aamc association of american medical colleges

AGENDA

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 22-23, 1988
8:00 a.m.
Washington Hilton Hotel
Caucus Room

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

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 22-23, 1988
Washington Hilton Hotel
Washington, DC

WEDNESDAY, June 22, 1988

6:00p	JOINT ADMINISTRATIVE BOARDS SESSION with Guest Speaker (TBA) Hemisphere Room
7:00p	JOINT ADMINISTRATIVE BOARDS RECEPTION AND DINNER Thoroughbred Room

THURSDAY, June 23, 1988

8:00a	COTH ADMINISTRATIVE BOARD MEETING Caucus Room
12:30p	JOINT AAMC ADMINISTRATIVE BOARDS LUNCHEON Conservatory Room
1:30p	AAMC EXECUTIVE COUNCIL BUSINESS MEETING Military Room

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

WASHINGTON HILTON HOTEL
Caucus Room
June 23, 1988
8:00am-12:30pm

COTH ADMINISTRATIVE BOARD MEETING
February 25, 1988

ATTENDANCE

PRESENT

J. Robert Buchanan, MD, Chairman
Spencer Foreman, MD, Immediate Past Chairman
Gary Gambuti, Chairman Elect
Jerome H. Grossman, MD
John E. Ives
William H. Johnson, Jr.
Larry L. Mathis
James J. Mongan, MD
Charles M. O'Brien, Jr.
Max Poll
Raymond G. Schultze, MD
C. Edward Schwartz

ABSENT

William S. Alexander
AHA Representative
Leo M. Henikoff, MD
Barbara A. Small

GUESTS

John W. Colloton
D. Kay Clawson, MD
Edward Stemmler, MD

STAFF

Ivy Baer
James D. Bentley, PhD
Catherine Cahill
Linda E. Fishman
Joan Hartman-Moore
Sonia M. Kohan
Dorothy Lehrman
Nancy E. Seline
Judith L. Teich
Melissa H. Wubbold

COTH ADMINISTRATIVE BOARD
MEETING MINUTES

February 25, 1988

I. Call to Order

Dr. Buchanan brought the meeting to order at 8:00a in the Caucus Room of the Washington Hilton Hotel. He began the meeting by introducing a new staff person in the Division of Clinical Services, Ivy Baer. He briefly reviewed her history, noting her Masters degree from Harvard and her law degree from Emory University, and outlined her anticipated duties within the Division. Dr. Buchanan then noted that ordinarily he would welcome the new Administrative Board members, whose appointments were approved at the 1987 AAMC Annual Meeting, but Leo M. Henikoff, M.D. was in Europe and Max Poll, due to transportation difficulties, was not expected until later in the meeting.

II. Chairman's Report

Dr. Buchanan then called on Dr. Raymond Schultze, chairman of the 1988 COTH Spring Meeting Planning Committee, for a final update on the program for that meeting. The brochure for the meeting was distributed for the first time as a handout, and Dr. Schultze briefly revisited the program noting the major topics were to be the nursing shortage; the JCAHO's proposed new survey as viewed by COTH; AIDS; and a final overview of the progress being made by the Association, the Division of Clinical Services, and a number of their respective committees.

Mr. Gambuti and Dr. Foreman were than called upon to discuss their plans for the Thursday evening, May 12, reception. They noted that plans for the reception were in fact "in place" and that the reception was to be held in the Pegasus Suite of the Rainbow Room atop Rockefeller Center. Dr. Schultze concluded discussion of the Spring Meeting by reminding the Board of the May 11-13 dates of the meeting and encouraging all Board members to attend.

Two additional handouts were distributed; the AAMC's most recent legislative update and the President's proposed budget. Dr. Buchanan noted a proposed 6% increase for biomedical research funding, with a significant increase for AIDS research. He deemed this, and the 9% general education increase, favorable. Dr. Bentley noted, however, the budget elimination of Title VII would be undesirable.

III. Consideration of the Minutes

ACTIONS: It was moved, seconded, and carried to approve the minutes of the September 10, 1987 COTH Administrative Board Meeting.

IV. Membership Applications

ACTION: It was moved, seconded, and carried to approve the following institutions for membership in the Council of Teaching Hospitals:

ALL CHILDREN'S HOSPITAL, St. Petersburg, Florida for full membership;

CHILDREN'S HOSPITAL OF PHILADELPHIA, Philadelphia, Pennsylvania for full membership; and

VETERANS ADMINISTRATION MEDICAL CENTER, Fort Howard, Maryland for corresponding membership.

V. Resident Hours and Supervision

The Board was asked to review, modify and recommended dissemination of an AAMC policy paper concerning the appropriate supervison and number of hours to be worked by housestaff. This paper originally had been drafted in response to a series of events in New York initiated by a grand jury investigation into the death of a patient treated at a teaching hospital and culminating in a series of recommended regulatory restrictions of housestaff hours and actions performed without direct supervision. A draft of the AAMC policy paper had been presented to the Board for comment at its September meeting, and revised versions were presented to a special session of the Executive Council in November and at the AAMC officers' retreat in December.

Dr. Buchanan asked the Board members to comment freely on the draft in the Executive Council Agenda, noting that particular controversy has surrounded the recommendation to limit the number of hours residents work. Dr. Grossman wondered how the number of hours each resident worked would be monitored. Dr. Foreman stated that without a specified limit on working hours, this document would be viewed as innocuous. Mr. Gambuti and Mr. Colloton reminded their colleagues of the public's perception that appropriate care might not be rendered if the resident were suffering from overwork. They believed that the medical education community had an obligation to protect the public from unnecessary risk. Dr. Schultze noted that there was no evidence that residents working more than 80 hours per week jeopardized patients' care, but he was aware that the public was concerned. Dr. Buchanan noted that there appeared to be general consensus in favor of stipulating a maximum work week of 80 hours.

