other residents in a program.
3.	1	?	-No response.
4.*	13	5	-One FMG is in initial training and "looks promising." -One FMG is participating in a four-month primary care training program. -Two FMG positions are held by refugees on a trial basis. -One FMG position is supported by the Taiwan government-GI fellow. -Three positions are supported by the U.S. Military. -One is a research fellowship.

*Includes data from four hospitals.

			-One is a research fellow supported by Israel. -Two are VA positions.
5.	9	2	-About 5-6 students are participating in an endodontics program and pay for the opportunity. -Two positions are held by "promising" FMGs.
6.	3	0	-All are opthalmology positions filled at the discretion of the department chairman. -Letters to associate Dean requesting to participate and validation of credentials required. -Are clinical fellows.
7.	9	?	-Are one-year "walk" positions primarily in anesthesiology, neurology, nuclear medicine and rehab-ilitation. -Applications are required and approved by the Dean. -Could be FMGs.
8.	8	0	-All 8 positions are actually paid by external sources, i.e., a state Heart Institute and various foreign countries.
9.	3	0	-Not FMGs.

			-Participating in a pediatric opthalmology program that lasts 6 months to one year. -It's possible that they could pay the department. (?) -Beyond residency.
10.	5	5	-All volunteer FMGs in a one-year program. If successful will enter funded residency position.
11.	6	1	-Actually one unfunded FMG position. -Three supported by foreign governments. -Other two public health, U.S. air force.
12.	33	33	-Said definitely all were FMGs without compensation. -Many of these people are "boat people". The Department of Radiology is attempting to help these people by allowing them to participate in this unpaid residency program. -There is an annual review process by radiology and only the most capable are allowed to continue in the program.

			-Individuals may eventually qualify for a "paid" residency slot.
13.	6	?-1	-Anesthesiology-5 positions, a very competitive program. No salary, but fringe benefits. -Residents are committed to unfunded training slot for 3 years or entire training period. -One FMG in radiation oncology.

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to organizations 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
One Dupont Circle, N.W.
Suite 200
Washington, D.C. 20036

I. HOSPITAL IDENTIFICATION

Hospital Name: Holy Cross Hospital

Hospital Address: (Street) 1500 Forest Glen Road

(City) Silver Spring (State) Maryland (Zip) 20910

(Area Code)/Telephone Number: (301) 565-0100

Name of Hospital's Chief Executive Officer: Sister Jean Louise, C.S.C.

Title of Hospital's Chief Executive Officer: President

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 450

Average Daily Census: 343

Total Live Births: 3,848

Admissions: 19,975

Visits: Emergency Room: 38,634

Visits: Outpatient or Clinic 9,650

B. Financial Data

Total Operating Expenses: $ 65,367,516

Total Payroll Expenses: $ 36,506,685

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 393,300
Supervising Faculty: $ 227,900

C. Staffing Data

Number of Personnel: Full-Time: _____ TOTAL FTE'S 1,717
Part-Time: _____

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 385
With Medical School Faculty Appointments: 150 (est.)

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

II. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	4	4	Required
Surgery	4	4	Required
Ob-Gyn	7	7	Elective
Pediatrics	3	3	Elective
Family Practice			
Psychiatry			
Other:			

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine	4	4		1975
Surgery	5	5		1975
Ob-Gyn	7	7		1975
Pediatrics	4	4		1975
Family Practice				
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: George Washington University

Dean of Affiliated Medical School: Ronald Kaufman, M.D.

Information Submitted by: (Name) Morris Feitel, M.D.

(Title) Vice President, Medical Affairs

Signature of Hospital's Chief Executive Officer:

Sr. Jean Louise C.S.C. (Date) 1/21/86

THE
GEORGE
WASHINGTON
UNIVERSITY
MEDICAL CENTER
Vice President for Medical Affairs / 2300 Eye Street, N.W. / Washington, D.C. 20037 / (202) 676-3727

January 31, 1986

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

Dear Dr. ~~Knapp~~ Dick:

Holy Cross Hospital, a major affiliate of The George Washington University Medical Center, is interested in pursuing membership in the Council of Teaching Hospitals. It is my understanding that it is appropriate for my office to endorse their application, and I am pleased to do so.

Holy Cross Hospital has been affiliated with The George Washington University School of Medicine and Health Sciences for the past ten years. The affiliation is across-the-board in Medicine, Surgery, Obstetrics and Gynecology, and Pediatrics, involving both medical students and housestaff. The Medical and Dental staff of Holy Cross have served as faculty to this program and have done it well.

I would, therefore, like to recommend the Holy Cross Hospital for membership in the Council of Teaching Hospitals, with the firm belief that they will be an important addition to the organization.

