

AGENDA

COTH ADMINISTRATIVE BOARD MEETING
ENVOY C
Embassy Row Hotel
2016 Massachusetts Avenue
Washington, D.C.
May 18, 1972

- I. Call to Order - 9:00 a.m.
- II. Approval of Minutes, Meeting of February 4, 1972 TAB A
- III. Recent Developments in Graduate Medical Education-Dr. Cooper
- A) Accreditation TAB B
- B) Studies of Cost and Financing
- IV. Membership
- A) Applications Received Since February Moratorium TAB C
- 1) Riverside Methodist Hospital, Columbus, Ohio
- 2) Community Hospital of Indianapolis, Inc., Indianapolis, Indiana
- B) Current Status of St. Joseph Infirmary TAB D
- C) Review of the Charge to the COH Membership - Criteria Committee Pg. 3 of minutes
- D) Dues Report TAB E
- V. Progress Report
- A) HMO Grant TAB F
- B) National Health Service Corps Negotiations
- C) Prison Health Care TAB G
- VI. Management Advancement Program - Dr. Wilson TAB H
- VII. COH Annual Meeting Program
- AAMC THEME: "From Medical School to Academic Health Center" TAB I
- VIII. JCAH Requirements and the University Owned or Operated Teaching Hospital TAB J
- IX. Legislative Report TAB K

*Pg. 11 of minutes
we were asked to
approve the pass.
is working w/
the JCAH*

X. Items Referred From AAMC Executive Council

A) Organization of Sub-Council Activities

TAB L

XI. New Business

XII. Adjournment

COTH ADMINISTRATIVE BOARD MEETING

Parlor A
Palmer House
Chicago, Illinois
February 4, 1972

Present:

George E. Cartmill, Chairman ✓
Irvin G. Wilmot, Immediate Past Chairman ✓
John H. Westerman, Secretary ✓
Robert A. Derzon ✓
David D. Thompson, M.D. ✓
Don L. Arnwine ✓
Herluf V. Olsen, Jr. ✓
Stuart M. Sessoms, M.D. ✓
Edward J. Connors
Joe S. Greathouse, Jr. ✓
Thomas H. Ainsworth, Jr., M.D., AHA Representative

Staff:

Grace W. Beirne
John M. Danielson
Robert H. Kalinowski, M.D.
Richard M. Knapp, Ph.D.
Catharine A. Rivera

I. Call to Order

Mr. Cartmill called the meeting to order at 9:00 a.m. in Parlor A of the Palmer House.

II. Consideration of Minutes

The Minutes of the meeting of October 28, 1971 were approved as distributed.

III. Membership

A) Communication from the Associated Medical Schools of Greater New York.

Mr. Danielson reviewed the historical development of the Associated Medical Schools of New York, and described the origin of the document received from that organization. On January 25, 1972, Mr. Danielson and Dr. Kalinowski met with the group in New York City to discuss the matter.

A number of points were made regarding the underlying implications of the communication:

1) The Task Force on COTH Goals and Objectives recommended the criterion of "Appropriate Affiliation", and left it undefined.

2) A more precise definition of a "teaching Hospital" is crucial for the future.

3) There are no judgmental criteria at the present time. We are forced to rely on AMA residency review or a dean's recommendation. This procedure automatically excludes osteopathic institutions.

4) If it were not for the current third party financing difficulties the issue would probably not be quite so acute. Since reimbursement is the major concern, the problem is really one of classifying teaching hospitals for reimbursement purposes.

5) It is difficult to establish membership criteria without a better articulation of AAMC Goals and Objectives.

6) Given the present trend in affiliation, COTH membership could exceed 1,000 if the definition of affiliation is not tightened. It is undesirable to approach the size and duplicate the function of the AHA.

7) Three important matters:

- a) What are the implications for the AAMC of having a large number ^{or} ~~of~~ a small number of hospital members?
- b) What are the implications for the hospital?
- c) If we fail to address the problem now, the issue will get tougher in the future.

Following further discussion, there was general consensus that changes in the criteria for COTH membership are necessary.

ACTION #1

IT WAS MOVED, SECONDED AND CARRIED THAT A MORATORIUM BE DECLARED ON NEW APPLICATIONS FOR COTH MEMBERSHIP. THE CHAIRMAN WAS DIRECTED TO ACTIVATE A COMMITTEE WITH THE FOLLOWING CHARGE:

A) TO EXAMINE THE INSTITUTIONAL CHARACTERISTICS OF THE PRESENT COTH MEMBERSHIP.

B) TO EXAMINE THE CURRENT CRITERIA FOR MEMBERSHIP, AND MAKE RECOMMENDATIONS FOR DESIRABLE CHANGES FOR THE FUTURE.

C) TO EXAMINE THE SELECTION PROCESS INCLUDING THE POSSIBILITY OF MOVING TOWARD SOME FORM OF INSTITUTIONAL EVALUATION AND REVIEW.

At this time, there was also discussion of the favorable aspects of including a hospital director on the medical school accreditation teams.

B) Mail Ballot Confirmation

ACTION #2

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING TWO APPLICATIONS FOR MEMBERSHIP IN COTH BE APPROVED AND SENT TO THE EXECUTIVE COUNCIL FOR ACTION:

1) HOSPITAL FOR JOINT DISEASES AND MEDICAL CENTER, NEW YORK CITY

2) VETERANS ADMINISTRATION HOSPITAL, DENVER, COLORADO.

ACTION #3

IT WAS MOVED, SECONDED AND CARRIED THAT THE FOLLOWING APPLICATION FOR MEMBERSHIP IN COTH BE REJECTED:

THE BUTLER HOSPITAL, PROVIDENCE, R.I.

C) St. Joseph Infirmary

In June of 1970, St. Joseph Infirmary was purchased by Extendicare, Inc.

ACTION #4 IT WAS MOVED, SECONDED AND CARRIED THAT THE STAFF BE DIRECTED TO REVIEW THE CORPORATE STATUS OF ST. JOSEPH INFIRMARY IN LOUISVILLE, KENTUCKY. IF THE HOSPITAL NO LONGER FUNCTIONS UNDER 501 (C)(3) CORPORATE STATUS, ACTION SHOULD BE TAKEN, WITH THE AID OF AAMC LEGAL COUNSEL, TO REVOKE MEMBERSHIP IN COTH.

IV. Items Referred From AAMC Executive Council

A) Eliminating the Freestanding Internship

Mr. Danielson reported that an AAMC Committee On Graduate Medical Education is being established, and that COTH would be requested to suggest individuals who could serve on the committee.

Following discussion, there was general consensus that the "Policy Statement" was appropriate.

ACTION #5 IT WAS MOVED, SECONDED AND CARRIED THAT THE COTH ADMINISTRATIVE BOARD APPROVE THE "POLICY STATEMENT ON ELIMINATING THE FREESTANDING INTERNSHIP"

B) Faculty Representation In the AAMC

Mr. Cartmill recalled that at the February 13, 1971 meeting of the AAMC, the following resolution was passed:

Be it resolved by the Assembly of the AAMC that there be an organization of the faculties of the member institutions represented in the governance of the Association. Therefore, the Assembly directs the Chairman and the President of the AAMC together with such other officers of the Association as the Chairman may designate, to meet with appropriate faculty representatives as well as the Executive Committees of the COD, CAS and the COTH to work out a proposed

organizational arrangement for this purpose to be presented to the Executive Council at its next meeting and to be incorporated in Bylaw revisions for presentation to the AAMC Assembly at the Annual Meeting in November, 1971.

The presentation in the Agenda book outlines discussion of the matter at the December 2-4, 1971 officers retreat.

One member stated the position that the objective should be the full integration of faculty into the AAMC. There was not unanimous agreement with this objective. A number of issues were raised including the fact that deans and hospital directors represent institutions. The question is how do faculty representatives fit into this framework. At this point in the discussion a motion was offered.

ACTION #6 IT WAS MOVED, SECONDED AND CARRIED THAT THE
COTH ADMINISTRATIVE BOARD FAVOR EFFECTIVE
REPRESENTATION OF MEDICAL FACULTY IN THE
GOVERNANCE OF THE AAMC; HOWEVER, THE BOARD
CONSIDERS IT INAPPROPRIATE TO MAKE A
RECOMMENDATION CONCERNING THE INTERNAL
ORGANIZATION OF ANY OTHER COUNCIL OF THE AAMC.

Following further discussion, the motion was withdrawn. However, consensus was reached on the following three points:

- 1- There should be effective participation and representation of medical faculty in the affairs and governance of the AAMC;
- 2- No decision was reached concerning which of the seven alternative proposals would most appropriately achieve this goal;

- 3- No recommendation should be made which affects the internal organization of any other AAMC Council.

C. Clinical Clerkships For Foreign Medical Graduates

Dr. Knapp reviewed the background of this issue. The Council on Medical Education of the American Medical Association adopted a policy statement on June 23, 1971 which would permit U.S. citizens who have studied medicine abroad to enter AMA-approved residencies even though they have not fulfilled all the requirements for graduation of the institution they are attending and requirements for licensure in the country of their education (ECFMG prerequisite). As an alternative to fulfilling these requirements, the Council on Medical Education will accept a special junior clinical clerkship provided by U.S. medical schools, separate and distinct from the usual clerkships used by the school for their own students. The Council requires that these students have passed an examination such as Part I of the National Boards, the ECFMG Examination, the FLEX Examination, or a new examination to be devised for this purpose. The most recent AMA guidelines for this clinical clerkship are attached to these minutes.

The stated purpose of this policy is to allow U.S. citizens to escape the necessity of meeting requirements for assigned social service. This is a particular requirement in Mexico. Students accepted under this policy will not be granted their degree by the foreign school. The U.S. schools accepting these students are also not expected to grant a degree.

The political pressure generated by this enlarging group of American citizens who desire ultimately to practice medicine in the U.S.A. is increasing rapidly. At present we know of three states which have made medical licen-

sure available to American FMG's without regard to ECFMG procedures.

(California, New Jersey, and Connecticut - other states are now considering the matter).

On December 16, 1971, the AAMC Executive Council considered this matter and felt that provision of clinical clerkships for foreign medical graduates was a matter for individual consideration by the individual schools and that no additional Association policy was necessary.

On December 17, 1971, this matter was reconsidered by the Executive Council and was referred to the Council of Deans for its consideration. A number of deans are concerned about this matter, and the Administrative Board requested the staff to be sure the COTH membership is fully informed about the matter.

V. Progress Report On HMO Grant

Dr. Kalinowski reported that successful workshops were held at Yale and Georgetown. Six other workshops are scheduled in Philadelphia, Chapel Hill, New York City, St. Louis, Denver and San Francisco. The current grant supporting these activities runs through March 31, 1972.

Negotiations are underway for an eighteen month continuation of the grant. The renewal proposal will include a technical assistance proposal as well as other activities to foster the development of HMO's in the academic setting.

Dr. Kalinowski also reported on an incipient relationship with the National Health Service Corps which was created December 31, 1970 when the President signed the Emergency Health Personnel Act. The Act enables the Corps to assign health teams to provide primary health care services to residents of inner-city and remote rural areas which have been designated by the HEW Secretary as having critical health manpower shortages.

The health teams are composed of physicians, dentists and nurses, as well as supporting health professionals, who are assigned for a period of two years, and through this service fulfill their draft obligations.

It may be desirable and appropriate for medical centers to provide preceptor and/or educational support to these teams. Negotiations are under way with the Corps to develop the financing to do so.

As a final matter, Dr. Kalinowski reported that a recent survey of medical schools completed by the Division of Health Services revealed that fifty-two percent of the schools (response rate to the survey was 95%) were providing medical services to a prison system; jail or detention center. More importantly, fifty percent of those not providing services stated they would be interested in developing programs if adequate funding were available.

Dr. Kalinowski has met with the following agencies: Drug Abuse Council, ABA Commission on Correctional Facilities and Services, Bureau of Prisons, Legal Enforcement Assistance Agency and HSMHA. A meeting yet to be scheduled, is being arranged under the auspices of the Commonwealth Fund to bring together interested parties.

VI. Future of Task Force Reports

The Board recommended that these reports might be considered as the basis for the upcoming COTH Regional Meetings.