Dr. Grossman recommended altering the second recommendation in the report regarding the policies and procedures hospitals and programs should have to delegate authority to residents as they progress from performing procedures under direct supervision to a largely independent practice. He recommended alternate language as follows:

> "Teaching hospitals and residency programs should have policies and procedures specifying the level of supervision which faculty and other supervising physicians exercise over residents at each level of training."

It was felt this alternate language would preclude anyone from inferring that residents should be "credentialled" to perform each service. The Board agreed with this change.

Mr. Gambuti expressed concern regarding the wording on the section dealing with access to care. He believed inner city hospitals would find this section derogatory. Dr. Bentley replied that the intent of the passage was to make the readers aware that inner city hospitals may have difficulty conforming to these proscriptions against more than 80 hours of work by residents since, many have substantial difficulty in attracting fully credentialled physicians to practice. The Board concurred that the point could be made with less inflammatory language. Mr. Schwartz suggested that the point might be reinforced by altering the language of the final recommendation to state that support must be made available to cover all of the additional costs incurred by hospitals implementing these changes. The Board appeared to concur with this suggestion.

Dr. Bentley asked for comments on the recommendation prohibiting moonlighting. The Board agreed that limiting the number of hours worked within a residency program without restricting moonlighting would be senseless. Dr. Foreman suggested that residents be allowed to moonlight if they did not exceed 80 hours per week, averaged over four weeks. Mr. O'Brien felt that some language should be inserted to the effect that the AAMC generally discourages moonlighting, but that when done, it should be consonant with the resident's skills and knowledge. The Board debated whether the statement about the resident's skills and knowledge should be included in this document. Some felt the issue of moonlighting was a sufficiently separate issue that it should not be addresed in this paper, except to the extent of counting moonlighting hours as work hours. Others were concerned that the inclusion of a statement about moonlighting hours would be interpreted as an AAMC endorsement of moonlighting. A motion was made to include a statement

decrying moonlighting in general and suggesting a resident be allowed to moonlight only in positions for which he/she is qualified. The motion was defeated.

Mr. Colloton suggested that the section of the fourth recommendation concerning senior residents supervising more junior residents was redundant and unnecessary. The Board concurred it should be deleted.

ACTION: It was moved, seconded, and carried to recommend: (1) continued support for the specification of a maximum of 80 hours of work per week; (2) that moonlighting be included in the count of hours; (3) the section on access be modified to remove the implication of inappropriate treatment being provided; (4) the recommendation on delegating authority to residents to perform procedures be altered to delegate responsibility for appropriate supervision to faculty; (5) that the language of the clinical recommendation concerning the additional costs incurred by hospitals in implementing this change be altered to indicate that all costs should be borne by the hospitals' payers; and, (6) the reference to the responsibilities of senior resident supervising junior residents be deleted. In addition, Dr. Buchanan asked the Board for approval to appoint a delegate to any committee formed to resolve differences between the amendments suggested by the Council of Deans, the Council of Academic Societies, and the Council of Teaching Hospitals. it was moved, seconded, and unanimously approved to grant Dr. Buchanan this authority.

VI. ACGME Task Force Report

In a separate action to address the need to limit resident hours and ensure adequate supervision, an ACGME task force drafted two amendments to the General Essentials of Accredited Residency programs and a set of other recommendations. The amendments suggested: (1) specific services hospitals must provide (e.g., phlebotomy services, laboratory and radiology information retrieval services) and lounge and food facilities for residents while on duty or on call; (2) modifications to the existing essentials that clearly specify supervisory responsibility. Several members of the Board indicated their vehement opposition to the specification of hospital staffing and operational decisions as contained in the first proposed revision to the General Essentials.

ACTION: The Board voted to delete the proposed amendments that specified the facilities and resources to be supplied in support of residents. The remainder of the document was accepted.

VII. Statement on Professioinal Responsibility (AIDS)

The Board was asked to review a policy statement on professional responsibility drafted by the AAMC's Committee on AIDS and the Academic Medical Center (Executive Council Agenda, pg. 91). The draft policy underscored the responsibility of the physicians, medical students, and residents to render care to the ill despite any personal jeopardy; set forth responsibilities for faculty and administration to provide information, appropriate facilities, and equipment to minimize the health care giver's risk; and delineated the need for access to disability and life insurance coverage.

ACTION: After making some changes in the text of the statement, the Board adopted the statement. The changes did the following: removed references to negative attitudes toward persons at risk for acquiring AIDS; softened a sentence about the extent of the risk of physicians acquiring AIDS; added teaching hospitals to medical school faculty and administration as those having responsibility for this issue; and added "access to health insurance" to "accesss to disability coverage and life insurance."

VIII. IMSP Bylaws

The Board was asked to ratify a set of bylaws for the International Medical Scholars Program (IMSP) in which the AAMC had agreed to participate following discusssion at the previous Executive Council meeting.

ACTION: The Board voted unanimously to approve the bylaws.

IX. Health Manpower Act

Board members were asked to consider a series of staff recommendations concerning federal health manpower programs in Title VII of the Public Health Service Act. AAMC staff requested the Board's direction because legislation to reauthorize Title VII will be introduced by Senator Kennedy and is expected to contain significant changes in some of the programs, mainly those for under-represented minorities and the categorical training programs in primary care.