Sincerely,

Ronald P. Kaufman, M.D.
Vice President for Medical
Affairs and Executive Dean

RPK/jmp

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: **HUMANA HOSPITAL-UNIVERSITY**

Hospital Address: (Street) **530 S. Jackson Street**

(City) **LOUISVILLE** (State) **KENTUCKY** (Zip) **40202**

(Area Code)/Telephone Number: (**502**) **562-4002**

Name of Hospital's Chief Executive Officer: **Gary V. Sherlock**

Title of Hospital's Chief Executive Officer: **Executive Director**

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): **404**

Average Daily Census: **294**

Total Live Births: **2,456**

Admissions: **16,532**

Visits: Emergency Room: **37,748**

Visits: Outpatient or Clinic: **39,705**

B. Financial Data

Total Operating Expenses: $ 54,510,997

Total Payroll Expenses: $ 27,850,352

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 3,334,800 Residents*
Supervising Faculty: $ 480,170 Dept. Chair*

*Represent Humana Hospital-University's Subsidy

C. Staffing Data

Number of Personnel: Full-Time: 1,164
Part-Time: 294

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 243
With Medical School Faculty Appointments: 243

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

CHIEFS OF SERVICE ARE NOT PAID AS FULL-TIME BY HUMANA

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

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	8 (4 Jr./4 Sr.)	265 (Jr. & Sr.)	ALL REQUIRED
Surgery	20	30/36 EA. QTR.	2 REQ./18 ELECTIVE
Ob-Gyn	8	125	1 REQ/7 ELECTIVE
Pediatrics	12	47	All Elective
Family Practice	6	178	1 REQ/5 Elective
Psychiatry			
Other: NEUROLOGY	1	144	Required

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine	47	43	4	2/1927
Surgery	34	33	1	SEE BELOW*
Ob-Gyn	12	12	-	1930 - AMERICAN BD.
Pediatrics	6	4	2	2/1927
Family Practice	6	4	2	1/1973
Psychiatry	15	7	8	ADULT - 4/8/46 CHILD - 5/18/62
Other:				
NEUROLOGY	3	1	2	APRIL 9, 1982
EMER MED	17	17	-	MAY 22, 1984
OPHTHALMOLOGY	5	5	-	NOVEMBER 1962
PATHOLOGY	7	7	-	1948
ANESTHESIOLOGY	13	11	2	1958 - ACGME
RADIOLOGY	-	-	-	12/1973
RADIATION ONCOLOGY	2	1	1	FALL OF 1969
TOTAL	167	145	22	

[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.

DEPT. OF SURGERY/SPECIALTY	DATE OF INITIAL APPROVAL	DATE OF LAST APPROVAL
General Surgery	2/1927	4/18/83
Plastic & Reconstructive	6/1973	11/19/82
Urology	4/1958	2/22/83
Otolaryngology	12/19/37	1/18/83
Neurosurgery	10/1952	11/17/81
Thoracic & Cardiovascular	11/1968	7/17/84

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: **UNIVERSITY OF LOUISVILLE**

Dean of Affiliated Medical School: **DONALD R. KMETZ, M.D.**

Information Submitted by: (Name) **REBECCA BLUE**

(Title) **ADMINISTRATIVE SPECIALIST**

Signature of Hospital's Chief Executive Officer:

(Date) 2/20/86

Donald R. Kmetz, M.D.
Vice President for Hospital Affairs
and Dean

School of Medicine
University of Louisville
Louisville, Kentucky 40292
(502) 588-5184

UNIVERSITY of LOUISVILLE

November 19, 1985

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

Gentlemen:

I am pleased to submit this letter of support on behalf of Humana Hospital University's application for membership in the AAMC Council of Teaching Hospitals.

Humana Hospital University serves as the University of Louisville School of Medicine's major teaching hospital. The Chief of Staff is the Dean of the School of Medicine and the chiefs of services in the hospital are chairmen or designees of the appropriate departments within the School of Medicine. This administrative organization preserves the academic mission of the School of Medicine which is to provide undergraduate and postgraduate medical education.

Clearly, Humana Hospital University is vital to the existence of the School of Medicine. With a bed capacity of 404, this acute care facility provides a major clinical experience for medical students and housestaff. It is also the site where most of our indigent care is provided. In view of the hospital's relationship to our academic institution, I believe it is not only appropriate but essential that Humana Hospital University be a member of COTH. I urge you to act favorably on this application.