The Task Force To Determine Recommended Goals & Objectives For COTH As Well As Future Criteria for Membership has been discharged. The Report of this group will be used as the basis for the new committee on membership criteria.

The Committee On House Staff Relationships to the Hospital and the AAMC has been discharged and will be replaced by the new AAMC Committee On

Graduate Medical Education on which COTH will have representation.

The Task Force to Analyze The Higher Costs of Teaching Hospitals has not been discharged, but its future is uncertain at this time.

VII. VA Sharing Task Force

Mr. Greathouse, Chairman of the Task Force, reported the group had its first meeting on Thursday, October 7, 1971. A second meeting has been scheduled for February 8, 1972. Mr. Greathouse outlined the issues which will be set forth in a report which will then be sent to the overall AAMC-VA Liaison Committee.

Dr. Knapp reported briefly on the February 3, 1972 meeting of the AAMC-VA Liaison Committee. Items discussed at that meeting were as follows:

- 1- Appointment procedures for hospital directors;
- 2- A revised "Guide For VA-medical school affiliation;
- 3- Guidelines for establishment of AAMC-VA consultation teams;
- 4- VA initiatives in area health education centers;
- 5- Current legislative and budgetary issues;
- 6- VA pilot project: Opening the staff of the VA hospital to community physicians (Beckley, W.Va.)

VIII. Annual Meeting

The overall theme of the meeting is, "From Medical School to Academic Health Center". The Chairman, Chairman-Elect and Immediate Past Chairman will serve as the COTH Program Committee. It was agreed that the COTH business meeting and program be completed in the afternoon following the luncheon on Friday, November 3, 1972.

IX. Internal AAMC Organization

Mr. Danielson briefly outlined the current internal organization of the AAMC, and formally announced that he would be resigning as Director of the AAMC Department of Health Services and Teaching Hospitals effective April 1, 1972. He will become General Director of the North Carolina Memorial Hospital effective on that date. The Board directed that the Minutes reflect the deep appreciation of Officers and Board members on behalf of the total COTH membership to Mr. Danielson for his outstanding leadership and contributions to the Council of Teaching Hospitals. Further, the Board expressed regret at his departure and sincere best wishes in his new endeavor.

At this time, the "Proposed Organization of Sub-Council Activities", as presented in Appendix B to these Minutes, was discussed.

X. Legislative Report

The testimony to be presented to the Senate Finance Committee on February 9, 1972, by Dr. Cronkhite was distributed and discussed. Dr. Ainsworth noted that no comments in the testimony were directed to the Bennet Amendment concerning PSRO's. He asked if the AAMC might consider including the issue in its testimony.

XI. Other Business

A) Letter of January 19, 1972 from Don Arnwine, Director of Hospitals, University of Colorado

Mr. Arnwine's letter is attached as Appendix C to these minutes. There was extensive discussion of JCAH's standards as they relate particularly to university hospitals. The discussion centered on the matter of medical staff by-laws and institutional governance, although a number of other issues were raised.

ACTION #7

IT WAS MOVED, SECONDED AND CARRIED THAT THE STAFF BE DIRECTED TO EXPLORE THE POSSIBILITY OF CO-SPONSORING WITH THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS A TWO DAY SEMINAR OR CONFERENCE ON "HOSPITAL ACCREDITATION STANDARDS IN THE UNIVERSITY SETTING"

B) Letter of January 4, 1972 from Michael J. Daly, Assistant Director, Hartford Hospital

Mr. Daly's letter is attached as Appendix D to the Minutes. Following discussion, there was general consensus at the meeting that it would be undesirable for COTH to develop a patient information statistical system for teaching hospital in view of the number of programs already in operation. However, there was agreement that the point raised was of ever increasing importance. Some type of educational campaign is clearly needed, but with an adequate data base to validate current assumptions. The staff was requested to explore the possibilities of working with current data collection activities of other organizations.

XII. Adjournment

There being no further business, the meeting was adjourned at 3:00 p.m.

U.S. CLERKSHIPS FOR U.S. CITIZENS STUDYING MEDICINE ABROADTENTATIVE GUIDELINES

The following guidelines are intended to relate specifically to the needs of American students who have completed four years of study at the Universidad Autonoma de Guadalajara, for remedial clerkships in accordance with the recommendations of the Commission on Foreign Medical Graduates and the Council on Medical Education. In addition, these guidelines are developed with the possibility that they will be of more general usefulness if similarly oriented clerkships are found to be necessary for individuals who have attended other foreign medical schools.

The following comments are intended to be suggestions, with final decision in all important areas to be made by the sponsoring U.S. medical school:

It should be recognized that the students who have been granted a Carta Pasante from the Universidad Autonoma are a heterogeneous group. The group contains a number of individuals who in less competitive times would have been able to gain admission to a United States medical school as well as students who should not be, under any circumstances, expected to pursue successfully a medical school career in the United States. These guidelines are intended to encourage clerkship training for the first group. Specifically, reasonable efforts should be made to direct the remedial education and training to those students who are of approximately the same order of competence as students admitted to U.S. schools. Alternate lists kept by some medical schools might be useful in this matter. Each U.S. school will need to develop its own means of assuring competence. The schools are not being urged to provide remedial training for students who are far below their minimal standards.

Those American educators who have had experience with Guadalajara students and those individuals who have studied the Guadalajara school are agreed that at the end of four years of training, the students, i.e. the holders of the Carta Pasante or Diploma, usually will have had little clinical experience. Many, in fact, have had no formal introductory courses in history taking and physical examination, and none has had clinical experience comparable to that in the typical American clerkship.

The following are suggested as guidelines for the clerkship:

- (1) The feasibility of providing the students with individualized instruction in history taking and physical examination at the onset of the clerkship should be considered.

(2) In keeping with the recommendation of the Commission on Foreign Medical Graduates, the clerkship should be one full academic year in duration.

(3) In view of the need for general experience, it is suggested that the clerkship cover several of the more general disciplines. The Mexican "internship" for which this clerkship is intended to be a substitute is comprised of three months each of medicine, surgery, pediatrics, and obstetrics-gynecology.

(4) The clerkship should be under the sponsorship of a U.S. medical school which should have responsibility for the program. It is suggested that these students should not be trained side by side with American medical students since their background is quite different. It is suggested, however, that the training be in a hospital affiliated with the medical school and under the supervision of physicians who hold medical school appointments.

(5) The medical school should have final responsibility for determining the criteria for admission to the program, the characteristics of the program itself, and the evaluation (if any) at the end. The minimum requirement would be for the medical school to certify to the Universidad Autonoma that the student had been in attendance for the full duration of the clerkship.

(6) There must be a screening examination which, combined with evaluation of other credentials, would provide assurance of competence to undertake the clerkship. It is suggested that Part I of the National Board Examination or the first part of Flex might be suitable for this purpose.

(7) It is suggested that it would be highly desirable for the medical school, in addition to providing whatever evaluation it deemed desirable to the Universidad Autonoma and the student, to use an American institution as the central repository for such an evaluation in the event it might prove to be necessary in subsequent years. It was felt that the interest of the United States public might not be fully protected if the student and the Universidad Autonoma were the only custodians of the evaluation.

(8) Recognizing that such a program would require some expenditure of effort or money, or both, by the medical school, it is suggested that the medical school might charge the student an appropriate fee. It is generally agreed, in view of the informal nature of the arrangement between the student and the medical school and the uncertainty regarding legal relationships, that tuition should not be charged without careful consideration of the legal implications.

(9) In order to emphasize the educational nature of the experience for the student and to clearly differentiate the experience from an externship, it is recommended that the hospital not be permitted to remunerate the student and that the student not be permitted to accept any remuneration for his services either from the hospital or from staff physicians.

GRL:kc
4/8/71

Revised
5/26/71
HCN:ltw

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET
CHICAGO, ILLINOIS 60610

GLEN R. LEYMASTER, M.D.
DIRECTOR
DEPARTMENT OF
UNDERGRADUATE MEDICAL EDUCATION

AMA CODE 312
527.1500

PROPOSED ORGANIZATION OF SUB-COUNCIL ACTIVITIESBackground

The bylaws of the AAMC provide that the voting membership of the Association shall be represented in three Councils which shall be organized in a manner consistent with rules and regulations approved by the Executive Council. There is no provision in the bylaws for any subordinate or sub-council membership organization, with the exception of the Organization of Student Representatives. The rules and regulations of the three councils, however, do provide that standing committees can be created or other major actions taken by the councils after approval of such recommendations by the Executive Council. This latter provision appears to be the only valid official means, outside of bylaw revision, by which subordinate council organizations can be brought into being.

At the present time there are four general classifications of such sub-council entities:

1. The committees of the Executive Council, both standing committees for purposes of governance, and ad hoc committees for the examination of specific issues;
2. The committees of the constituent Councils (COD, CAS, COTH), both standing and ad hoc;
3. Membership organizations involved in the governance of the AAMC, and therefore established by bylaw revision (OSR);
4. Functional or professional organizations which seek to advance their specialized subject matter interests rather than participate in governance (Group on Student Affairs, Business Officers' Section);

In addition, there are four other putative sub-council entities in various stages of development:

1. Organization of Faculty Representatives
2. Development Officers' Section
3. Planning Coordinators' Section
4. Public Relations Section

None of these four groups have any "de jure" status in the AAMC. With the exception of the faculty organization, the other three groups have a varying degree of "de facto" status and are seeking formal and valid identification within the AAMC as professional components fitting into classification #4 above. The proposed Organization of Faculty Representatives, if approved, would be involved in the governance of the AAMC (classification #3 above) and could therefore only be established through a revision of the Association bylaws.

The Issues

A sub-council structure encompassing functional elements of the institutional membership of the AAMC has developed on an ad hoc incremental basis without overall design or agreement upon the relationship of the sub-council activities to the Councils. Two of these groups have a formally approved status within the AAMC -- GSA and BOS. Three others do not have such formal status, but have some organization and present programs at the AAMC Annual Meeting -- DOS, PCS, and PRS.

For the most part these groups are concerned with three overall matters:

1. Their professional advancement;
2. The provision of consulting expertise;
3. The identification of problems and development of means for their solution.

Their present status and their pressures for further development present a set of issues that require either better clarification or resolution:

1. How and by what terminology should the formal organizational status of these groups be described?
2. What role and function should they serve within the AAMC?
3. What should be their organizational, functional, and program relationships with the governing structure of the AAMC and the AAMC staff structure?
4. What limits should be set upon their activities, internal organization and functioning, and further development?
5. What should be the policy toward further replication of such groups?
6. How should their activities be financed?

Recommendations

The proliferation of these groups, sections, and committees necessitates the formulation of an official AAMC policy encompassing all sub-council entities. This policy must differentiate among the various types, state the mechanism for their authorization, and establish clear and yet adaptable guidelines for their activities and relationships to the Councils and to the staff. Attached is a set of proposed "Guidelines for Sub-council Organization" for your review and approval. }<

GUIDELINES FOR SUB-COUNCIL ORGANIZATION

There shall be the following classes of sub-council entities, organized in accordance with the definitions and specifications listed below:

- A. ORGANIZATIONS -- an Organization of the AAMC is defined as a membership component, associated specifically with one Council of the Association, and having voting participation in the governance of the AAMC.
 - 1. Its establishment requires a bylaws revision approved by the AAMC Assembly.
 - 2. The Association shall assume responsibility for staffing and for basic funding required by the Organization.
 - 3. The Organization shall be governed by rules and regulations approved by the parent Council.
 - 4. All actions taken and recommendations made by the Organization shall be reported to the parent Council.
- B. GROUPS -- a Group of the AAMC is defined as a functional component, representing a specific area of staff interest and activity, and not involved in the governance of the Association.
 - 1. Chartering of a Group must be approved by the Executive Council and is valid for three years (subject to review and renewal at that time). ✓
 - 2. Commitment of AAMC staff support must precede the establishment of a Group. ✓
 - 3. Groups shall be informally organized; they may select a national chairman but should not develop formal rules and regulations. ✓
 - 4. AAMC funds shall not be used to support Group activities, except as specifically authorized by the Executive Council. ✓
- C. SECTIONS -- a Section of the AAMC is defined as a professional component, representing the interests of a professional group within the academic medical center, specifically associated with one Council of the Association, and having no involvement with the governance of the AAMC.
 - 1. The establishment of a Section must be approved by the Executive Council upon referral from the prospective parent Council.
 - 2. Each Section will be assigned one principal staff person, who will coordinate the activities of the Section with the parent Council and with the goals and objectives of the Association.