The discussion centered on two issues: federal funding for student loan programs and the extent to which funds intended to increase the access of the economically disadvantaged to medical education should be devoted to assuring minority group access. Board members favored support of primary care training, but in view of limited funds and significant need, did not believe podiatrists should be considered primary care practitioners.

With regard to ensuring both majority and minority applicants equal access to medical education, Board members emphasized that these programs need to be perceived as being even-handed in their distribution of funds, but recognized that there are serious problems in attracting the qualified minority applicants. Mr. Gambuti summarized by saying that 1) medical education is expensive; 2) the profession needs and wants more minorities; 3) both majority and minority economically disadvantaged applicants should have access to medical education; and 4) since medical schools apeared to have difficulty recruiting minority applicants, the reasons for the lack of minority applicants should be routinely assessed, and if the lack of available financial support is a cause, special action should be taken to make a greater proportion of the federal support available to minority disadvantaged applicants.

Board members asked if nursing education was benefited under this same Title of the Public Health Services Act. In light of the severe effects of the nursing shortage on many hospitals, the Board members were eager to ensure adequate support for nursing education. Staff was unaware of which title provided support to nursing students and nursing education programs, but promised to find out more about the issue. Dr. Grossman proposed that the Board address the nursing shortage separately at a future meeting.

ACTION: It was moved, seconded, and carried to support funding for primary care. The Board gave authority to the Chair to express their concerns regarding podiatrists and support for minority disadvantaged students at the Executive Council Meeting.

X. Intramural Research at NIH

Board members were asked to formulate their views on whether to support a comprehensive examination of the NIH intramural research program, with the understanding that one of the outcomes might be to privatize the function. Dr. Buchanan pointed out that endorsement of a study presented little risk, but that a second and larger issue was the Board's reaction to the notion of privatization. After general discussion Dr. Buchanan summarized that the Board believes the privatization of the intramural research program would be unwise, but would not want to prejudice a national study of all options for improving the NIH at its inception.

ACTION: It was moved, seconded, and carried that it be recommended to support the study to improve the intramural research function at NIH without making prejudicial statements about the option to privatize NIH at this juncture.

XI. Request from OSR

Dr. Buchanan raised one additional item of business not on the agenda. He had received a request from the Chair of the Organization of Student Representatives for a member of that group to be given permission to attend the meetings of the Council of Teaching Hospitals Administrative Board on a regular basis so that the OSR can be aware of the COTH's concerns on issues of interest to students. Dr. Buchanan asked the Board members how they felt about this request. Mr. Mathis indicated that he preferred that the Board meetings remain open so that any interested party could attend as an observer. The other Board members generally concurred with this statement, noting that if there was an issue that should not be discussed in the open, the Board could go into Executive Session.

Dr. Buchanan concurred with the other Board members but suggested that it might be appropriate to contact the Council of Deans to notify them of the request and intended response of the COTH Board prior to notifying the OSR chair since the OSR reports to the Council of Deans.

XII. Adjournment

There being no further business, the meeting was adjourned at 12:30p.

MEMBERSHIP APPLICATIONS

The following institutions have submitted membership applications for the AAMC Council of Teaching Hospitals to the COTH Administrative Board for consideration.

CHILDREN'S HOSPITAL OF THE KING'S DAUGHTERS
Norfolk, Virginia
RECOMMENDATION: Full Membership

INGHAM MEDICAL CENTER
Lansing, Michigan
RECOMMENDATION: Full Membership

TULANE MEDICAL CENTER
New Orleans, Louisian
RECOMMENDATION: Full Membership

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: Children's Hospital of The King's Daughters

Hospital Address: (Street) 800 West Olney Road

(City) Norfolk (State) Virginia (Zip) 23507

(Area Code)/Telephone Number: (804) 628-7700

Name of Hospital's Chief Executive Officer: Stephen S. Perry, Jr.

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): 144

Average Daily Census: 101.2

Total Live Births: N/A

Residential Psyc Beds 72

Managed Peds Beds 78

Admissions: 5,526

Visits: Emergency Room: N/A

Visits: Outpatient or Clinic 39,532

Home Health 9,883

Ambulatory Surgery 1,573

Physical Therapy 3,252

B. Financial Data

Total Operating Expenses: $34,858,922

Total Payroll Expenses: $16,004,437

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $1,058,099 Resident Fees
Supervising Faculty: $715,111 Physician Fees

C. Staffing Data

Number of Personnel: Full-Time: 638
Part-Time: 363

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 180
With Medical School Faculty Appointments: 40*

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

Pediatrics, Pathology, Infectious Disease, Gastroenterology
Neonatology, Anesthesiology, Nephrology, Endocrinology
Neurology, Cardiology, Intensivology, Psychology

Does the hospital have a full-time salaried Director of Medical Education?: F. Stanley Porter, M.D., Vice President for Medical Affairs, has this function.

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine			
Surgery			
Ob-Gyn			
Pediatrics	58	58	Required
Family Practice			
Psychiatry			
Other:			

* 40 Physicians have Full-Time Faculty Appointments with the medical school. The majority of the rest of the active staff have adjunct clinical faculty appointments.