Sincerely yours,

Donald R. Kmetz, M.D.
Vice President for Hospital
Affairs and
Dean, School of Medicine

DRK/mp

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: Toronto General Hospital

Hospital Address: (Street) 200 Elizabeth Street,

(City) Toronto (Prov. ~~State~~) Ontario (Zip) M5G 2C4

(Area Code)/Telephone Number: (416) 595-3300

Name of Hospital's Chief Executive Officer: Mr. W. Vickery Stoughton

Title of Hospital's Chief Executive Officer: President

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn): 1,000

Average Daily Census: 86%

Total Live Births: 3,540

Admissions: 31,750

Visits: Emergency Room: 39,626

Visits: ~~Outpatient~~ Clinic: 238,105

B. Financial Data

Total Operating Expenses: $ 169,306,180

Total Payroll Expenses: $ 108,197,517

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 7.6 M.
Supervising Faculty: $ difficult to determine*
total house staff = 235

*NOTE: These expenses are the responsibility of the University

C. Staffing Data

Number of Personnel: Full-Time: 3790
Part-Time: 821

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 350
With Medical School Faculty Appointments: 350

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

the clinical services do not have full time salaried chiefs

Does the hospital have a full-time salaried Director of Medical Education?: Dr. W. Anderson

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	9	9	Required
Surgery	8	8	"
Ob-Gyn	5	5	"
Pediatrics	5	5	"
Family Practice	4	4	"
Psychiatry	5	5	"
Other: Anaesthesia	2	2	"
ENT	2	2	"
Electives	9	9	"
Selectives	5	5	"
	54	54	

B GRADUATE MEDICAL EDUCATION

Type of Residency	Positions Offered	U.S. & Canadian Grads	Foreign Grads	Date of Initial Accreditation	
Family Practice	10	7	3	1969	(1)
Psychiatry	12	12			(2)
Anaesthesia	16	15	1		(2)
Oral Surgery	8	8		1980	(3)
Pathology	13	11	2		(2)
Microbiology	1	1			(2)
Biochemistry	1	1			(2)
Radiology	12	12			(2)
Obstetrics and Gynaecology	7	4	3		(2)
ENT	6	3	3		(2)
Ophthalmology	5	3	2		(2)
Emergency	9	9		1983	
General Medicine	34	34			(2)
Sub-specialties	18	16	2		(2)
General Surgery	27	27			(2)
Sub-specialties	7	5	2		(2)

(1) As accredited by the College of Family Practice Physicians of Canada.

(2) As accredited by the Royal College of Physicians and Surgeons. In 1970 the Royal College began to accredit programs on a university basis rather than on an individual hospital basis which began in 1948. All residency programs at the hospital are accredited.

(3) As accredited by the Canada Dental Association.

IV. SUPPLEMENTARY INFORMATION SEE ATTACHED

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: _____

Dean of Affiliated Medical School: _____

Information Submitted by: (Name) W. Vickery Stoughton

(Title) President

Signature of Hospital's Chief Executive Officer:

W Vickery Stoughton (Date) November 25, 1985

Faculty of Medicine
University of Toronto
Office of the Dean

December 13, 1985

Association of American Medical Colleges
Council of Teaching Hospitals
One Dupont Circle, North West
Suite 200,
Washington, D.C.
20026 U.S.A.

Dear Sir:

I am writing to support enthusiastically the application of the Toronto General Hospital for membership in the Council of Teaching Hospitals. I have spoken with Mr. W.V. Stoughton President of the hospital, regarding the benefits of the hospital's participation in the Council and believe that these benefits will also accrue to the University of Toronto.

The Toronto General Hospital is the largest teaching hospital with a research focus in Canada, and themajor teaching hospital affiliated with the University of Toronto. Although our teaching program is conducted at several hospitals throughout Toronto, a majority of the Departmental Chairmen at the University are also Department Heads at Toronto General Hospital.

On an annual basis, Toronto General Hospital provides the clinical setting for roughly 230 interns and residents from our University of Toronto program. The total number of students who are affiliated with the Faculty of Medicine and are involved with Toronto General Hospital is 532. In addition to the Faculty of Medicine, Toronto General Hospital students also come from the University of Toronto Faculties of Dentistry, Nursing and Social Work, not to mention various community colleges and technological institutes. The education program at Toronto General Hospital serves more students in undergraduate and graduate medical and ancillary programs than any other hospital in Canada.

Cont'd.../2

Medical Sciences Building
Toronto, Ontario, M5S 1A8
(416) 978-2710

I believe that the Toronto General Hospital as a teaching facility will be strengthened by the support and sharing of ideas achieved through an organization such as the Council.

If you require additional information in support of my recommendation, I will forward it upon your request.

Yours sincerely,

Frederick H. Lowy, M.D.
Dean

FHL/ses

COTH/AAMC AS A VEHICLE TO PROVIDE COMPETITIVE ECONOMIC SERVICES

The characteristics and role of the AAMC Council of Teaching Hospitals and Department of Teaching Hospitals have been discussed and debated since the formal establishment of COTH in 1966. A recent comprehensive review was completed in April 1984 entitled, "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." In January 1985, these matters were revisited by the COTH Administrative Board. A copy of the agenda item which served as the basis for that review of the issues follows as Attachment A.