3. Each Section must report all programs and activities to the parent Council through the principal staff person relating to the Section.

4. The Association shall provide no additional staff support or funding, except as specifically authorized by the Executive Council.

5. Each Section may develop rules and regulations which must then be approved by the parent Council.

D. COMMITTEES -- a Committee of the AAMC is defined as a standing body reporting directly to one of the official components of the Association (Executive Council, Councils, Organizations, Groups, Sections), charged with a specific continuous function.

1. Committees of the Executive Council may be charged with roles related only to governance, program, liaison, and awards.

2. Committees of the Councils and Organizations may be charged with roles related only to governance and program. *who can talk to issues?*

3. Committees of the Groups may be charged with roles related only to program.

4. Committees of the Sections may be charged with roles related only to the program and internal governance of the Section.

E. COMMISSIONS -- a Commission of the AAMC is defined as a body charged with a specific subject matter function, assigned for a definite term of existence, and reporting directly to one of the official components of the Association. All previous "ad hoc committees" shall become known as Commissions.

1. A Commission may be charged by the AAMC component to which it is to report, or by the Executive Council.

2. No Commission may be charged for a term longer than 2 years, at the end of which it shall be re-charged or dissolved.

UNIVERSITY OF COLORADO
MEDICAL CENTER
4200 EAST NINTH AVENUE
DENVER, COLORADO 80220

APPENDIX C

COLORADO GENERAL HOSPITAL
COLORADO PSYCHIATRIC HOSPITAL
CHILDREN'S DIAGNOSTIC CENTER
SCHOOL OF MEDICINE
SCHOOL OF NURSING
SCHOOL OF DENTISTRY

January 19, 1972

Mr. John Danielson, Director
Council of Teaching Hospitals
and Health Services
One Dupont Circle
Washington, D.C. 20036

Dear John:

If the agenda for the February 4 meeting of the Administrative Board is still open, I would like to propose an item for the agenda.

I have been through five surveys by the Joint Commission on Accreditation of Hospitals while here at the University Hospitals. I have had varying degrees of difficulty in gaining their acceptance of our Medical Staff Bylaws and the organization of our medical staff vis-a-vis the faculty of the School of Medicine. The last survey was conducted in August of 1971, under the newly-adopted Standards by the Joint Commission, and they had more to say on this subject than they ever have before.

It has long been my contention that the "Standard Medical Staff Bylaws" published by the Joint Commission are not practical in every respect for a university hospital, and have had several conversations with representatives of the JCAH on this subject. They tend to agree; however, the Standards make no distinction between a university hospital and a community hospital as they relate to medical staff bylaws or any other requirements.


I have been considering the possibility of sponsoring a seminar (perhaps 1 1/2 to 2 days long) in which I would invite the chief executive officer and the chief of the medical staff (or his counterpart) to come together with a bona fide representative of the JCAH to "hammer out" a set of model bylaws that would be applicable to the university setting. I have, through one of my staff, presented this proposition to Dr. Charles Jacobs, and he seemed to be interested.

What I would like to ask you to consider placing on the agenda is whether or not this would be a legitimate activity of COTH, the possibility being that COTH would sponsor such a seminar and possibly co-sponsor with the JCAH. I would still be happy to host the meeting, but if it is of equal concern to our colleagues, perhaps it would be well to consider as a COTH activity.

I will be happy to elaborate on the subject at the meeting if you feel that it is a good agenda item.

Looking forward to seeing you in Chicago.

With kind regards,


Don L. Arnwine
Director of Hospitals

DLA/dk

HARTFORD HOSPITAL

HARTFORD, CONNECTICUT 06115

January 4, 1972

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

Dear Mr. Knapp:

This letter is written as a follow-up to the telephone conversation that Dr. Hamilton and I had with you on December 27, 1971.

In the past several years Hartford Hospital has been subjected to intense scrutiny by third party agencies in the area of utilization review. We are confident that the utilization surveillance program that we have developed is a good one, and yet, we find that we are being challenged to defend our medical care practices. Third parties are using standards supplied by the Professional Activity Study (PAS), and, in Connecticut, the Connecticut Utilization and Patient Information Statistical System (CUPISS), to judge the appropriateness of our care. While these programs seem to be ideally suited for evaluation of the average community hospital, we are finding that they cannot cope with some of the more complicated cases frequently seen by a large teaching hospital which acts as a referral center.

It is our contention that the type of care rendered here is not comparable to other institutions in the area. Our average length of stay should not be judged inappropriate on the basis of the experience of outlying, smaller, community hospitals. This is presently being done.

The purpose of this letter, then, is to propose that the Council of Teaching Hospitals consider either the development of a patient information statistical system for teaching hospitals, or, an educational campaign, designed for third party agencies, to demonstrate the non-comparability of teaching hospital statistics with others. We are convinced that the level and intensity of care rendered by teaching hospitals is only comparable to other like hospitals. Our fear is that unless we can develop an information system to satisfy our third party critics, we will be forced to submit to standards that do not recognize some of the unique aspects of care in the teaching hospital.

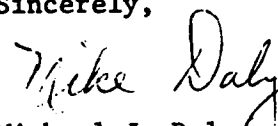
Mr. Richard M. Knapp, Ph.D

-2-

January 4, 1972

If you feel that this proposal warrants further action, we will be more than happy to discuss the subject at your convenience.

Sincerely,



Michael J. Daly
Assistant Director

MJD/ps

cc: Mr. John Danielson
Dr. T. Stewart Hamilton
Dr. Michael Lazor

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #72-5

February 8, 1972

TO: Voting Members of the Assembly

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

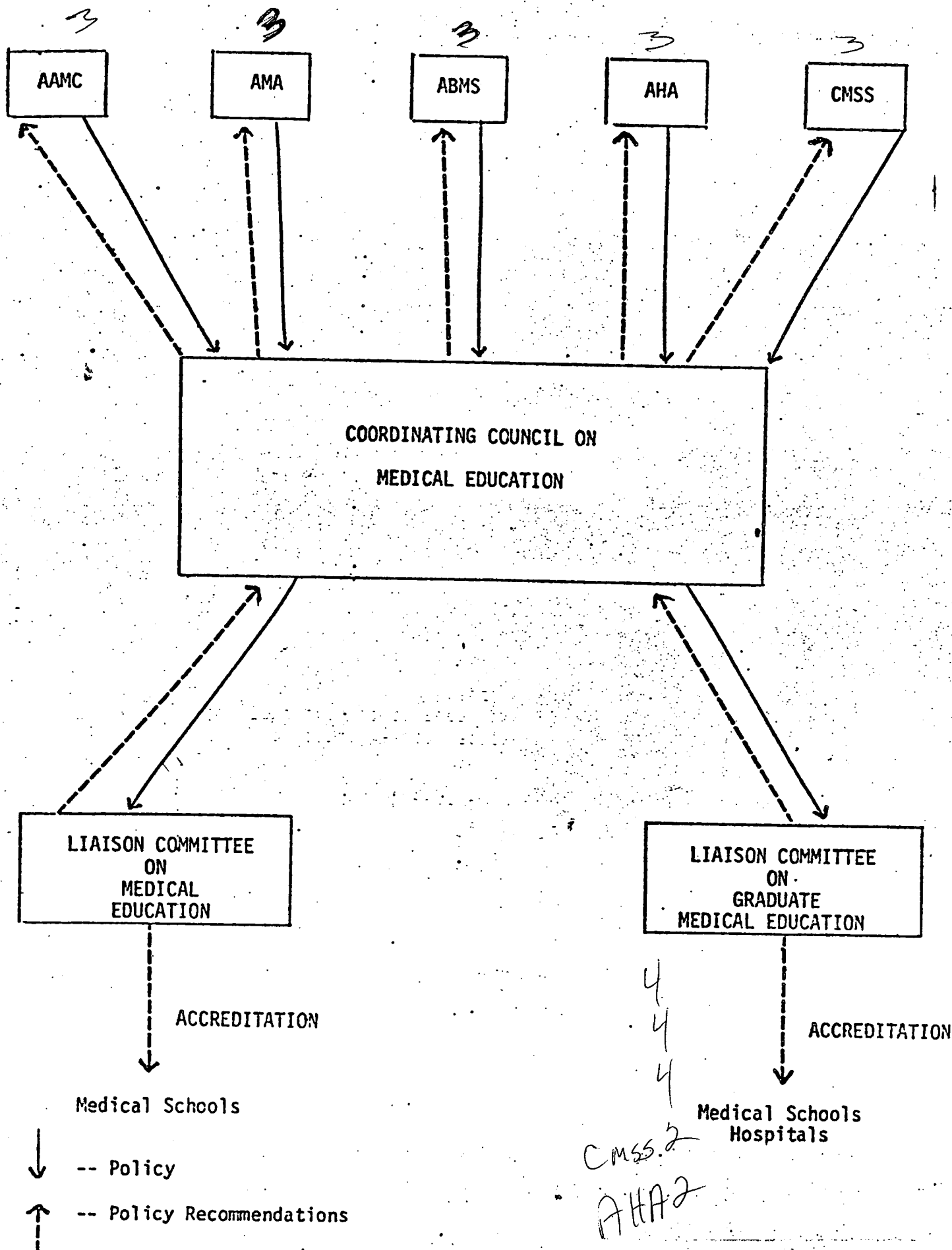
SUBJECT: ACCREDITATION OF GRADUATE MEDICAL EDUCATION

The establishment of a formal body to accredit programs of graduate medical education has been an activity of the AAMC since 1968. Representatives of the American Medical Association, American Board of Medical Specialties, American Hospital Association, and the Council of Medical Specialty Societies have joined with us in considering various mechanisms for accomplishing this, either coupled with or separated from the undergraduate accreditation role of the LCME.

On January 25, 1972 representatives of these five groups met in Washington and reached agreement on five points, defining a basic organizational structure for the accreditation of all medical education.

1. As soon as possible, there will be established a Liaison Committee on Graduate Medical Education, with representation from each of the five organizations, to serve as the official accrediting body for graduate medical education.
2. Simultaneously, there will be established a Coordinating Council on Medical Education to consider policy matters for both undergraduate and graduate medical education, for referral to the parent organizations.
3. The existing Liaison Committee on Medical Education and the new Liaison Committee on Graduate Medical Education will have the authority to make decisions on accreditation in their respective areas within the limits of policies established by the parent organizations and with the understanding that Residency Review Committees will continue to function.
4. All policy decisions will continue to be subject to approval by the parent organizations.
5. Policy recommendations may originate from any of the parent organizations or from the two liaison committees, but will be subject to review by the Coordinating Council before final action is taken by the parent organizations.

This agreement would establish an accrediting mechanism which works as follows:



The AAMC Executive Council approved this agreement on February 5, 1972 and we are now preparing to negotiate on the details of representation, distribution of cost, and to establish initial policies of organization. While it is generally agreed that programs of continuing education and allied health programs might eventually be accredited under this umbrella, no definite plans to accomplish this have been developed. It was felt that efforts should be devoted at this time to the initiation of the Liaison Committee on Graduate Medical Education. Experience with this new body will be useful in planning extension of accrediting activities to other areas.

March 7, 1972

Edgar O. Mansfield, Ph.D.
Administrator
Riverside Methodist Hospital
3535 Olentangy River Road
Columbus, Ohio 43214

Dear Dr. Mansfield:

We have received the Riverside Methodist Hospital application for membership in COTH. As you may know, the COTH Administrative Board also serves as the membership selection committee.

COTH membership presently numbers 403 teaching hospitals. There has been increasing concern on the part of Administrative Board members that the time is approaching when a thorough analysis of the current criteria for COTH membership is necessary. Thus, at its February 4, 1972 meeting the Board declared a moratorium on new COTH membership applications until such an analysis is completed.

The Chairman was directed to activate such a committee which will make its report to the November 3, 1972 COTH Institutional Membership meeting in Miami, Florida. The Committee is currently in the process of being appointed, and will begin its deliberations shortly.