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine				
Surgery	2			
Ob-Gyn				
Pediatrics	31	26	5	1962
Family Practice	1			
Psychiatry				
Other:				
Orthopedics	1	1		
Urology	2	2		
Ophthalmology	.5	.5		
ENT	2	2		
Plastic Surgery	1	1		
Neurosurgery	1	1		

[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: The Eastern Virginia Medical School of The Medical College of Hampton Roads

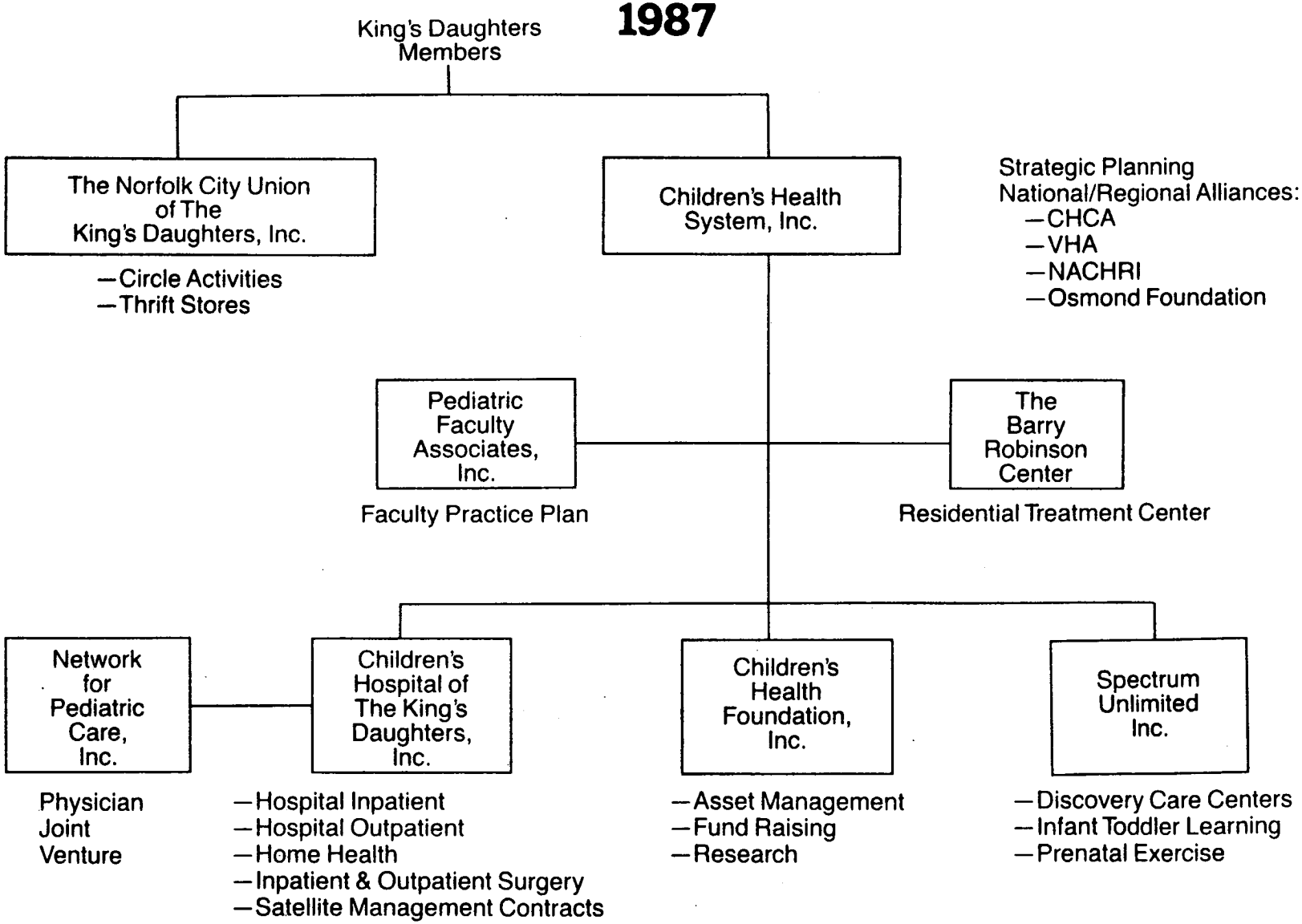
Dean of Affiliated Medical School: Richard G. Lester, M.D.

Information Submitted by: (Name) Kendra M. Bradshaw

(Title) Senior Executive Secretary

Signature of Hospital's Chief Executive Officer: [signature] (Date) 3/29/88

Children's Health System Corporation Structure 1987



EASTERN VIRGINIA MEDICAL SCHOOL
POST OFFICE BOX 1980
NORFOLK, VIRGINIA 23501

OFFICE OF THE DEAN

TELEPHONE (804) 446-5800

March 15, 1988

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

Dear Council:

This letter is written in strong support of the application being made by the Children's Hospital of the King's Daughters in Norfolk, Virginia for membership in the Council of Teaching Hospitals. The Children's Hospital is the major educational focus for our medical school's pediatric programs. It is the primary location for the third year pediatric clerkship for our medical students. A variety of electives are centered at the Children's Hospital. The pediatric residency program has its major locus at that institution. Other residency programs (e.g. surgery, radiology) also use the CHKD for their programs as these relate to diseases of children.

Our full-time pediatric faculty are largely housed in facilities made available by CHKD. This faculty is responsible for the referral practice of pediatrics, for the operation of the outpatient facilities of the Children's Hospital and for the educational programs for both undergraduate medical students and postgraduate residents.

The relationship between the Children's Hospital of the King's Daughters and the Eastern Virginia Medical School is defined by a formal Affiliation Agreement between our institutions. The importance of CHKD to our educational programs is of the highest magnitude.