As a result of the discussion at the January 1985 meeting, respective Board members outlined the goals and services of VHA, CJH, UHC, and AHS at the April Administrative Board meeting. In addition, VHA president, Don Arnwine, set forth service and advocacy programs of VHA on the evening preceding that Board meeting.

The history of the specific question of whether or not the COTH/AAMC should become involved in specific service programs for its members is as follows.

In early May 1982, Dick Knapp received the attached memorandum from Chuck O'Brien concerning exploration of the establishment of a capital purchasing group (Attachment B). The issue was placed on the agenda of the June 24 COTH Administrative Board meeting. Chuck O'Brien and Eric Munson joined the Board for its discussion of the issue. In that discussion, the following points were raised:

- Is the AAMC's role and mission to organize or sponsor service programs for its constituents? While it can be pointed out that the centralized medical application service and the medical college admission test fall in such a category, these are without a doubt very distinctive activities;

- The question of the extent to which such a service program might be the first of a series of such programs which could divert the energies of the staff away from the primary mission of the organization was discussed;

- A number of individuals questioned whether or not there were not existing groups that could be joined by interested hospitals;

- There were questions concerning the real savings of such efforts on large big ticket items. The latter point was that in many cases major teaching hospitals have been able to obtain or negotiate discounts on their own.

The COTH Administrative Board recommended to the AAMC Executive Council that a small ad hoc committee be appointed to explore the issue with particular reference to the points made in the discussion. The Executive Council approved the appointment of such an ad hoc committee.

The ad hoc committee was asked to review, discuss, and make recommendations on the following questions:

- Is there a need for group purchasing of major capital equipment which is currently not being met?

- o If yes, what are the options available?

- o Is there any initiative the Association of American Medical Colleges should take?

Members of the committee were James W. Bartlett, MD, Chairman; Robert E. Frank; Richard Janeway, MD; Glenn Mitchell; Eric Munson; and Charles O'Brien.

The ad hoc committee met on September 8, 1982 and Dr. Bartlett reported the discussion at the meeting of the COTH Administrative Board meeting the following day. He explained that the committee recognized that as part of their research, patient care and education missions, AAMC constituents are high technology users for whom group purchasing could offer significant savings and market position benefits. These constituents include not only teaching hospitals, but also medical schools which often utilize high technology (e.g.; nuclear magnetic resonators) that is not yet reimbursable for use by hospitals in patient care.

Dr. Bartlett stated that the committee expressed some fear of being "aced out" of opportunities by other purchasing groups and determined that the AAMC should explore the major equipment needs of its constituency and the alternative group purchasing arrangements available to them. He noted that representatives of two major equipment purchasing groups, Voluntary Hospitals of America (VHA) and the Metropolitan Associations Purchasing Service (MAPS), attended the committee meeting. He reported that the committee discussed the broader question of the roles of COTH and the AAMC in relation to advocacy and representation versus a service orientation. Also addressed by the committee were the unique problems of state university hospitals which have limited purchasing flexibility and the critical concerns regarding capital formation and the difficulties in acquiring capital. Dr. Bartlett felt it was particularly interesting to note that the committee's discussion focused almost exclusively on radiology, which apparently consumes the largest portion of most hospitals' capital equipment budgets.

At that Administrative Board meeting, a number of Board members emphasized that placing the AAMC in the role of a shared services contractor (or some similar relationship) would be a substantial departure from its traditional role. In addition, some Board members noted such an activity would place the COTH/AAMC in competition with state and local hospital associations with which COTH/AAMC needs to maintain cooperative relationships for advocacy purposes. In addition, management of these service programs in some associations was perceived to have begun to detract from the principal mission of the association. Finally, some of these services initiated and operated by state and local hospital associations were activities by which some hospitals and multi-hospital systems wished to create their own diversification programs.

Dr. Rabkin expressed appreciation to Dr. Bartlett and Mr. Frank for their work on the ad hoc committee and agreed with the committee's recommendation to pursue more information on constituent needs and available alternatives prior to committing the Association to any significant new course. Both Dr. Dalston and Mr. Reinertsen were concerned that the need for urgent AAMC action on this issue was not being adequately sensed. Dr. Knapp responded that the need to do something, particularly for the Appalachian Teaching Hospital group that originally approached the Association for assistance, is fully recognized. Dr. Bartlett stated that the committee concurred with this view, but recognized the need to first assess the situation.

Although no official action was taken by the Administrative Board, there was the consensus that the following ad hoc committee recommendations should be presented to the AAMC Executive Council:

- "In light of the rapidly changing structure of the hospital field and market, the AAMC should examine what group services are needed by teaching hospitals and medical schools, and how such services might be effectively provided to preserve and strengthen both the individual institution and the influence of teaching hospitals and medical schools as groups of institutions."