Following action on membership criteria in Miami, your application will be reviewed.

In the meantime, if you have any questions, or if we can be of service in any way, please let me know.

Sincerely,

RICHARD M. KNAPP, PH.D.
Director
Division of Teaching Hospitals

RMK:car

(Please type)

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

March 7, 1972

Mr. Allen M. Hicks
President
Community Hospital of Indianapolis, Inc.
1500 North Ritter Avenue
Indianapolis, Indiana 46219

Dear Mr. Hicks:

Mr. Danielson has asked that I respond to your letter of February 28th.

We have received the Community Hospital of Indianapolis, Inc. application for membership in COTH. As you may know, the COTH Administrative Board also serves as the membership selection committee.

COTH membership presently numbers 403 teaching hospitals. There has been increasing concern on the part of Administrative Board members that the time is approaching when a thorough analysis of the current criteria for COTH membership is necessary. Thus, at its February 4, 1972 meeting the Board declared a moratorium on new COTH membership applications until such an analysis is completed.

The Chairman was directed to activate such a committee which will make its report to the November 3, 1972 COTH Institutional Membership meeting in Miami, Florida. The Committee is currently in the process of being appointed and will begin its deliberations shortly.

Following action on membership criteria in Miami, your application will be reviewed.

In the meantime, if you have any questions, or if we can be of service in any way, please let me know.

Sincerely,

RICHARD M. KNAPP, PH.D.
Director
Division of Teaching Hospitals

RMK/car

Application for Membership
in the
Council of Teaching Hospitals

(Please type)

Hospital: Community Hospital
Indianapolis 1500 North Ritter Avenue
City Street
Indiana 46219
State Zip Code

Principle Administrative Officer: Allen M. Hicks
Name
President
Title

Date Hospital was Established Ground breaking - 9/23/54; 1st admission 8/6/56

Approved Internships:

Type	Date Of Initial Approval by CME of AMA*	Total Internships Offered	Total Internships Filled
Rotating		None	
Straight		"	

Approved Residencies:

Specialties	Date Of Initial Approval by CME of AMA*	Total Residencies Offered	Total Residencies Filled
Medicine		None	
Surgery		"	
OB-Gyn		"	
Pediatrics		"	
Psychiatry		"	
Other		"	

Information Submitted By:

Allen M. Hicks
Name

February 28, 1972
Date

President
Title of Hospital Chief Executive

Allen M. Hicks
Signature of Hospital Chief Executive

*Council on Medical Education of the American Medical Association and/or with appropriate A.M.A. Internship and Residency Review Committees.

PLEASE READ INSTRUCTIONS ON REVERSE SIDE

Instructions:

Please complete all copies and return three copies to the Council of Teaching Hospitals, Association of American Medical Colleges, One Dupont Circle, N.W., Washington, D.C. 20036, retaining the Blue Copy for your files.

Membership in the Council of Teaching Hospitals:

Teaching Hospital members shall be organizations operated exclusively for educational, scientific, or charitable purposes. Hospitals as institutions will be members of the Council and each institution will be represented by a person designated by the hospital for the purpose of voting at business meetings of the Council. All members will vote at the Annual Meeting for officers and members of the Executive Committee.

Membership to the Council will be determined by the following criteria:

- a. those hospitals nominated by a medical school Institutional Member or Provisional Institutional Member of the AAMC from among the major Teaching Hospitals affiliated with the Members and elected by the Council of Teaching Hospitals, or
- b. teaching hospitals which have approved internship programs and full, approved residencies in at least 4 recognized specialties including 2 of the following: Medicine, Surgery, Obstetrics-Gynecology, Pediatrics, and Psychiatry, and are elected by the Council of Teaching Hospitals

The voting rights of the Council of Teaching Hospitals in the Assembly of the AAMC shall be as follows: The Council of Teaching Hospitals shall designate 10 percent of its members, up to a maximum of 35, each of whom shall have 1 vote in the Assembly.

If nominated by a School of Medicine, complete the following:

Name of School of Medicine Indiana University

Name of Dean Glenn W. Irwin, Jr., M.D.

Address of School of Medicine 1100 West Michigan Street

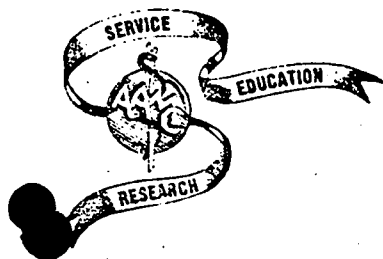
Indianapolis, Ind. 46202

FOR COTH OFFICE USE ONLY

Date _____ Approved _____ Disapproved _____ Pending _____

Remarks _____

Invoiced _____ Remittance Received _____



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

May 1, 1972

A. Kenneth Peterson
Executive Vice-President
Mount Sinai Hospital
2215 Park Avenue
Minneapolis, Minnesota 55404

Dear Mr. Peterson:

Thank you for your letter indicating your interest in becoming a member of the Council of Teaching Hospitals. The membership criteria as they now stand are outlined in the attached copy of the Rules and Regulations.

There has been increasing concern, however, on the part of the Administrative Board members that the time is approaching when a thorough analysis of the current criteria for COTH membership is necessary. Thus, at its February 4, 1972 meeting the Board declared a moratorium on new COTH membership applications until such an analysis is completed. The Committee will make its report to the November 3, 1972 Institutional Membership Meeting in Miami, Florida. Following action on membership criteria in Miami, a new COTH membership application will be sent to you.

COTH membership currently numbers 404 teaching hospitals, with the annual dues set by the Administrative Board at \$1,000. Members receive on a regular basis, copies of the Journal of Medical Education, Datagram (which is now included within the JME), AAMC Bulletin, COTH Reports, COTH Memoranda, your copy of the AAMC Directory, and the COTH Directory as well as other publications pertinent to the field of medical education.

In the meantime, if we can be of service in any way, please let me know.

Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Division of Teaching Hospitals

RMK/plf

Attachment: COTH Survey of House Staff Policy - 1971
COTH Directory
Executive Salary Survey

April 28, 1972

Rodger C. Johnson
Administrator
General Rose Memorial Hospital
1050 Clermont Street
Denver, Colorado 80220

Dear Mr. Johnson:

Thank you for your letter indicating your interest in becoming a member of the Council of Teaching Hospitals. The membership criteria as they now stand are outlined in the attached copy of the Rules and Regulations.

There has been increasing concern, however, on the part of the Administrative Board members that the time is approaching when a thorough analysis of the current criteria for COTH membership is necessary. Thus, at its February 4, 1972 meeting the Board declared a moratorium on new COTH membership applications until such an analysis is completed. The Committee will make its report to the November 3, 1972 Institutional Membership Meeting in Miami, Florida. Following action on membership criteria in Miami, a new COTH membership application will be sent to you.

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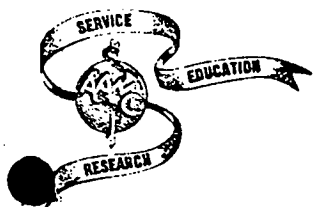
In the meantime, if we can be of service in any way, please let me know.

Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Division of Teaching Hospitals

RMK/plf

Attachment: COTH Survey of House Staff Policy - 1971



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
SUITE 200, ONE DUPONT CIRCLE, N.W., WASHINGTON, D.C. 20036

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

WASHINGTON: 202: 466-5175

April 6, 1972

Mr. George H. Schmitt
Administrator
The St. Joseph Infirmary
735 Eastern Parkway
Louisville, Kentucky 40217

Dear Mr. Schmitt:

It has been reported to me that the St. Joseph Infirmary has become a for-profit institution and is no longer recognized as a public charity under Section 501 (c)(3) of the Internal Revenue Code.

If this information is not correct, I would appreciate a written clarification of your institutional situation. If we do not hear from you by May 1st, I will assume that our information is accurate.

Sincerely,

John A. D. Cooper, M.D.

cc: Mr. George Cartmill
Dr. Richard Knapp ✓



St. Joseph Infirmary

PRESTON AT EASTERN PARKWAY • P.O. BOX 17264 • LOUISVILLE, KENTUCKY 40217 • AREA CODE 502/636-7140

GEORGE H. SCHMITT
Executive Director

April 11, 1972

John A. D. Cooper, M.D.
Association of American Medical Colleges
Suite 200, One Dupont Circle, N.W.
Washington, D. C. 20036

Dear Dr. Cooper:

I am in receipt of your letter of April 6, 1972 inquiring whether we qualify under Section 501 (c) (3) of the Internal Revenue Code.

Our hospital was purchased from the Sisters of Charity of Nazareth by Extendicare, Inc., effective June 1, 1970. As an investor-owned hospital we no longer qualify under Section 501 (c) (3) of the Internal Revenue Code.

If this inquiry relates to whether we can remain as a member of the Council of Teaching Hospitals, we would like for you to take it under consideration that we have been a member since 1968 and I believe you will find the records to show that we have been a most cooperative and interested member. The ownership of our hospital has firmly committed itself to the betterment and continued support of the graduate medical education program. We presently have five Residency Programs (Surgery, Obstetrics-Gynecology, Radiology, Internal Medicine, Pediatrics, and an Internship rotating program).

We are most anxious to maintain our membership in the Council of Teaching Hospitals and would hope that you also would see our membership to be advantageous to your association.

Thank you for your kind consideration in this matter.

Cordially,

George H. Schmitt

GHS:ms

cc: Mr. John Danielson
Dr. Richard Knapp

DUES OUTSTANDING FOR FISCAL YEAR 1971-72

on the way

letter went to 15 delinquent on April 7, 1972

University District Hospital, San Juan, Puerto Rico ✓

U. S. Public Health Service Hospital, Carville, Louisiana ✓

Veterans Administration Hospital, Buffalo, New York ✓

Wayne County General Hospital, Eloise, Michigan ✓

VA, Jackson, Miss. - will go on the way - they called about increase

HOSPITALS DROPPED DURING FISCAL YEAR 1971-72

Jersey City Medical Center, Jersey City, New Jersey - *no pay in 2 yrs.*

U. S. Public Health Service Hospital, San Francisco, Calif. - *drop after inquiry about this year's dues*

St. Charles

New bills for \$1,000 went out May 1, 1972

St. Joseph's was not billed

78 hospitals have pd. so far

ARTICLE I - DESCRIPTION AND SCOPE OF WORK

- A. The contractor will plan and carry out activities directed toward the development of at least five (5) Health Maintenance Organization's in University Medical Centers. The contractor will concentrate his activities as outlined in this contract, on a small and select number of university medical centers likely to assure the development of five (5) HMO's. The contractor will develop specific methods and criteria for the selection of such university medical centers and proceed to select them subject to approval of the Project Officer.

Definition of an HMO, for the purposes of this contract is:

An HMO is an organization which can be either a separate legal entity or a cooperating group consisting of legally recognized organizations functioning on a contractual basis with these characteristics:

- has an organized health care delivery system which includes health manpower and facilities capable of providing or otherwise arranging for the provision of comprehensive health services, which include as a minimum, ambulatory physician care, inpatient hospital and physician care, emergency care and out-patient preventive medical services.
- has a voluntarily enrolled population consisting of individuals and families who have chosen through the process of dual choice individually or as members of a defined group of individuals to contract with the HMO for the provision of a range of health services which the HMO assumes responsibility to make available.
- has a financial plan which guarantees the delivery of the agreed upon set of services on a prenegotiated and prepaid per person or per family basis.
- has an identifiable managing organization which assures legal, fiscal, public and professional accountability.
- has arrangements whereby the organization to a significant degree bears the risk of providing health services on a prenegotiated basis and requires that providers of professional services in the system participate to some degree in sharing this assumed risk.