It is a pleasure for me to recommend that the Children's Hospital of the King's Daughters be admitted to membership in the Council of Teaching Hospitals.

Sincerely,

Richard G. Lester, M.D.
Dean and Vice President for
Academic Affairs

RGL/ndb 3-16

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: Ingham Medical Center

Hospital Address: (Street) 401 W. Greenlawn

(City) Lansing (State) MI (Zip) 48910

(Area Code)/Telephone Number: (517) 334-2320

Name of Hospital's Chief Executive Officer: Edward B. McRee

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): 258

Average Daily Census: 166

Total Live Births: 0

Admissions: 10,419

Visits: Emergency Room: 30,586

Visits: Outpatient or Clinic 54,261

B. Financial Data

Total Operating Expenses: $ 59,913,961

Total Payroll Expenses: $ 28,934,434

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 924,809
Supervising Faculty: $ 187,772

C. Staffing Data

Number of Personnel: Full-Time: 1,059
Part-Time: 478

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 462
With Medical School Faculty Appointments: 146

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

Emergency Medicine Anesthesia

Pathology

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	35	27	Required
Surgery	40	32	Required
Ob-Gyn	0		
Pediatrics	20	13	Required
Family Practice			
Psychiatry	5	1	Elective
Other: Cardiology, GI,	?	31	Elective
Pulmonary, Neurology,			
Pediatric Specialties,			
Orthopedics, etc.			

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				
[3] Medicine	24	24	0	1971
Surgery				
Ob-Gyn				
[3] Pediatrics	20	16	4	1973
[4] Family Practice	6	6	0	1985
Psychiatry				
[5] Other: Pulmonary	3	2	1	1976
Pediatric Pulmonary	2	2	0	1985
Gastro-enterology	2	2	0	1986
Oncology	3	3	0	1980
Infectious Disease	1	1	0	1986

[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.

[3]Through Michigan State University Affiliated Hospitals (Graduate Medical Education, Inc.).

[4]College of Osteopathic Medicine, Michigan State University

[5]Michigan State University Affiliated Hospitals based at Ingham Medical Center.

IV. SUPPLEMENTARY INFORMATION

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

(See Attached)

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: Michigan State University College of Human Medicine

Dean of Affiliated Medical School: W. Donald Weston, M.D.

Information Submitted by: (Name) Samuel M. McMahon, M.D.

(Title) Vice President of Medical Affairs

Signature of Hospital's Chief Executive Officer:

(Date) February 25, 1988

MICHIGAN STATE UNIVERSITY

COLLEGE OF HUMAN MEDICINE • OFFICE OF THE DEAN
EAST FEE HALL

EAST LANSING • MICHIGAN • 48824-1316

February 29, 1988

James Bentley, Ph.D.
Vice President
Division of Clinical Services
Association of American Medical Colleges
Council of Teaching Hospitals
ONE Dupont Circle, NW
Suite 200
Washington, D.C. 20036

Dear Jim:

I am writing this letter as Dean of the College of Human Medicine at Michigan State University in support of the application of Ingham Medical Center in Lansing for membership on the Council of Teaching Hospitals.

Ingham Medical Center has worked closely with the College of Human Medicine in its education mission as long as this college has been in existence. It has been a particularly strong supporter of our teaching programs in the fields of Internal Medicine and Pediatrics. Ingham Medical Center is a full partner in Graduate Medical Education, Inc., which is a partnership of this medical school with community hospitals for education in Internal Medicine and Pediatrics. The Ingham Medical Center has also supported fellowships in Pulmonary Medicine, Pediatric Pulmonary Medicine, Hematology/Oncology, Infectious Disease, and Gastroenterology. Fellows in these later specialties are based at Ingham Medical, as are the university teaching services in each of these sub-specialty fields.

The Ingham Medical Center has also worked closely with our Department of Surgery in developing a surgical residency in the mid 1970's and, more recently, in aiding the development of a new surgical residency which is currently accredited to McLaren Hospital in Flint, Michigan, but which will come under the umbrella of Michigan State University Department of Surgery.

Members of our faculty have always felt welcome at Ingham Medical Center, and are accepted there as full participants in its medical staff. I am pleased to have this opportunity to recommend the Ingham Medical Center as a member of the Council of Teaching Hospitals.

Sincerely,

W. Donald Weston, M.D.
Dean

WDW:lms

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Tulane Medical Center Hospital

Hospital Address: (Street) 1415 Tulane Avenue

(City) New Orleans (State) LA (Zip) 70112

(Area Code)/Telephone Number: (504) 588-5263

Name of Hospital's Chief ~~Executive~~ Administrative Officer: Bernard C. Rudegeair

Title of Hospital's Chief ~~Executive~~ Administrative Officer: Assistant Vice President for Hospital Affairs

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

Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	290	Admissions:		69,175
Average Daily Census:	191.0	Visits:	Emergency Room:	13,880
Total Live Births:	307	Visits:	Outpatient or Clinic	157,000

B. Financial Data

Total Operating Expenses: $ 60,464,000

Total Payroll Expenses: $ 33,167,000

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 165,000
Supervising Faculty: $1,803,386

C. Staffing Data

Number of Personnel: Full-Time: 1,300
Part-Time: 200

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 224
With Medical School Faculty Appointments: 224

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

Psychiatry (2) | Clinical Lab (4) | Pediatric Cardiology (1)

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	7	63	6 - Elective 1 - Required
Surgery (1)	7	30	6 - Elective 1 - Required
Ob-Gyn			
Pediatrics	7	13	6 - Elective 1 - Required
Family Practice			
Psychiatry (2)	3	9	3 - Elective
Other: Anesthesiology	1	19	1 - Elective
Pathology	1	4	1 - Elective
Radiology	1	60	1 - Elective

(1) Includes Ophthalmology, etc.
(2) Includes Neurology

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	3	2	1	11/9/87
Surgery	9	8	1	7/16/87
Ob-Gyn	3	3	0	2/4/87
Pediatrics	13	11	2	11/25/85
Family Practice				
Psychiatry	5	5	0	12/5/85
Other: Anesthesiology	14	13	1	5/12/87
Dermatology	1	1	0	1/6/87
Neurology	3	3	0	11/11/83
Ophthalmology	4	4	0	1/10/86
Orthopaedic Surgery	4	3	1	7/25/85
Otolaryngology	2	2	0	11/8/85

[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.