- "With respect to group purchasing, the AAMC staff should be requested to assess the access of AAMC constituents (teaching hospitals and medical schools) to currently operating group purchasing activities for major capital equipment and ascertain if the need for improved and broader access to such services is a specified need of AAMC constituents."

The participants at the AAMC Officers' Retreat in December 1982, reviewed and discussed the recommendations of the ad hoc Committee on Joint Major Equipment Purchasing. The report recommended and the AAMC Executive Council concurred on September 9, 1982 that:

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

- AAMC staff should examine what group services are needed by teaching hospitals and medical schools.

At the December 1982 AAMC Officers' Retreat, it was agreed upon review that with the growth and potential of regional and national group purchasing activities and other developments, it would be unwise for the AAMC to develop such a program. In addition, it was agreed that such a program to serve medical schools is not warranted based on any expression of interest thus far.

With respect to the second recommendation, there was extensive discussion of the fact that in some respects, multihospital systems are taking on associaton functions and objectives, and some associations are assuming essentially service functions of multihospital systems. It was recognized that these hospital systems as well as other organizations will be competitors for the time, effort, and loyalty of AAMC hospital constituents. It was agreed that thus far excellent communication and participation by leaders of these organizations in the activities and programs of the AAMC has served the AAMC well. There was also an awareness that this is a matter that will require constant attention in the future. At the same time, it was agreed that the AAMC should not engage in service programs as a method of competing with these other organizations. Service programs should be developed only if there is a clearly expressed constituent desire for them and only then if the service is a unique one, or one which the AAMC is uniquely qualified to provide.

In January 1983, the following recommendation based on the report from the Officers' Retreat was approved by the COTH Administrative Board and the AAMC Executive Council.

> The AAMC staff should monitor constituent service needs and be alert to changing relationships of members of newly developing organizations or

consortia with the AAMC. No formal service program should be initiated at this time.

During 1984 and 1985, networks and consortia such as VHA, AHS, CJH (now Premier Alliance), and UHC have intensified their activities and broadened the scope of their efforts. The COTH Administrative Board and AAMC staff of the Department of Teaching Hospitals have had informal and formal discussions of the emerging issues as the roles of consortia and alliances have begun to take clearer shape. For the most part, the discussions have focused on exploring the role and function of COTH/AAMC with regard to matters of education programs, information and data collection, research, service, and advocacy as these evolving organizations initiate new activities.

As these alliances and consortia have begun to mature, they are beginning to develop and market various types of insurance products as joint ventures with insurance company partners. These products are designed as "patient acquisition strategies" to provide market share advantages to their sponsors. This is a type of service activity, but one which is quite different from group purchasing, shared insurance pools, or other activities which lead to economic advantage but don't directly deal with specific competition for patients.

The question before the Administrative Board at its January 1986 meeting was, "What role can the AAMC staff members play if asked to participate in the development of insurance products of any one of the alliances or consortia?" Jim Bentley had been asked to participate as a member of the National Health Care and Insurance Delivery Council of the University Hospital Consortium. Mr. Baker, UHC President, outlined the activities of that Council as exploring the various options of networking for academic medical centers and the type of insurance products that might be useful to academic medical centers. He indicated that he feels strongly that the AAMC and the Association of Academic Health Centers (AAHC) have a role in the development of these linkages and a vital role in exploring the networking possibilities. Mr. Derzon, who is chairman of that UHC council, indicated that the initial effort of the council is an analytical one and is not yet at the point where he would call it a product development activity, although he didn't foreclose the possibility that this might in fact develop. Mr. Ives made the point that 1/3 of the core membership of the Council of Teaching Hospitals - that is the so-called "medical center hospitals" - are members of the consortium, and viewed this as a high priority agenda item. He further indicated that seven members of the University Hospital Consortium are members of the COTH Administrative Board, and that there was a relationship between the consortium and the staff of the Department of Teaching Hospitals which was based on trust and competence.

Drs. Foreman and Buchanan questioned whether the Association staff should be involved in the basic economic interests of COTH members. They indicated that it would be a mistake for the staff to be identified as "advocates" of any one of the various groups that are beginning to emerge. To tap the staff for one organization and not to make this same service available to all could lead to some difficult problems. In addition, if the staff were made available to all such organizations, there would be problems of conflicts of interest and also the question of whether or not this was a wise way for the staff to spend its time. If the AAMC has a policy (as it does) with regard to the consulting time of its staff members, it could be possible that a staff member might work with one of these groups as a paid consultant. However, even this arrangement should be approached cautiously. Mr. Munson indicated that he thought there might be a difference between open and full communication as an observer with the activities

of these newly emerging organizations versus membership on a specific committee of one of these organizations. He felt that it is important to the AAMC that its staff stay up-to-date on key issues of member concerns, and felt that open communication was necessary to achieve this. Mr. Baker indicated that he felt that the basic question was, "What role does the AAMC play in the emerging service arrangements in the new competitive environment?"