B. In performance of this contract, the contractor specifically shall:

1. Establish a project advisory committee to provide overall advice and guidance to implement, review, and evaluate progress of the project. The committee composition will include but not be limited to the following:
 - DHEW Project Officer or his designee
 - AAMC representatives
 - Project Director
2. Include but not be limited to the following selection criteria
 - a. Evidence of a conscientious and effective effort by the university medical center to reach a "go-no go" decision
 - b. Potential for early successful operation
 - c. Service to medically underserved areas
 - d. Involvement of consumer in planning and during developmental and operational phases
 - e. Service to Federal beneficiaries
3. Provide (1) the personnel, (2) materials, and (3) facilities required to perform the identified functions and tasks which will enable a university medical center to proceed toward the development of an HMO.
4. Address but not be limited to the following tasks in assisting university medical centers to:
 - a. Plan an organization which can accept responsibility for delivery of comprehensive health care to its prepaid enrollees.
 - b. Plan the health care delivery system to provide at a minimum ambulatory physician care, inpatient hospital and physician care, emergency care, outpatient preventive medical services, with assured access for the enrollees and with mechanisms to assess and insure the quality of care provided.

- c. Plan for revenue sources to assure fiscal viability.
 - d. Plan for marketing and enrollment services which can realistically support the operation of the HMO.
 - e. Develop a prepaid benefit package(s) appropriate to service needs of enrollees.
 - f. Plan for an information system as approved by the Project Officer which not only provides for adequate internal controls needed for successful operation, but also provides information for evaluation of effectiveness by the Secretary, DHEW.
 - g. Identification of legal barriers to the formation of an HMO.
 - h. Consideration of educational, training, evaluation and research activities that could be undertaken within the HMO and identification of sources of dollar support for such activities.
5. Form project teams for each selected project and include but not be limited to: DHEW Regional Representative, AAMC Project Director and representatives of the selected project. The purpose of the project team will be to monitor the progress of each selected project.
 6. Report in writing quarterly to the DHEW Project Officer reports of methodology and progress of each project in carrying out, but not limited to, the following activities:
 - the university medical center's understanding of the processes in planning and launching an HMO. This statement should include, but not be limited to
 - local health care delivery system status
 - support or resistance to HMO formation in the target community
 - major obstacles to formation of an HMO
 - major reasons for formation of an HMO at this time
 - perceived technical assistance needs
 - consultation with and comments from the appropriate Areawide Comprehensive Health Planning Agency are required.

7. Work closely with the university medical centers toward:

- a. The structuring of Health Maintenance Organization (intended or existing)
 - (1) Articles of incorporation or other organization documentation.
 - (2) Compliance with all legal and statutory requirements concerning charter of incorporation, ownership of property, professional practice, taxes, etc.
 - (3) Specific structure and process to establish and review HMO policies including plans for enrollee involvement.
 - (4) Process by which HMO is to relate to State Comprehensive Health Planning Agency, the appropriate areawide health planning agency, and the State Hill-Burton agency.
- b. Assuring adequate financial arrangements (intended or existing)
 - (1) Projected cost estimates for start-up
 - Cost estimates of physical plant modernization, replacement, expansion, or rental
 - Estimate of marketing costs
 - (2) Actuarial analysis; determination of costs - i.e., projected cost per unit, per enrollee, per resource.
 - (3) Identification of revenue sources
 - Initial capital investment
 - Initial operating costs/deficits
 - Borrowed funds
 - Payment sources

- (4) Specific plans for covering operating losses or for the distribution of operating surplus.
- (5) Contingency financing plan to cover build-up or phase out costs if the HMO does not reach a break-even on schedule.

c. Assuring Health Plan Marketing (intended or existing)

- (1) A general description of the population in target market.
- (2) Description of the intended (or existing) enrollment population according to demographic characteristics, size, projected enrollment growth, etc.
- (3) Projected enrollment of population
 - Description of geographic areas to be marketed
 - Types of groups - i.e., union, Federal beneficiaries, etc.
 - Marketing strategy and projected market penetration
 - Decisions affecting benefit(s) package that will be competitive and marketable to each group.

d. Designing of the Health Care Delivery System (intended or existing)

- (1) Projected staffing patterns, staff organization and recruitment, arrangements for facilities and for inpatient care, continuity of care, emergency care, 24-hour access, scope of services to be provided, and related health record and data systems.
- (2) Development of mechanisms and procedures for assessment and assurance of quality of care, e.g., provision for medical audit, internal peer review and monitoring of quality.
- (3) Development of practices and services which emphasize the health maintenance concept, etc.

- Preventive services such as immunization programs, screening, routine physical, etc.
- Follow-up and recall of abnormal findings, well-baby visits, etc.
- Outreach efforts
- Enrollee health education
- Continuing education opportunities for physicians
- In-service training for nurses, paramedics, etc.

ARTICLE II - ARTICLES OR SERVICES TO BE FURNISHED AND DELIVERY TIME

The contractor shall submit to the Project Officer, Health Services and Mental Health Administration, 5600 Fishers Lane, Rockville, Maryland 20852, the following items in the quantities and during the periods listed below:

<u>ITEM</u>	<u>DESCRIPTION</u>	<u>QUANTITY</u>	<u>DELIVERY</u>
1.	Selection criteria utilized in selection of the five (5) AAMC projects, names of advisory committees members, and projects selected for HMO development.	5	Eight (8) weeks from effective date of contract
2.	Progress in the development of five (5) HMO's	5	Monthly reports beginning two (2) months from effective date of contract
3.	Status report on developmental and operational experience of five (5) HMO's	5	As an HMO becomes operational and each month thereafter until project completion
4.	Preparation and submission of project methodologies employed, evaluation reports and recommendations as detailed in the Scope of Work	5	Twelve (12) months from effective date of contract

ARTICLE III - DESIGNATION OF PROJECT OFFICER

Paul Kosco is hereby designated as Project Officer for this contract. The Project Officer or his authorized representative's responsibility will be to coordinate with the Contractor in administering the technical aspects of this contract. The Project Officer is not authorized to make any changes which affect the contract amount, terms, or conditions. The Contracting Officer is the only party authorized to bind the Government.

ARTICLE IV - DESIGNATION OF PROJECT DIRECTOR

Work and services shall be conducted under the direction of The Government reserves the right to approve any necessary successor to the designated Project Director.

ARTICLE V - REVIEW AND APPROVAL

Review and approval of the work hereunder shall be performed by the Contracting Officer or his duly authorized representative.

ARTICLE VI - NOTICE TO GOVERNMENT OF DELAYS

Whenever the Contractor has knowledge that any actual or potential situation is delaying or threatens to delay the timely performance of this contract, the Contractor shall, within ten (10) days, give notice thereof, including all relevant information with respect thereto, to the Contracting Officer.

ARTICLE VII - PROCUREMENT OF ALL MATERIAL, DATA, AND SERVICES

Except as otherwise provided herein, procurement of all material, data, and services necessary for performance under the terms of this contract shall be the responsibility of the Contractor.

ARTICLE VIII - COMPETITION IN SUBCONTRACTING

The Contractor agrees to select subcontractors on a competitive basis to the maximum practical extent consistent with the objectives and requirements of this contract.

ARTICLE IX - CONSULTANT SERVICES

Except as otherwise expressly provided elsewhere in this contract, and notwithstanding the provisions of the clause of this contract entitled "Subcontracting", the prior written approval of the Contracting Officer shall be required:

- (a) Whenever any employee of the contractor is to be reimbursed as a "consultant" under this contract; and

- SPECIAL PROVISIONS
- (b) For the utilization of the services of any consultant under this contract exceeding the daily rate set forth elsewhere in this contract or, if no amount is set forth, \$100.00, exclusive of travel costs, or where the services of any consultant under this contract will exceed ten days in any calendar year.

Whenever Contracting Officer approval is required, the contractor will obtain and furnish to the Contracting Officer information concerning the need for such consultant services and the reasonableness of the fees to be paid, including, but not limited to, whether fees to be paid to any consultant exceed the lowest fee charged by such consultant to others for performing consultant services of a similar nature.

ARTICLE X - IDENTIFICATION OF DATA

The Contractor shall identify the technical data delivered to the Government pursuant to the requirements of this contract with the number of this contract, and the name and address of the contractor or subcontractor who generated the data.

ARTICLE XI - DEVELOPMENT AND USE OF FORMS

Any forms which may be developed by the Contractor for use in the performance of this contract shall be submitted to the Project Officer for review and approval prior to their use. The Project Officer shall be responsible for obtaining clearance from the Office of Management and Budget, if required, prior to his approval for use by the Contractor.

ARTICLE XII - PUBLICITY AND PUBLICATIONS

- A. The Contractor agrees that it will acknowledge Health Services and Mental Health Administration, Department of Health, Education, and Welfare support whenever projects funded in whole or in part by this contract are publicized in any news media.
- B. The Contractor shall include in any publication resulting from the work performed under this contract an acknowledgement substantially as follows:

"The Project upon which this publication is based was performed pursuant to Contract No. HSM 110-72- with the Health Services and Mental Health Administration, Department of Health, Education, and Welfare."

ARTICLE XIII - CONTRACTOR AND SUBCONTRACTOR LISTING REQUIREMENT

- A. As provided by 41 CFR 50-250, the Contractor agrees that all employment openings of the Contractor which exist at the time of the execution of this contract and those which occur during the performance of this contract, including those not generated by the contract and including those occurring at an establishment of the Contractor other than the one wherein the contract is being performed but excluding those of independently operated corporate affiliates, shall, to the maximum extent feasible, be offered for listing at an appropriate local office of the State employment service system wherein the opening occurs and to provide such periodic reports to such local office regarding employment openings

and hires as may be required: Provided, That this provision shall not apply to openings which the contractor fills from within the contractor's organization or are filled pursuant to a customary and traditional employer-union hiring arrangement and that the listing of employment openings shall involve only the normal obligations which attach to the placing of job orders.

The Contractor agrees further to place the above provision in any subcontract directly under this contract.

Attachments: to HSM 110-HMO-22(2)

Cost and Price Analysis forms (2)

General Provisions (Negotiated Cost-Reimbursement Contract)

Alterations to Contract General Provisions (December, 1969)

Annex 1: Price Reduction for Defective Cost or Pricing Data

Billing Instructions, Health Services and Mental Health Administration,
Cost Reimbursement Negotiated Research Development and Technical Service
Contracts

Representations and Certifications (3)

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM #72-15

March 24, 1972

TO: Council of Deans

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

SUBJECT: AAMC Prison Health Services Survey

A summary of the results of the AAMC survey of medical school involvement in providing health services to prisons or prison systems is enclosed. I appreciate very much your cooperation with the survey and believe that you will be interested to learn the current participation of medical schools in this area of health service.

Of the 103 schools that responded to the survey, fifty-four schools reported that they provide service to a state prison or local detention center. Twenty-nine of the forty-eight schools not now providing services reported that they would be interested in participating in a service program if adequate funding for these services were available. Although no effort was made to determine the volume of services provided, the responses indicate that medical schools in their university-owned hospitals or through affiliated hospitals participate in a broad scope of inpatient and outpatient services, including general medical-surgical and psychiatric services along with social rehabilitative services for drug addiction and alcoholism. Medical faculties, house staff, and students are involved in providing care.

Descriptions of special programs were returned with questionnaires in some instances. One school which provided services both in its teaching hospital and jail facilities had recently reviewed the total expenditures for outpatient care to prisoners and concluded that this money could be spent more effectively in a coordinated program. As a result, medical school faculty have developed a proposal for support of a staff to develop a program of health care for prisoners that would emphasize the "rehabilitative potential of the jailing situation" and to pursue sources of funding for an expanded and more comprehensive program. Another school has participated in a project to bring about "significant and lasting changes in the structure and operation of the correctional system" in its area. The program will be directed toward the existing institution and will also involve medical center faculty in the operational design for a new county jail to be built in the next few years. In this instance, the expertise of the medical faculty is being applied to development of solutions to problems in health service to prisons but most of these services will not be provided by medical school personnel. In other communities, the medical schools have become involved in service delivery programs for prison inmates. These programs have often been initiated in response to the problems that arise where there is inadequate or unsupervised health care to prisoners. The relationships between medical schools and prison systems are not without problems, but those schools involved suggest that along with the positive benefit to the community and to the prisons, these service relationships give valuable opportunities for teaching and research.

The AAMC survey was undertaken following discussions with Bob Glaser and Quigg Newton of the Commonwealth Fund. There is also interest in improving the effectiveness of the nation's correctional system in both the legislative and the executive branches of the government. Comprehensive approaches to reorganization and reform of our correctional institutions are being sought, not only by the government, but also in the private sector. The American Bar Association has appointed a Commission on Correctional Facilities and Services, a group that has had the cooperation of other professional and public service groups, including the American Medical Association. Many medical schools too have already demonstrated their commitment to improvement and reform of the health aspects of prisons.