Thoracic Surgery	1	1	1	12/3/87
Pathology	2	2	0	5/24/83
Plastic Surgery	1	1	0	6/10/87
Psychiatriy (Child)	7	5	2	12/5/85
Radiology	10	10	0	5/23/86
Urology	2	2	0	4/5/85

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: Tulane Medical Center

Dean of Affiliated Medical School: James Hamlin, M.D.

Information Submitted by: (Name) Bernard C. Rudegeair

(Title) Assistant Vice President for Hospital Affairs

Signature of Hospital's Chief Executive Officer:

Bernard C. Rudegeair (Date) 2/24/88

Tulane University Medical Center

School of Medicine
1430 Tulane Avenue
New Orleans, Louisiana 70112
(504) 588-5462

Office of the Dean

February 22, 1988

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

Dear Dr. Bentley:

I am writing in support of the application for membership in the Council of Teaching Hospitals by Tulane University Hospital.

The university hospital is wholly owned by Tulane University and is an integral part of the Tulane Medical Center, which is made up of the hospital, the School of Medicine, the School of Public Health and the Delta Primate Center. This hospital represents the primary hospital of the School of Medicine for its faculty practice plan and is completely staffed by the faculty of Tulane School of Medicine. It serves as a teaching hospital for all of the residencies in our training program and is one of the three main teaching hospitals utilized for our medical student training. It also provides a clinical base for research programs in many of our clinical departments. The hospital is fully accredited by the JCAH.

Membership in the Council of Teaching Hospitals will be extremely important to the future of the teaching and training programs of the School of Medicine. The administration of the hospital looks forward with enthusiasm to an active participation in the programs of the Council.

Sincerely yours,

James T. Hamlin III, M.D.
Dean

JTH/nb

COTH SPRING MEETING FOLLOWUP
Criteria for the Spring Meeting

Background

The COTH Spring Meeting was started in 1977 and has now been held in eleven different cities (see attachment A). The meeting has been attended generally by about 175 COTH representatives (the 1987 meeting in Dallas had a very low attendance of 120.) While the formal attendance policy is to invite the CEO and allow him to bring a guest but not send a substitute, it is the staff impression that the meeting is attracting fewer CEOs and more COOs from academic medical centers and an increasing number of vice presidents for medical or academic affairs from affiliated community hospitals.

The shift in attendance patterns raises questions about the criteria which should be used to plan and evaluate the success of the COTH Spring Meeting. Clearly, the meeting serves a number of purposes. It:

- o provides a continuing education program of speakers for senior executives in member hospitals;
- o provides, or could provide, an opportunity for members to participate in discussion sessions with each other of critical issues facing major teaching hospitals;
- o provides an informal setting for members to renew acquaintances and exchange ideas;
- o bridges the several competing hospital alliances and helps create a community of interest in academic medicine;
- o provides an opportunity for affiliated hospital executives to meet with academic medical center CEOs, and
- o provides an opportunity for senior AAMC and selected staff associates to meet with COTH members on an extended basis.

With these several purposes (and perhaps others), the meeting has been planned annually by a special committee generally chaired by an Administrative Board member. The committee identifies preferred topics and, if possible, suggests speakers. Staff then identify all speakers, confirm them with the planning committee chairman and announce the meeting. While each year produces its own crop of both successful and disappointing speakers, member reactions to topics are often contradictory: topic A is liked by some and seen as too operational or dated by others.

The 1989 Spring Meeting will be held at the Hotel del Coronado in San Diego. This requires many members to make a major commitment in travel time. Similarly, speaker costs increase with a west coast meeting and the registration fee will probably be increased above the current $250. With a significant dues increase proposed about the time of the meeting, a good meeting could stimulate support for COTH and the AAMC; a poor meeting could lead to member dropouts.

Discussions

Given the several considerations raised above, the Board is requested to discuss and provide staff with guidance on the following questions:

- o What are the primary goals of the COTH Spring Meeting?
- o How should the success of the meeting be measured?
- o Should the meeting be planned by a special committee or by the Administrative Board during the AAMC annual meeting in November?
- o Should the meeting invitation be expanded to include COOs and/or vice presidents for medical affairs?

COTH SPRING MEETINGS

1978-1990

1978	St. Louis, MO
1979	Kansas City, MO
1980	Denver, CO
1981	Atlanta, GA
1982	Boston, MA
1983	New Orleans, LA
1984	Baltimore, MD
1985	San Francisco, CA
1986	Philadelphia, PA
1987	Dallas, TX
1988	New York, NY
1989	San Diego, CA (May 10-12)
1990	Boston, MA (May 9-11)

SPRING MEETING FOLLOWUP:
Joint Commission Experiment

Background

For the past decade, academic medical center hospitals have complained repeatedly about the surveys and decisions of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO). In the mid-seventies, many of the complaints resulted from JCAHO concerns about the outdated facilities of many academic medical center hospitals and about the failure of university trustees to exercise the traditional board functions of a free-standing hospital. As a result of major building projects, the JCAHO complaints about facilities have declined. JCAHO orientation programs for surveyor personnel have reduced complaints about the governance of university-owned hospitals. Now, hospital and faculty complaints about the JCAHO are focused on a more serious issue: JCAHO concerns with quality assessment (QA) activities of medical center hospitals.