In reviewing this issue, it is important to know the alliances or consortia in which COTH constituents maintain membership. These data are being gathered, and will be available for Board review at the April 10 meeting.

The fundamental question in the two most recent policy debates has been, "Should the COTH/AAMC directly initiate service programs which provide economic advantages to its members?" In reviewing the matter, the question of whether services should be made available to all COTH/AAMC members needs attention. As the competitive environment has intensified, local and regional competition between medical centers has intensified as well. This appears to be particularly true with regard to "patient acquisition strategies" of teaching hospitals and faculty practice organizations. This issue is particularly relevant to multiple medical center cities and cities where relationships between medical center hospitals and faculty physicians, and affiliated hospitals and physicians are less than fully cooperative in the new environment.

SHOULD THE COTH/AAMC INITIATE SERVICE PROGRAMS AND ACTIVITIES TO MEET THESE NEEDS? IF SO, SHOULD THEY BE OFFERED TO ALL COTH/AAMC CONSTITUENTS?

If the answer to the first question is no, then the next issues are:

WHAT ROLE SHOULD THE AAMC PLAY IN THE EMERGING SERVICE ARRANGEMENT IN THE NEW COMPETITIVE ENVIRONMENT?

WHAT RELATIONSHIP(S) SHOULD THE AAMC HAVE WITH THE ORGANIZATIONS EMERGING PRIMARILY TO PROVIDE ECONOMIC BENEFITS TO HOSPITALS?

MEMBERSHIP AND SERVICE ISSUES FOR THE COUNCIL OF TEACHING HOSPITALS

The paper "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals" has been reviewed by the AAMC membership on a number of occasions:

November 1983	Approved for discussion by the COTH Administrative Board
December 1983	Reviewed and discussed at the AAMC Officers' Retreat
January 1984	Included on the agenda of the AAMC Executive Council (meeting cancelled)
April 1984	Included on the agenda of the AAMC Executive Council which recommended transmitting it to the AAMC membership
	Presented and discussed at the Appalachian Council of Teaching Hospitals
	Mailed to all AAMC members
May 1984	Presented and discussed at the Western University Hospital Council
	Presented and discussed at the annual COTH Spring Meeting
December 1984	Discussed at the AAMC Officers' Retreat

While the paper was presented generically, to a large degree in many of the sessions referenced above the issue of investor owned hospital participation in the COTH/AAMC dominated the discussion. The COTH Administrative Board has been asked once again to review this issue. However, a number of other related COTH membership issues have continued to occupy the concern and the attention of the staff.

In order to discuss these issues it is useful to review COTH membership criteria and restate important segments of the "New Challenges" paper.

There are two categories of COTH membership: teaching hospital membership and corresponding membership. Both membership categories require the applicant institution to have a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education and a letter recommending membership from the dean of the affiliated medical school.

Teaching hospital membership is limited to not-for-profit -- IRS 501 (C)(3) -- and publicly owned hospitals which sponsor or significantly participate in at least four approved, active residency programs. At least two of the approved residency programs must be in the following specialty areas: internal medicine,

surgery, obstetrics-gynecology, pediatrics, family practice or psychiatry. In the case of specialty hospitals -- such as children's, rehabilitation and psychiatric institutions -- the COTH Administrative Board is authorized to make exceptions to the requirement of four residency programs provided that the specialty hospital meets the membership criteria within the framework of the specialized objectives of the hospital.

Teaching hospital members receive the full range of AAMC and Council services and publications. In addition, their COTH representatives are eligible to participate in the AAMC's governance, organization, and committee structure.

Non-profit and governmental hospitals and medical education organizations (e.g., consortia, foundations, federations) not eligible for teaching hospital membership may apply for corresponding membership. To be eligible for corresponding membership an organization must have a demonstrated interest in medical education, a documented affiliation agreement with a medical school accredited by the LCME, and a letter recommending membership from the dean of the affiliated medical school. Corresponding members are eligible to attend all open AAMC and COTH meetings and receive all publications. Representatives of corresponding members are not eligible to participate in the governance of the AAMC. Hospitals which are eligible for teaching hospital membership are not eligible for corresponding membership. There are currently 35 corresponding members of COTH.