Because of the current level of activity demonstrated in this survey of medical schools and because of the interest in this activity expressed by medical schools not now involved, Dr. Robert Kalinowski, Director of the Division of Health Services, and I are continuing discussions with Dr. Glaser and Dr. Reginald Fitz of the Commonwealth Fund, representatives of the Department of Justice, and of some of the medical schools now active in prison health services. At a meeting scheduled for May 15, we will explore further ways in which to stimulate support for and interest in participation of medical schools in health services to prison systems.

<u>Number of Medical Schools Receiving Survey</u>	<u>Number of Responses</u>	<u>Rate of Response</u>
108	103	95%

NOTE: The survey was mailed to 110 medical schools. However, the responses received from the two medical schools which are two year schools for basic sciences were not included in the final calculations.

1. Medical Schools Providing Medical Services to a Prison System

	Number of Medical Schools	Percent of Responses
Institutions providing medical care services to a prison system, jail or detention center	54	52%
No services provided	49	48
TOTAL	103	100

1b. Medical Schools Providing No Medical Services to Prison Systems

No services provided but interested in program with funding	29	59%
No services provided and not interested	19	39
TOTAL	48	98

The following tables include only the 54 medical schools that do provide medical care services to a prison system. Several schools were involved in more than one type of program.

2. Types of Institutions Providing Medical Care Services to Prison Systems

Types of Institutions Providing Service	Number of Medical Schools	Percent of Responses/54
Medical School	27	50%
University-owned Hospital	22	41
Affiliated Teaching Hospital	27	50
TOTAL	76	XX

3. Types of Service Provided to Prisons by Medical Schools.

Types of Service Provided	Number of Medical Schools	Percent of Responses/54
General medical-surgical	44	81%
Psychiatric	34	63
Rehabilitative (Total # of schools)	17	32
Drug addiction	11	20
Alcoholism	10	19
Other	5	9
Special Projects	9	17

4. Medical Personnel Who Provide Services to Prison Systems

Personnel	Number of Medical Schools	Percent of Responses/54
Faculty	47	87%
Interns	39	72
Residents	46	86
Medical students	28	52
Other	5	9

5. Institutions that Provide Inpatient and Outpatient Services to Prison Systems.

Type of Service	University Hospital	Affiliated Teaching Hospital	Prison Hospital or Infirmary
INPATIENT (49 schools)	21	22	15
Adult male	20	22	15
Adult female	19	21	7
Children	9	10	3
OUTPATIENT (45 schools)	19	19	11
Adult male	18	19	11
Adult female	17	17	6
Children	7	8	2

6. Type of Agreement between Medical Schools and Prison Systems

Prison System	Medical Schools with an Informal Relationship with Prison System	Medical Schools with an Affiliation Agreement with Prison System	TOTAL
Federal	3	1	4
State	21	7	28
Local detention center	18	9	27
Other	4	1	5
TOTAL	46	18	64

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MEMORANDUM # 72-14

March 6, 1972

TO: Council of Deans

FROM: Marjorie P. Wilson, M.D.

SUBJECT: Progress Report--Management Advancement Program

Several times since last spring, in reports of the President John Cooper, in the weekly News Letter, in my reports to regional COD meetings, we have commented on work toward the development of what has been called a "management advancement program" Progress has been slow, but definite. We have sought input from many individuals representing diverse viewpoints and with some considerable diversity of experience and expertise. The definition of the specifics of the effort is far from complete, however.

Three very significant developments have occurred in recent weeks which prompt this interim report. We are in the process of forming the permanent steering group for the projects, and Ivan Bennett has agreed to serve as chairman. The Carnegie Corporation has made a planning grant to allow us to carry the planning of the overall program forward and to provide partial support for an initial seminar next fall. The Grant Foundation has also generously approved a grant to help defray the costs of the first orientation seminar. We are thinking in terms of an intensive week's seminar designed specifically for deans.

Time has been devoted so far to conceptualizing an approach to bringing what is known of organization development to the broad group of institutions which have indicated an interest, and to designing an executive development or management development program for individuals. The seminar mentioned above would be a first effort along this latter line and is also do-able on the short range. Particular effort has been directed at seeking the best qualified managerial and organizational expertise available in the country to work with us. The steering committee will have to commit itself to considerable interaction with such advisors to assure the appropriateness of the educational efforts to the real problems of academic medical centers. The AAMC will provide a facilitating function in bringing the deans and medical

center executives together with those with the expertise in management to design the educational program. It will assume a coordinating function in making the results of these efforts as widely available as possible to those individuals and institutional teams who are interested and wish to participate. Needless to say, participation will be entirely voluntary and this special program will be a supplement to, rather than a substitute for, regular COD activities and meetings. Also, space available in the initial effort will undoubtedly be limited.

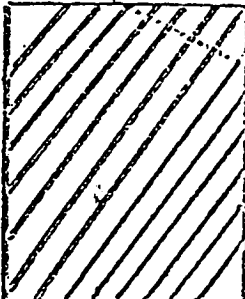
After the work of the next few weeks, we should be able to provide a much more detailed report on the feasible directions and dimensions of the program. The plan is to seek the major funding of the program from foundations and other granting sources.

Questions and comments are welcome. Do not hesitate to contact me by letter or telephone at (202) 466-5192.

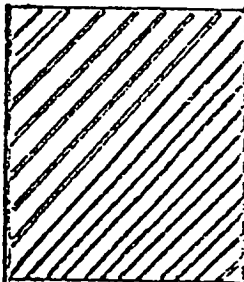
ANNUAL MEETING PROGRAM FORMAT

(5-Day Meeting)

Option #1 (1970 format)

	I.	II.	III.	IV.	V.
AM		PLENARY SESSION	PLENARY SESSION	PLENARY SESSION	MISCELLANEOUS MEETINGS
PM	COTH Business Meeting COD Program Miscellaneous Meetings	COD Business Meeting CAS Program Miscellaneous Meetings	CAS Business Meeting COTH Program Miscellaneous Meetings	ASSEMBLY	MISCELLANEOUS MEETINGS

* Option #2 (1971 format)

	I.	II. <i>Friday</i>	III. <i>Saturday</i>	IV. <i>Sunday</i>	V.
AM		PLENARY SESSION	PLENARY SESSION	PLENARY SESSION	MISCELLANEOUS MEETINGS
PM	Miscellaneous Meetings	CAS Business COD Business COTH Business Miscellaneous Meetings	COD Programs CAS ASSEMBLY	MISCELLANEOUS MEETINGS	MISCELLANEOUS MEETINGS

Council Program meetings could be scheduled at different times, or in conjunction with the Business meetings (as this year).

2 Plenary Sessions

COD Programs either Sat. or Sunday morning

Documents Setting Up Graduate Medical Education Committee Approved

Two implementing documents to set up a Liaison Committee on Graduate Medical Education (LCGME) and a Coordinating Council on Medical Education were approved March 30 by representatives of the five organizations involved in the expansion of the accrediting structure for medical education. The American Medical Association, the Association of American Medical Colleges, the American Hospital Association, the American Board of Medical Specialties, and the Council of Medical Specialty Societies previously had agreed on the establishment of a formal body to accredit programs of graduate medical education and on five basic organizational points for the accreditation of all medical education. (*February Bulletin*)

The latest documents, if approved by the five parent organizations, would implement establishment of the LCGME and of the Coordinating Council and would set forth the name, authority, purpose, function, composition, officers, and financing of these new groups. The two implementing proposals will go before the AAMC Executive Council at its May 19 meeting for recommendation to the Assembly in November.

The proposed documents stipulate that the AAMC, the AMA, and the ABMS would each have four representatives on the LCGME, that the CMSS and the AHA would have two representatives each, and that one representative would be appointed from the government and one from the public. The Coordinating Council would be composed of three representatives from each of the five organizations, one government representative, and one public member.

Plenary Session Program for 1972 Annual Meeting Completed

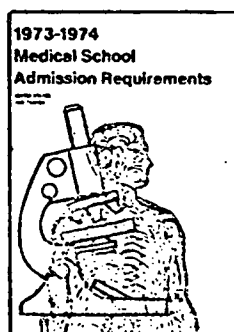
The program for the plenary sessions at the 1972 Annual Meeting of the AAMC, to be held November 2 through 6 at the Hotel Fontainebleau in Miami Beach, Florida, has been completed. The theme of the program will be "From Medical School to Academic Health Center."

The plenary sessions will be November 3 and 4. The speakers and their general topics will be: Dr. Russell A. Nelson, president, The Johns Hopkins Hospital—the AAMC chairman's address; Dr. John R. Hogness, president, Institute of Medicine of the National Academy of Sciences—the education of health professionals as a team; Dr. Ivan L. Bennett, Jr., dean, New York University School of Medicine—the continuum of undergraduate and graduate medical education; Dr. Philip R. Lee, chancellor, University of California, San Francisco Campus, School of Medicine—the governance of the academic health center; Dr. Clark Kerr,

chairman, Carnegie Commission on Higher Education—Alan Gregg Memorial Lecture; Dr. Edmund D. Pellegrino, vice president for health sciences and director of the Health Sciences Center, State University of New York at Stony Brook Medical School—academic medicine's responsibility for area health education centers; Mr. Arthur E. Hess, deputy commissioner, Social Security Administration—the role of the academic health center in delivering health care; Dr. Joshua Lederberg, chairman, Department of Genetics, Stanford University School of Medicine—expanded research efforts in the modern academic health center.

As in the past, numerous groups will meet in conjunction with the AAMC Annual Meeting. Many of the Council of Academic Societies constituent societies will hold meetings in Miami Beach, as will all of the groups and sections formally or informally affiliated with the Association. The three AAMC Councils will hold business meetings on the afternoon of November 3, and the AAMC Assembly will meet on the afternoon of November 4.

Now Available
Medical School
Admission Requirements
U.S.A. and Canada, 1973-74



The 23rd edition of this official handbook, published by the AAMC, provides up-to-date information on premedical planning, choosing a medical school, and medical school admission processes. Sections discuss minority group students, combined M.D. degrees, studying abroad, financial aid, and alternatives for rejected applicants. The book contains two-page descriptive entries for the U.S. and Canadian medical schools, detailing entrance requirements and programs of each school.

To order, write:
Association of American
Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

February 18, 1972

John D. Porterfield, III, M.D.
Director
Joint Commission On Accreditation
of Hospitals
645 N. Michigan Avenue
Chicago, Illinois 60611

Dear Dr. Porterfield:

I am writing to you in my official capacity as Director of the Council of Teaching Hospitals (COTH). The organizational role of COTH in the Association of American Medical Colleges is presented in the attached organization chart. I have also enclosed a list of the COTH Administrative Board members.

The Administrative Board serves as the executive body of COTH. At its most recent meeting, the Administrative Board engaged in an extensive discussion of JCAH's standards as they relate particularly to university hospitals. The discussion centered on the matter of medical staff by-laws and institutional governance, although a number of other issues were raised.

Following discussion, the Board directed the staff to explore the possibility of co-sponsoring with the Joint Commission a two-day seminar or conference on this issue. In this manner, chief executive officers and chiefs of medical staffs (by whatever title) could come together with representatives of the JCAH and hopefully arrive at some reasonable solutions in applying accreditation standards in the university setting. Hopefully, a model could evolve that would be beneficial to both the JCAH and university hospitals.

Thus, the purpose of this letter is to request that you consider the possibility of jointly sponsoring such a conference with us. I shall look forward to hearing from you.

Sincerely,

JOHN M. DANIELSON
Director
Council of Teaching Hospitals

JMD/plf

Attachments: Organizational chart
List of Administrative Board members

**Joint
Commission**

on Accreditation of Hospitals

645 North Michigan Avenue Chicago, Illinois 60611

John D. Porterfield, M.D.