In 1984, the JCAHO did a small, informal study of the objections of medical center hospitals. They found hospitals and faculties expressed the following:

- o academic medical center hospitals were upset that the JCAHO granted a longer accreditation period to some "second-rate" community hospitals than to medical center hospitals,
- o the JCAHO gave no recognition to the teaching process of the academic medical centers as an alternative quality assurance mechanism,
- o the JCAHO emphasis on committees and recorded minutes was not adapted to the "full-time medical staff" model of the academic medical center, and
- o JCAHO surveyors were not viewed as capable of questioning or judging care provided by expert faculty in academic medical center hospitals.

In response to the JCAHO findings, the COTH Administrative Board met with JCAHO representatives twice in 1984. The discussions were mutually beneficial.

As a result of the COTH-JCAHO discussions, the JCAHO appointed a special committee of medical center staff to address the problems of accrediting medical center hospitals. The committee, whose membership is shown in Attachment A, met twice in 1985 and recommended JCAHO make a serious study of the degree to which the academic medical center hospital's processes for education and research address the JCAHO concerns with quality assessment.

The JCAHO has now completed the requested study of academic medical center hospitals. It concluded that academic medical center hospitals have a low level of compliance with JCAHO medical staff standards for quality assessment. It recommended developing a pilot project to identify and measure the distinctive quality enhancing features of these hospitals, but called for full compliance with quality assessment standards for common diagnoses and treatment.

Discussion

At the 1988 COTH Spring Meeting, Donald Avant from the JCAHO and Paul Sanzaro, M.D., a JCAHO consultant, reported on the project's development and first trial phase. A copy of the handout given to meeting attendees is included as Attachment B. Following the JCAHO presentation, Barbara McNeil, M.D., a special JCAHO surveyor; Durwood Bradley, M.D., chief of staff at the University of Alabama Hospital; and John Reinertsen, Executive Director of the University of Utah Hospital presented their views as participants in the first project trial. All questioned whether the hospital's benefit from the project was worth the cost in time and effort. Similarly, the staff perception of the attitude of the Spring Meeting attendees was that the benefit of the JCAHO special project was not worth the effort. Therefore, the COTH Administrative Board is requested to discuss the following issues:

1. Is there a consensus among board members about the benefit, or lack thereof, of the present JCAHO project on academic medical center hospitals?

2. What actions does the Board recommend AAMC staff take regarding the JCAHO project:

    a. support JCAHO effort to continue with its trial and evaluation and work to ensure that the approach remains an option at the discretion of the hospital;

    b. monitor carefully the second trial of the project scheduled for late this year and report to the COTH Board in February;

    c. meet with JCAHO staff in an effort to modify the project and field trial in a specific way; or

    d. meet with JCAHO staff in an effort to halt further activity.

Attachment A

JOINT COMMISSION ON THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS

Study to determine whether an academic health center's involvement in research and teaching represents an effective mechanism for systematic Quality Assurance.

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Joint Commission
on Accreditation of Healthcare Organizations

A Modified Survey Process in Academic Health Centers

In 1986, a special study of 17 academic health centers (AHC) identified certain teaching and research activities that could be interpreted as meeting the intent of the Joint Commission standard on monitoring and evaluation of quality and appropriateness (M&E), i.e., improving the quality and appropriateness of care for participating patients and future patients presenting with similar conditions.

In 1987, a limited test of provisional guidelines for a modified survey process was conducted. The results of this test indicated that it would be feasible to evaluate whether specified AHC teaching and research activities met the intent of M&E.

In November-December 1988, the Joint Commission will pilot test a modified survey process for academic health centers. A proposed DRAFT Protocol for Modified Survey Process in Academic Health Centers is attached.

875 North Michigan Avenue
Chicago, Illinois 60611
312/642-6061

DRAFT

PROTOCOL FOR MODIFIED SURVEY PROCESS IN ACADEMIC HEALTH CENTERS

1. The Joint Commission has determined that certain teaching, research and patient care activities that are uniquely pervasive and well-developed in academic health centers (AHC) should be considered in assessing compliance with the Commission's standards on monitoring and evaluation of quality and appropriateness of patient care and clinical performance (M&E). To this end, the Commission has developed a modified survey process (MSP) for AHC that will supplement the existing survey procedure and scoring guidelines by evaluating the degree to which certain specified activities of clinical departments and services meet the requirements for M&E. The specific standards in the Accreditation Manual for Hospitals that are addressed by the MSP are MS.6.1.1; DR.4; ER.9; HO.7; NM.4; PA.7; RA.4; RP.6; SP.6; SA.5.

2. In the MSP, Joint Commission surveyors will continue to follow the existing survey process and scoring guidelines. The survey team will be joined by a consultant surveyor with current academic background. This surveyor will examine specified AHC activities conducted by major clinical departments and services and determine the extent to which the activities achieve the intent of the Joint Commission standard on M&E. The central consideration in this determination is demonstrable clinical benefit conferred on participating patients or made available for future patients who present similar conditions or problems.