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

Teaching Hospital Relationships with the College of Medicine

	Number of Members	Percent
1. Common ownership with the college of medicine	64	15%
2. Separate non-profit hospitals where the majority of the medical school department chairmen and the hospital chiefs of service are the same person	28	7%
3. Public hospitals where the majority of the medical school department chairmen and the hospital chiefs of service are the same person	23	6%
4. Affiliated hospitals not otherwise classified which are designated by the medical school dean as a major affiliate for the school's clinical clerkship program*	152	37%

5.	Affiliated hospitals not otherwise classified which are designated by the medical school dean as a limited affiliate for the school's clinical clerkship program*	44	11%
6.	Specialty hospital	27	7%
7.	Veterans Administration hospital	74	18%

(*Source: 1983-84 Directory of Institutions and Agencies participating in Residency Training, Accreditation Council for Graduate Medical Education, pp. 351-421.)

Of the 127 accredited U.S. medical schools, 107 have a relationship with a teaching hospital in the initial three categories listed in the Table. Three additional schools have a relationship with a hospital that would qualify for one of these three categories, but the hospital has not elected to become a COTH member. Humana Hospital University, related to the University of Louisville School of Medicine, is ineligible to join COTH under current membership criteria. In 16 medical schools, the majority of medical school chairmen of clinical departments are not chiefs of service in one particular teaching hospital.

This categorization of the Council of Teaching Hospitals portrays the membership as it currently exists. It should be understood that teaching hospital/medical school relationships are continually evolving. Hospitals affiliated with newer medical education programs will mature and become more closely integrated and longstanding hospital relationships with medical schools may change in character.

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

New Hospital Organizations Competing for National Attention

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

- The American Hospital Association has established constituency centers, including one for "metropolitan hospitals," in which teaching hospitals have a very significant role as members and officers;
- The Catholic Health Association has reorganized and substantially strengthened its Washington office;
- The Federation of American Hospitals has become an effective and highly visible organization;

- The National Association of Public Hospitals is four years old and has established a stable membership;

- The Association of Academic Health Centers has established a Board level committee on teaching hospital issues;

- The National Council of Community Hospitals has made its presence felt, and appears to be a viable organization;

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

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

- Increasingly hospitals and hospital associations are hiring Washington-based law firms and consulting firms for "representation" purposes. The relationships between these lawyers and the AAMC staff is unclear and often uncomfortable.

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

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

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

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

- The Consortium of State University Hospitals, which began as a small research interest group, has incorporated as the University Hospital Consortium (UHC) to offer shared service and joint venture economic activities to academic medical center hospitals. UHC currently has more than 25 members from 115 hospitals in the first three categories of COTH membership set forth earlier in this agenda item, and anticipates growth in membership in the next six months.

- Two other hospital alliances, Associated Healthcare Systems and United Healthcare, have merged to form American Healthcare Systems (AHS). They have begun to develop a Washington office for lobbying, a national preferred provider organization and economic services.

- New organizations are also forming to represent clinical units or programs of the hospital. During the current year, hospitals with burn care units, as an example, began forming their own organization.

The development of these new organizations suggests that multi-hospital systems, cooperatives, and other organizational entities are to some degree taking on traditional functions of associations.

The teaching hospital paper entitled, "New Challenges..." contained a number of recommendations. However, in addition to the subject of investor owned teaching hospitals, discussion during the year has focused primarily on two issues. First, with a few exceptions, COTH members and the members of other AAMC Councils have supported the position that COTH should include all types of teaching hospitals rather than be limited to some more limited definition of academic medical center hospitals. Secondly, COTH and other AAMC members have supported the recommendation not to develop and emphasize economic service programs (e.g., joint purchasing, fringe benefit insurance, consulting). This consensus may have contributed to the decision of the Consortium of State University Hospitals to reorganize.

Issues for Discussion

Voluntary Hospitals of America (VHA), American Healthcare Systems (AHS), University Hospital Consortium (UHC), and the Federation of Jewish Hospitals (FJH) have been developed or transformed to offer shared service and joint venture economic activities to their respective members. In order to discuss the possible relationships that might develop between these newly emerging organizations and COTH/AAMC it is useful to think about the issue from the perspective of advocacy activities and efforts, economic service activities and information sharing activities.

Advocacy Activities and Efforts

By its very nature and structure, the COTH/AAMC is focused on advocacy. In the past two decades, this advocacy has focused on supporting the expansion and development of member capabilities. In the near future, the advocacy emphasis will shift to protecting the diversity of the membership and preserving special benefits, subsidies, and advantages available to teaching hospitals. With third party payers increasingly setting fixed levels of expenditures for hospital services, the AAMC must work to protect the teaching hospital share. The UHC and FJH have not developed Washington based advocacy efforts. AHS has hired an individual who is developing a Washington office and planning an advocacy strategy. VHA engaged an individual on a part-time basis who provides information and advice to VHA members, but has done so without a high profile of testimony before congressional committees and other kinds of efforts.