Director (312) 642-6061

March 20, 1972

John M. Danielson, Director
Council of Teaching Hospitals
Association of American Medical Colleges
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear John:

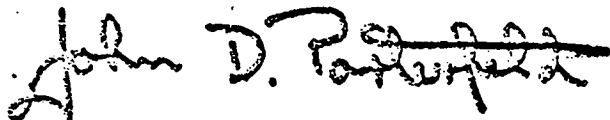
Please forgive this long delay in answering your letter of February 18, 1972. We have been up to here in court suits and attorneys for some weeks now and the daily mail has suffered.

The Joint Commission staff would be very interested in discussing with you a COTH/JCAH sponsored seminar on the unique accreditation programs of teaching hospitals. In addition to that exercise itself, perhaps out of it could come a subsidiary 'Guidelines for the Application of Accreditation Standards to Teaching Hospitals'. We have a small brochure of this nature for our surveyors with reference to federal military hospitals, which also have special translation problems. It is useful, it appears, not only to our field staff but to military hospital personnel seeking guidance in preparing for accreditation surveys.

We have a Kellogg grant to support a program of workshops for trustees, administrators and medical staff members. It is well-booked in advance and appears to be very well received. I am sure that we can find time to discuss this special purpose session.

Dr. Walter Carroll, Associate Director for Research and Education, is in charge of the workshop program. He has an able staff and I am sure will soon be in communication with you on your proposal.

Sincerely,



John D. Porterfield, M.D.
Director

JDP:dg

cc: Walter W. Carroll, M.D.

Member Organizations

American College of Physicians

American Hospital Association

American College of Surgeons

American Medical Association

April 6, 1972

Walter W. Carroll, M.D.
Joint Commission On
Accreditation Of Hospitals
645 North Michigan Avenue
Chicago, Illinois 60611

Dear Dr. Carroll:

The purpose of this letter is to follow-up our telephone conversation of yesterday, April 5.

I have enclosed a copy of John Danielson's original letter to Dr. Porterfield. You'll note that the reference in the second paragraph is to university hospitals. In this instance, the intention was to convey that the problems were peculiar to those teaching hospitals which are owned or operated by a university or free-standing college of medicine.

What I would propose is that I get together four or five of the administrators of these hospitals who have recently been surveyed to discuss specific problems they may have with the accreditation process. In this way a conference could be organized around the problems identified by these individuals. With this in mind, I have attached a list of the 62 university owned or operated teaching hospitals. If you could tell me which of these 62 hospitals have been surveyed in the past eighteen months, I'd like to bring a small group of these hospital directors together for consideration of this matter.

I'll be interested in your thoughts. Hopefully You'll receive this letter prior to our conversation on Monday or Tuesday.

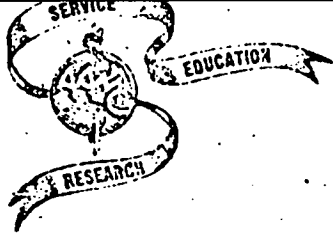
Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Division of Teaching Hospitals

RMK/plf

Attachment: as indicated

b.c.c. George Carroll



ASSOCIATION OF AMERICAN MEDICAL COLLEGES
COUNCIL OF TEACHING HOSPITALS

ONE DUPONT CIRCLE, N.W.
WASHINGTON, D.C. 20036
202/466-5127

April 18, 1972

James E. Moon
Administrator
University of Alabama
Hospitals & Clinics
619 South 19th Street
Birmingham, Alabama 35233

Dear Jim:

At its most recent meeting, the COTH Administrative Board engaged in an extensive discussion of the standards of the Joint Commission On Accreditation of Hospitals as they relate to university owned or operated teaching hospitals. The discussion centered on the matters of medical staff by-laws and institutional governance, although a number of other issues were raised.

Following discussion, the Board directed the staff to explore the possibility of co-sponsoring with the JCAH a short seminar or workshop on this issue. In this manner, chief executive officers and chiefs of medical staff (by whatever title) could come together with representatives of the JCAH and hopefully arrive at some reasonable solutions in applying accreditation standards in the university owned or operated teaching hospital.

Following initial correspondence from John Danielson, Dr. Porterfield stated that the Joint Commission staff would be very interested in discussing a COTH/JCAH sponsored seminar on the unique accreditation problems of university hospitals.

The JCAH does have a new educational program for this purpose which has been functioning for a year under the direction of Dr. Walter Carroll, Associate Director for Research and Education. Of the 62 university owned or operated teaching hospitals, Dr. Carroll has reported that yours is one of ten such hospitals which has been surveyed by the JCAH since July 1, 1971, the point at which the new standards were implemented.

The purposes of this letter are outlined in the following questions:

- 1) During the most recent JCAH review, were there problems in applying the standards due to the organizational peculiarities of being a university owned or operated teaching hospital?

James E. Moon
Page Two
April 18, 1972

- 2) If so, do you believe these problems could be usefully discussed at a one or two day seminar which might result in a model set of guidelines for use by JCAH field staff?
- 3) Would you be willing to serve as a member of a planning committee if such a seminar were to be organized?

I'd be interested in any other comments you might have with regard to this proposal, and look forward to hearing from you.

Sincerely,

RICHARD M. KNAPP, Ph.D.
Director
Division of Teaching Hospitals

RMK/plf

cc: Walter W. Carroll, M.D.

Nelson F. Evans
Administrator
University Hospital
650 Harrison Avenue
Boston, Massachusetts 02118

John F. Harlan, Jr.
Director
University of Virginia Hospital
Jefferson Park Avenue
Charlottesville, Virginia 22903

Burwell W. Humphrey
Administrator
1364 Clifton Road, N.E.
Atlanta, Georgia 30322

John F. Imirie, Jr.
Vice-President for the Medical College
of Virginia Hospitals
Medical College of Virginia Hospitals ✓
1200 E. Broad Street
Richmond, Virginia 23219

Baldwin G. Lamson, M.D.
Director
U.C.L.A. Hospitals & Clinics ✓
10833 Le Conte Avenue
Los Angeles, California 90024

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Director
University of Kansas Medical Center Hospital
Rainbow Blvd. at 39th Street
Kansas City, Kansas 66103

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Vernon E. Schaefer
Director
Temple University Hospital
3401 N. Broad Street
Philadelphia, Pennsylvania 19140

Richard C. Schripsema
Hospital Administrator
University Hospital
University of Nebraska
Omaha, Nebraska 68105

*4 received
plus
Nelson F. Evans
Virginia*

Eugene L. Staples
Director
West Virginia University Hospital
Morgantown, West Virginia 26506 ✓



the University of Alabama in Birmingham / 619 SOUTH NINETEENTH STREET / BIRMINGHAM, ALABAMA 35233

the Medical Center / UNIVERSITY OF ALABAMA HOSPITALS AND CLINICS April 26, 1972

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

Dear Dick:

Regarding your letter of April 18, 1972, on Joint Commission standards, I'd be happy to participate in such a program. To answer your three specific questions:

1. Regarding our recent JCAH survey, we did experience some problems in applying the standards due to the organizational peculiarities of being a university owned or operated teaching hospital, but they certainly did not prove too insurmountable.
2. I do believe that these problems could be usefully discussed at a one or two day seminar, which might result in a model set of guidelines for use by the JCAH.
3. I would be willing to serve as a member of a planning committee if such a seminar were organized.

Good to hear from you.

Sincerely,

James E. Moon
JAMES E. MOON
Administrator

JEM:ws



Virginia Commonwealth University

Medical College of Virginia

April 20, 1972

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

Dear Dick:


In response to your letter of April 18 concerning our recent JCAH review, and in specific response to the three questions that you pose, I will respond with the following.

To my knowledge, there were no problems in applying the standards due to our organizational peculiarities. We presented the University Board meetings that covered hospital aspects and described the action of a Board committee that was concerned with the hospital. I would agree that a strict interpretation of the JCAH requirements would have left us in a nonconforming situation. However, such was not pursued by the two members of the survey team.

The answers to your second and third questions are difficult based on what I have said above. I do believe that the situation should be clarified so that the survey team need not feel they are compromising the "letter of the law". I would be happy to participate in such an activity in any way that would be of assistance to university teaching hospitals.

The two members of our survey team were Everett King, M.D. and Helen Aurich, R.N.

Sincerely yours,


John F. Imitie, Jr.
Vice President - V.C.U.
Medical College of Virginia Hospitals

JFI/ap
I-2-430

Health Sciences Center • Richmond, Virginia 23219



OFFICE OF THE DIRECTOR
HOSPITALS AND CLINICS
THE CENTER FOR THE HEALTH SCIENCES
LOS ANGELES, CALIFORNIA 90024

April 25, 1972

Richard M. Knapp, Ph.D.
Director
Division of Teaching Hospitals
One DuPont Circle, N.W.
Washington, D.C. 20036

Dear Dick:

During our last accreditation review which was conducted in October, 1971, we did not encounter any particular problems in complying with standards due to the organizational peculiarities of being a University owned or operated teaching hospital.

The principal area of concern to the examiners where our organizational differences from the typical community hospital affect our method of delivery of patient care was in the degree that we delegate the peer review function to the individual departments of the medical staff rather than conduct hospital wide reviews. As long as adequate departmental records were available, this degree of decentralization did not appear to bother the examiners. On the whole the review went well without any particular problems, although I must admit that we had worked very hard in preparation for the review.

I would be willing to serve as a member of a planning committee, if you wish me to do so, in preparation for a joint COTH/JCAH seminar, even though we did not encounter any particular problems at the time of the review.

Sincerely,

A handwritten signature in cursive script, appearing to read "Baldwin", is written above the printed name.

Baldwin G. Lamson, M.D.

BGL:np

West Virginia
University

MEDICAL CENTER

MORGANTOWN, WEST VIRGINIA 26506

University Hospital

April 25, 1972

Dr. Richard M. Knapp, Director
Division of Teaching Hospitals
Assoc. of American Medical Colleges
One Dupont Circle N.W.
Washington, D. C. 20036

Dear Dr. Knapp:

In response to your letter of April 18th, we would be most happy to join with other members of the COTH in working with the Joint Commission on Accreditation of Hospitals for special or specific regulations as they might apply to University Hospital setting.

We were visited by Dr. Earl Weir and Mr. J. Landon Rule on July 18th through the 20th of last year. We were very pleased with the attitude of both surveyors and it is the first time in twenty-two years of my history that I have found the Joint Commission inspection to be a rewarding one. The Medical Staff at the Hospital was particularly pleased with the Medical Chart Workshop conducted by Dr. Weir, and found it most helpful and informative.

I am enclosing a confidential copy of their recommendations and comments as they pertain to our institution. I thought this might be helpful to you, particularly seeing what these two reviewers had to say about our institution.

I feel that Dr. Weir and Mr. Rule met us with a great deal of understanding, and particularly, as it relates to the fact that we are a teaching hospital. With the new criteria established by the Joint Commission on Accreditation of Hospitals, there is an opportunity for the reviewers to interpret the facility, and its practice and procedure. This was very important in the inspection

Dr. Richard M. Knapp
April 25, 1972
Page Two

by Dr. Weir and Mr. Rule. It would be very difficult to have had some of our former inspectors review us particularly in terms of their attitude and rigid interpretation of standards.


While we enjoyed a good experience with the two reviewers, I can see that there would be great problems had they not brought the understanding with them that they did. I, therefore, would be quite willing to serve on the Planning Committee and would strongly recommend that a seminar be conducted.

We spent many weeks in preparation for the Joint Commission visit. I would think it would be particularly rewarding to have a seminar session for teaching hospitals as it relates to the preparation that goes with the inspection process itself. In addition, there is real need for broader interpretation of some of the regulations as they might pertain to teaching hospitals.

Again, I would like to re-emphasize the fact that had the reviewers been more rigid in their interpretation of more specific standards there would have been a great deal of difficulty evidenced in their visitation with us. As it stood, they were reasonable in their interpretation and, as I have indicated, we found it an educational and very worthwhile experience.

I look forward to hearing from you in the future regarding this matter.

Very truly yours,


Eugene L. Staples
Director

ELS/msr
enc.

DATE OF SURVEY
JULY 19, 20, 1971

SURVEYOR
EARL F. LEE, M. D.
J. LONDON FULF, ADM.

REVIEWER
OTTO ARNDT, M. D.