3. The modified survey process applies to Departments of Medicine, Surgery, Obstetrics-Gynecology, Pediatrics and Psychiatry; other clinical departments designated as major by the AHC on the basis of large numbers of discharges per year; and medically-directed support services: Anesthesia, Diagnostic radiology, Emergency, Hospital-sponsored ambulatory care; Nuclear medicine; Pathology and Medical laboratory; Radiation oncology; Respiratory care; and Special care units.

4. Approximately six months prior to the accreditation survey, the AHC will be requested to provide certain materials and information required for the MSP. These pertain to the following specific activities:

A. Clinical research and clinically-oriented bench and epidemiological research.

B. Decision-making multispecialty patient care conferences.

C. Management of patients by subsubspecialists.

D. Multiple independent working consultations on patients.

E. Expert consensus in clinical interpretations.

F. Concurrent or prospective control mechanisms which assure quality.

DRAFT

Certain utilization data will also be requested (see 7 below).

The requested materials are to be forwarded to the Joint Commission as soon as feasible and well before the scheduled survey dates to allow the consultant surveyor sufficient time to review them prior to the actual site visit.

5. The materials pertaining to clinical research are best compiled by each department and service. Each should forward the following:

   A. A complete list of papers published by the faculty of the respective departments and services in the preceding 24 months, reporting the results of clinical research and other types of clinically oriented research.

   B. Reprints (or copies) up to a total of 100 or a 10% sample of all titles, whichever is the larger number.

   C. Abstracts of all clinical research projects currently underway but not yet published.

6. The AHC is also requested to provide the following:

   A. A compilation of all patient care conferences in which at least three specialties or subspecialties are represented for the purpose of making clinical decisions and for which the following summary data are available: frequency and number per year; subspecialties of faculty in attendance; number of patients seen and the conditions or problems presented; decisions made; follow-up reports on outcomes.

   B. A description of the main settings for "subsubspecialty" care:

      1. A listing of all specialized centers and the number of discharges per year, e.g., clinical research center; trauma center; AIDS center; spinal rehabilitation; neuro intensive care; neonatal intensive care; and the like.

      2. A listing of all highly subspecialized services, inpatient and outpatient, and the total number of patients receiving each per year, e.g., cardiac, liver or bone marrow transplants; in vitro fertilization; management of infection in immunosuppressed patients; inserting cardiac conduits; implanting artificial organs; consultation on such disorders as coagulopathy in pregnant women, severe or refractory forms of rheumatoid arthritis, ventricular arrhythmias, and the like.

   C. The total number of inpatients in the preceding 12 months who received three or more working consultations for their main clinical problem.

D. Listing of all services in which diagnoses or interpretations are made routinely through consensus of faculty, e.g., in diagnostic imaging and in pathology, and the estimated proportion of interpretations that is made by consensus.

E. Listing of all prospective or concurrent control mechanisms, e.g., required prior approval for use of special blood products or components, or designated antibiotics; mandatory second faculty consultation prior to elective surgery; mandatory faculty review of all high risk obstetric or pediatric cases.

7. Each AHC is also requested to provide the following data:

A. Number of discharges from each of the major clinical departments in the preceding 12 and 24 months.

B. Number of hospital discharges in preceding 12 and 24 months.

C. Number of inpatients transferred to a clinical department from another hospital in the preceding 12 months.

8. Communications between the Joint Commission and the AHC regarding the modified survey process and exchange of materials will be handled through a designated office. Consultation will be available through this office regarding interpretation of the requests for presurvey materials and information. The designated office will notify the AHC of any requests by the consultant surveyor for additional information or clarification of materials already provided.

9. During the actual survey, the consultant surveyor responsible for the MSP will visit clinical departments and support services as may be necessary to confirm and amplify the information that was received and reviewed prior to the survey. The schedule for these visits will be discussed at the opening conference.

10. The consultant surveyor will report his or her findings and conclusions to the Joint Commission physician surveyor who will include these in arriving at the compliance score for M&E in the clinical departments (MS.6.1.1) and in the medically directed support services (DR.4, ER.9, HO.7, NM.4, PA.7, RA.4, RP.6, SP.6, SA.5).

SPRING MEETING FOLLOWUP:
The Supply of Nurses

Background

At its September 1987 and February 1988 meetings, the COTH Administrative Board, in unstructured discussion, identified the present and growing shortage of nurses as a critical issue for teaching hospitals. With the supply of nurses already less than the demand and with the number of high school graduates falling for the next several years, the present nurse shortage may be protracted.

While the nursing shortage is a major problem for many COTH member hospitals, AAMC staff have identified only limited roles for the Association: (1) maintaining an open and supportive relationship with the American Association of Colleges of Nursing, (2) ensuring our testimony on behalf of medical education programs and funding do not undermine equally important nursing programs and funding, and (3) repeatedly agreeing to retain the Medicare passthrough for nursing and allied health programs. In light of these on-going actions, the Board is requested to discuss what, if any, role should the AAMC pursue to address the nursing shortage?

At the 1988 COTH Spring Meeting, four presentations and four breakout sessions on nursing supply were held. While some of the presentations were not what was expected, three of the breakout sessions were well attended and participants in all four sessions reported a stimulating exchange of ideas. During the presentations and breakout sessions, staff made a conscious effort to listen for ideas on the supply of nurses that the AAMC could or should consider; however, the breakout session discussions focused primarily on local hospital operating issues which are not appropriate for a national association.

Discussion

The Board is requested to suggest what, if any, role the AAMC should explore to address the nursing shortage.