VHA is the most longstanding of these new organizations (formed in 1977). Don Arnwine, President, VHA has agreed to join the COTH Administrative Board for a discussion of this issue at the April 3 Board meeting. Any other suggestions for engaging this issue and avoiding possible conflict would be helpful.

Economic Service Activities

As indicated earlier, one fundamental reason for the establishment of these organizations is to offer shared service, and joint venture economic activities to their members. In the view of some observers, the need to do so has been substantially fueled by the aggressive efforts of investor owned hospital chain organizations.

At the AAMC Officers' Retreat in December 1982, agreement was reached that it would be unwise for the Association to develop these kinds of service programs unless there is a clearly expressed constituent desire for a service and the

Association would be uniquely qualified to provide that service. This decision was approved at the AAMC Executive Council meeting on January 20, 1983.

Teaching hospitals compete in three markets: in an immediate local market for primary hospital services; in a somewhat broader local market for tertiary hospital services, and in a regional or national market for payer revenues. In each of these markets, many teaching hospitals are competing with each other as well as with community hospitals. A decision to emphasize economic goals would require a willingness to advantage some members at the expense of others.

Notwithstanding the difficulties which might ensue, there are individuals who believe the AAMC should re-evaluate its January 20, 1983 decision. In addition, the American Hospital Association has offered to work with AAMC to develop or "broker" arrangements on a partnership basis if a decision to move ahead in this area were reached.

Should the AAMC reopen the question of providing economic service opportunities to its members?

Information Sharing Activities

Information sharing through survey efforts and "research reports" is a major function of the COTH/AAMC. The Housestaff Survey, Executive Salary Survey, and Survey of University Owned Teaching Hospitals' Financial and General Operating Data are examples of information sharing. Medical education costs, resident staffing patterns, case mix research, and the impact of the Medicare payment system are other examples of information sharing. Since the COTH membership reaches across all the newly developing and probably competitive organizations, it would appear logical for COTH to continue current surveys and initiate new efforts as the need arises. Inevitably some of these organizations will undertake their own efforts in these areas.

What actions can be taken to assure unnecessary duplication does not occur, and that harmonious relationships continue?

Categorization of COTH Members

As set forth earlier, COTH members have been classified on the basis of their relationship with a college of medicine. This categorization and the table presented earlier in this agenda item appear in the document entitled "New Challenges for the Council of Teaching Hospitals and the Department of Teaching Hospitals." A number of individuals have expressed an interest in obtaining the list of those hospitals in the first three groups in the table. Staff of the University Hospital Consortium wished to review it to better understand which teaching hospitals might usefully be pursued as possible members of that organization. A copy of the list was provided to Myles Lash, President, UHC. The letter sent to Mr. Lash follows this agenda item. A copy of the list was provided to The Commonwealth Fund Task Force on Academic Health Centers on the condition the names of the hospitals on the list not be identified in the research results.

While it might be difficult for a researcher to accomplish, the variables to reconstruct the list are public data. This being the case, is there any reason the list shouldn't be shared with researchers and others who wish to use it?

Attachment B

Office Memorandum • GEORGETOWN UNIVERSITY HOSPITAL

To: Dick Knapp

Date: April 29, 1982

From: Charles M. O'Brien, Jr.
Hospital Administrator

Subject: COTH Sponsorship of Capital Purchasing Program

At the spring meeting of the Appalachian Council of University Teaching Hospitals, the Appalachian group discussed and expressed its support for the concept of the exploration of capital purchasing section by a larger group, either an independently organized consortium of teaching hospitals possibly under the COTH. One of the major discussion points has been the impact of both proprietary and not for profit groups and their ability to capitalize on their bulk purchasing power for equipment. As centers which over the next several years will be purchasing substantial amounts of high cost technological equipment it appeared to the Appalachian Council that there is an opportunity which should be fully explored. For example, it was pointed out that recently the Sun Alliance had issued an order for 15 CAT scanners. The best price for the top of the line General Electric scanner is approximately $1.2 million and they purportedly received bids from General Electric for $800,000 per unit. Multiplying the number of institutions in the COTH who will be purchasing CAT scanners, nuclearmagnetic equipment, cath labs, etc., it would seem that within the group of the Council of Teaching Hospitals a very substantial opportunity exists to capitalize on that part of the market sharing which the Council of Teaching Hospitals institutions singularly represent.

Such a program could be easily implemented without substantial staff costs and could serve as a method or mechanism, at least at the subregional area, to develop more joint programs that could assist the teaching hospitals in their increasingly competitive environment.

The group had asked me to convey their sentiments to the Council of Teaching Hospitals to see if there is an interest, and if there is to start discussions on how such programs could be implemented. I would be pleased to discuss it further.

cc: Members of the Appalachian Council