RECOMMENDATIONS AND COMMENTS

- Medical* 1. The medical staff rules and regulations should be amended in order to require that:
- a) Medical records on discharged patients be completed within 15 days after the discharge of the patient; and
 - b) Operative reports be recorded by the surgeon immediately after the operation has been completed.
- Nursing* 2. A brief and pertinent written care plan should be developed for each patient and should be coordinated with the patient's medical plan of care.
- G. Mann* 3. There should be a continuing training and educational program for the development of nursing personnel and it should be under the direction and supervision of a qualified person.
4. The exhaust hoods for cooking ranges should be equipped with an approved automatic carbon dioxide or dry chemical extinguishing system.
5. The walk-in freezer should be connected with the emergency power generating system.
6. A more comprehensive automatic fire extinguishing system should be installed in the soiled linen and trash chutes.
7. All hazardous areas of the hospital, such as the general storage areas, should be protected by an automatic fire extinguishing system.
8. Smoke stops should be installed in corridors in which there is more than 150 feet between such barriers.
9. Departmental housekeeping should be improved in the general storage areas.
10. A plan should be developed whereby water is made available when the usual source of water is not usable or available.
- R.R.* 11. Clinical entries, when dictated, should designate the date of dictation; the date of transcription on transcopies filed in the medical record is also recommended.
- Medical* 12. Medical records on discharged patients should be completed within 15 days after the discharge of the patient.

- Both*
Medical
Medical
13. The complete necropsy protocol should be made part of the decedent's medical record within three months after prosection.
 14. There should be documentation in evidence of periodic review by the medical staff of all transfusions of blood and blood components, in order to assess transfusion reactions, evaluate blood utilization, and to make recommendations regarding specific improvements in transfusion services.
 15. Drug reactions should be reported to the pharmacist, as well as the physician who ordered the drug, to ensure that appropriate reporting may be carried out.

REFERENCE IS MADE TO THE "ACCREDITATION MANUAL FOR HOSPITALS."

RATING BY BOARD OF COMMISSIONERS: ACCREDITATION FOR TWO YEARS.

es

has been an improvement in the management of the hospital since the last visit. The hospital is well equipped and the staff is well trained. The hospital is in good financial condition and the services are of high quality.

Copies of this letter with recommendations have been sent to the chair of the governing board of the hospital. The hospital is well equipped and the staff is well trained. The hospital is in good financial condition and the services are of high quality.

Your hospital is entitled to a Certificate of Accreditation for two years. The hospital is well equipped and the staff is well trained. The hospital is in good financial condition and the services are of high quality.

If any question should arise relative to this letter, please contact the Board of Commissioners. The hospital is well equipped and the staff is well trained. The hospital is in good financial condition and the services are of high quality.

The Commission wishes to thank you for the information and for your cooperation in the process of accreditation. The hospital is well equipped and the staff is well trained. The hospital is in good financial condition and the services are of high quality.

Sincerely,
[Signature]
[Name]
[Title]
[Address]
[City, State, Zip]

Outline for Association testimony on the Kennedy and Rogers HMO legislation

Introduction

Standard material, identifying the AAMC, its constituency and its broad interests.

General Comments

1. Existence of bills indicates interest in changing the present system. Changes should be made as part of a national health strategy. Finance v. program.

2. In general, the AAMC supports the intent of the legislation to provide federal support for the concept of prepaid comprehensive health services to defined populations in a framework that emphasizes preventive rather than curative action. This is a concept with vast potential for advancing the nation's health.

3. The role of the academic health center will be varied -- sponsor, catalyst, affiliate for tertiary services. Educator will be an important role since a generation of doctors will be functioning in HMO settings and will have to receive some of their education in such settings.

4. The AAMC comments are based on realistic and pragmatic assessment of the current health scene. Such an assessment will lead the AAMC to utter some harsh truths about some of the provisions of the legislation. It is vastly more important to begin the process successfully of changing the health care system than to attempt, and fail, to remake in a single stroke the way health care is provided in America.

Health Maintenance Organizations

The HMO in Context

Forty-year national experience with prepaid group practice. Kaiser-Permanente is the classic model -- a hospital-based plan. There are non-hospital-based plans, HIP of New York; physician-run plans; for-profit plans; academic health center plans.

Legislation

1. Administration: HR 5615; S 1182, the Health Maintenance Organization Assistance Act. The most general and vaguely worded of the proposals.

2. Roy: HR 11728, the Health Maintenance Organization Act. More detailed and specifically worded. Goes beyond basic financial support to include special project authority, a new advisory council, and aid for management and clinical training.

3. Kennedy: S 3327, the Health Maintenance Organization and Resources

Development Act. The broadest and most specifically worded of the proposals. An omnibus measure, organized into five titles spread across 88 pages. In addition to assistance for HMOs, also provides assistance for HSOs (essentially medical foundation plans); area health education centers; establishment of an independent federal Quality of Care Commission to set norms and standards, require compliance with them, and administer a newly created federal medical malpractice insurance program; extension of a number of existing health programs, including Comprehensive Health Planning and Regional Medical Programs.

Association Comments

1. Comprehensive benefits -- Administration too vague, not enough incentive for improvement. Kennedy too detailed, unrealistically comprehensive, cost would make it impossible to finance. Recommendation is for a combination of Administration and Roy provisions --

To qualify as an HMO, an organization must embody the following characteristics:

a. The organization or group of cooperating organizations constituting the HMO shall constitute a comprehensive health-care delivery system with clearly identifiable points of responsibility for all managerial, administrative and service functions.

b. It shall assume responsibility for providing or effectively arranging for reasonably comprehensive health care services including at least physician services (including consultant and referral services); inpatient and outpatient hospital services; members' health education services and education in the appropriate use of health services; diagnostic laboratory and diagnostic and therapeutic radiologic services; rehabilitation services (including physical therapy); preventive health services; emergency health services; out-of-area emergency health services; and such other personal health services as the HEW Secretary may determine are necessary to insure the protection, maintenance and support of human health.

c. It shall receive compensation for such services to its enrolled participants primarily on the basis of predetermined periodic rate; however, it may also serve non-enrolled beneficiaries on a fee-for-service basis and may require modest copayments as agreed upon in advance to supplement its periodic rate with respect to certain services to enrollees.

d. It shall be responsible for providing all covered services for a contract period within the revenue provided through the predetermined rate and copayment method of reimbursement, under arrangements whereby the organization bears, and the cooperating units within the organization share, financial responsibility for the appropriate and effective utilization of health care resources to meet the health care needs of the enrollees.

2. Open enrollment -- Completely unrealistic to require initially without universal entitlement (national health insurance). There is no universal entitlement at the present time. Open enrollment is not required of other forms of health care delivery. Recommendation is for a progressive enrollment policy aimed at producing an HMO membership whose demographic composition

is representative of the population served. There should be a subsidy or incentive award to encourage enrollment of high-risk population.

3. Medically needy -- Roy requires a minimum enrollment from medically underserved areas; Kennedy sets a maximum on such enrollment. Both approaches should be rejected. Recommendation for the HEW Secretary to have authority to determine that there is reasonably representative proportion of enrollees from medically underserved areas.

4. Profit v. nonprofit -- Nothing to be said in testimony. If asked, to support loans and contracts only (no grants) to for-profit HMOs, with adequate safeguards. The reason is that there are some good examples of for-profit prepaid plans now operating. Also, a major portion of the nation's health industry is for-profit.

5. Preemption of state laws -- Both Roy and Kennedy provide for the preemption of state laws that would restrict the establishment and operation of HMOs. We plan to support this.

6. Advisory council; quality care commission -- Roy proposes an HMO national advisory council; Kennedy proposes a new, independent federal regulatory agency, to be known as the Quality of Care Commission. The AAMC supports establishment of the Commission to establish national norms and standards, with the approval of the advisory council whose functions and powers and duties would be modified to fit this new role. The administration of the federal quality standards should be through DHEW, to avoid duplicating the HEW bureaucracy. To help the Commission carry out its duties, Kennedy proposes to transfer to it the National Center for Health Statistics. The AAMC approves.

7. Federal medical malpractice insurance -- Kennedy proposes to establish a federal medical malpractice insurance program to be administered by the Quality of Care Commission (see 6 above). The AAMC supports creation of such an insurance program, urges its administration through DHEW.

8. Initial HMO financing -- The AAMC supports the proposed federal assistance for planning, developing, construction and initial operating assistance which each of the legislative proposals provide through a variety of grants, contracts, direct loans, and guaranteed loans and interest subsidies.

Area Health Education Centers

Origin of the Concept

Carnegie Commission, in its 1970 report "Higher Education and the Nation's Health -- Policies for Medical and Dental Education."

Legislation

Title III of the Kennedy bill (s 3327) authorizes a new program of assistance to university health centers or to regional medical programs (where they exist) for creation of area health education and service centers.

Association Comments

The Association supports the concept of the area health education center as a linking mechanism between the academic health center and the community health service scene. Such mechanisms can be supported under existing legislation, through the Regional Medical Program Service and the Bureau of Health Manpower Education. The AAMC urges that support be provided through these agencies and that title III be dropped from the Kennedy bill.

Comprehensive Health Planning - Regional Medical Programs

Legislation

Title V of the Kennedy bill (S 3327) proposes to extend virtually without change a number of federal health programs which are due to expire June 30, 1973. Among them are CHP and RMP.

Association Comments

CHP and RMP should be abolished. Their functions should be turned over to a single state health agency and substantial federal support should be provided for the adequate staffing and operations of the agency. A suggested role for the newly enhanced state health agency would be to implement the tough federal standards established by the Quality of Care Commission (see 6 above, under Association Comments on HMOs). The functions of the new state agencies might include planning for the arrangement, distribution and character of health services in a state; exercising a controlling role in decisions concerning the location of capital investment or the development of services, particularly those supported with public funds; providing technical assistance for the qualitative improvement of health services as required by the federal quality standards; performing the broad public health function aimed at the health of the population rather than the health of individuals. Appropriate provision should be made for national health resources -- such as academic health centers -- which happen to be located in a certain state.

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GUIDELINES FOR SUB-COUNCIL ORGANIZATION

There shall be the following classes of sub-council entities, organized in accordance with the definitions and specifications listed below:

- A. ORGANIZATION -- an Organization of the AAMC is defined as a membership component, associated specifically with one Council of the Association, and having voting participation in the governance of the AAMC.
 - 1. Its establishment requires a bylaws revision approved by the AAMC Assembly.
 - 2. The Association shall assume responsibility for staffing and for basic funding required by the Organization.
 - 3. The Organization shall be governed by rules and regulations approved by the parent Council.
 - 4. All actions taken and recommendations made by the Organization shall be reported to the parent Council.
- B. GROUPS -- a Group of the AAMC is defined as representatives of a functional component of constituent institutional members. Groups are created to facilitate direct staff interaction with representatives of institutions charged with specific responsibilities and to provide a communication system between institutions in the specific areas of a Group's interest. Group representatives are appointed by and serve at the pleasure of their deans. Groups are not involved in the governance of the Association.
 - 1. Establishment of a Group must be by the President of the Association with the concurrence of the Executive Council.
 - 2. All Group activities shall be under the general direction of the AAMC President or his designee from the Association staff.
 - 3. Groups may develop rules and regulations, subject to the approval of the AAMC President. An Association staff member shall serve as Executive Secretary.
 - 4. Budgetary support for Groups must be authorized by the Executive Council through the normal budgetary process of the AAMC.
 - 5. The activities of Groups shall be reported periodically to the Executive Council.
- C. COMMITTEES -- a Committee of the AAMC is defined as a standing body reporting directly to one of the official components of the Association (Executive Council, Councils, Organizations, Groups), charged with a specific continuous function.
 - 1. Committees of the Executive Council may be charged with roles related only to governance, program, liaison, and awards.

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2. Committees of the Councils and Organizations may be charged with roles related only to governance and program.
 3. Committees of the Groups may be charged with roles related only to program.
- D. COMMISSIONS -- a Commission of the AAMC is defined as a body charged with a specific subject matter function, assigned for a definite term of existence, and reporting directly to one of the official components of the Association. All previous "ad hoc committees" shall become known as Commissions.
1. A Commission may be charged by the AAMC component to which it is to report, or by the Executive Council.
 2. No Commission may be charged for a term longer than 2 years, at the end of which it shall be re-charged or dissolved.

4/17/72