aamc association of american medical colleges

MEETING SCHEDULE
COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD

June 29-30, 1983
Washington Hilton Hotel

WEDNESDAY, June 29, 1983

6:30pm	COTH ADMINISTRATIVE BOARD MEETING Chevy Chase Room
8:00pm	COTH ADMINISTRATIVE BOARD DINNER Dupont Room

THURSDAY, June 30, 1983

9:00am	COTH ADMINISTRATIVE BOARD MEETING Farragut Room
1:00pm	JOINT ADMINISTRATIVE BOARD LUNCHEON Monroe West
2:30pm	EXECUTIVE COUNCIL BUSINESS MEETING Monroe East

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

A G E N D A

COUNCIL OF TEACHING HOSPITALS
ADMINISTRATIVE BOARD MEETING

June 30, 1983
Washington Hilton Hotel
9:00am-1:00pm

Association of American Medical Colleges
COTH Administrative Board Meeting
April 21, 1983

PRESENT

Earl J. Frederick, Chairman
Haynes Rice, Chairman-Elect
Mitchell T. Rabkin, MD, Immediate Past Chairman
James W. Bartlett, MD, Secretary
Jeptha W. Dalston, PhD
Spencer Foreman, MD
Robert E. Frank
Irwin Goldberg
Sheldon S. King
Glenn R. Mitchell
John V. Sheehan
C. Thomas Smith
William T. Robinson, AHA Representative

STAFF

James D. Bentley, PhD
John A. D. Cooper, MD
Joseph C. Isaacs
Thomas J. Kennedy, Jr., MD
Richard M. Knapp, PhD
Mary M. McGrane
Nancy E. Seline
August G. Swanson, MD
Kat S. Turner
Melissa H. Wubbold

I. Call to Order

Mr. Frederick called the meeting to order at 9:00am in the Farragut Room of the Washington Hilton Hotel. Before moving ahead to the agenda, he indicated that by tradition, the COTH Nominating Committee is chaired by the COTH Immediate Past Chairman, and includes the current Chairman and one at-large appointed member. Dr. Rabkin will chair the Committee, Mr. Frederick will serve with him, and Mr. Frederick has appointed Fred Cowell of Jackson Memorial Hospital in Miami to be the third member of the Committee. Mr. Cowell has agreed to serve. A memorandum will go out to the membership the first week in May asking for their suggestions.

Mr. Frederick stated that the Board had a full agenda before it so he planned to get through Item VIII by 10:30am, and add a discussion of the Medicare cost report to the list of what needed to be discussed by 10:30am. At 10:30am, Dr. Cooper and Dr. Kennedy were to join the group to discuss the remainder of the agenda. There was consensus that there was no need to discuss agenda Item XI - MCAT related projects.

II. Consideration of the Minutes

ACTION: It was moved, seconded, and carried to approve the minutes of the April 21, 1983 Administrative Board Meeting.

III. Membership Applications

Dr. Bentley reviewed the membership applications. Based on staff recommendation and Board discussion, the following action was taken:

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

(1) LUBBOCK GENERAL HOSPITAL, Lubbock, Texas for full membership;

(2) THE METHODIST HOSPITAL, Houston, Texas for full membership;

(3) LATROBE AREA HOSPITAL, Latrobe, Pennsylvania for corresponding membership;

(4) TULSA MEDICAL EDUCATION FOUNDATION, INC., Tulsa, Oklahoma for corresponding membership.

During the course of discussion with regard to membership applications, the issue of the size of residency programs was raised, particularly in the context of discussing the Germantown Hospital and Medical Center application. In addition, the question of whether

all members of a consortium or education foundation should be required to belong as a condition of acceptance of the group based organization maintaining membership was raised. A number of questions related to this matter were also discussed. Based on this discussion, the following actions were taken:

ACTION: It was moved, seconded, and carried that the application of the Germantown Hospital and Medical Center be held over until the June meeting, and that in the interim the staff acquire more information with regard to medical school faculty appointments of the hospital's medical staff and the extent to which any salary money was available for chiefs of service or chiefs of education on a full or part-time basis.

ACTION: It was moved, seconded, and carried to direct the staff to prepare a list of COTH members which have less than 50 residents and less than four residency programs.

These matters and a discussion of the issues surrounding membership for consortia should constitute a report that will be prepared for discussion at the June Administrative Board meeting.

IV. COTH General Session at the 1983 AAMC Annual Meeting

Dr. Knapp reviewed the titles for the COTH General Session over the past 11 years. He began the discussion by suggesting that Paul Starr, author of the book entitled, The Social Transformation of American Medicine, might be an appropriate speaker for the meeting. The general subject of changing ethical values and issues surrounding medical service was discussed as was the possibility of addressing the financing (and cost) of graduate medical education. Following this discussion there was a general consensus that a program should be planned around the general theme title, "Ethical Concerns and Economic Realities".

V. Location of 1985 COTH Spring Meeting

Mr. Frederick reviewed the six cities that will have been sites for the meeting since 1978, and indicated that the meeting in 1984 will be in Baltimore, Maryland. Following brief discussion, it was recommended that the staff make arrangements to have the meeting in San Francisco. It was agreed that San Diego would be the second choice if arrangements could not be made in San Francisco.

VI. Criteria for Entry in Graduate Medical Education in the United States

Dr. Knapp indicated that the policy statement had been derived from a set of consensus statements that were circulated in the fall and

winter of 1982, and which were endorsed by the Executive Council at its January 1982 meeting. The one change is an addition that requires that the criteria apply to all fifth pathway students as well as other individuals who are to enter graduate medical education programs.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council approve the policy statement as worded in the Executive Council agenda book.

VII. Elaboration of Transitional Year Special Requirements

August Swanson, MD, Director of the AAMC Department of Academic Affairs joined the Administrative Board for a discussion of this item. There was extensive discussion of the purpose of transitional programs and the extent to which they complicate the environment and to some degree increase the costs of education. However, Mr. Frank pointed out that the policy decision concerning the establishment of the transitional year residency is already accepted and the purpose of this document is to set forth the special requirements for review and accreditation of these programs.

ACTION: It was moved, seconded, and carried to recommend that the AAMC Executive Council approve the Special Requirements for the transitional year residency.

VIII. Medicare Cost Report

While several major hospital and healthcare organizations are supporting the elimination of the Medicare cost report, AAMC staff have been of the general impression that COTH members have more to lose than gain from the report's elimination. To ensure that staff was reflecting the position of the Administrative Board, a supplemental agenda item requested the Board to consider whether the AAMC should advocate elimination or retention of the cost report, and cited advantages of eliminating or retaining the cost report. In an active discussion involving numerous board members, it was agreed that (1) preparation of the cost report involved relatively small incremental costs for COTH members; (2) some advantages for eliminating the cost report were disadvantages for COTH members (i.e., forces HCFA to set prospective rates for all hospital services and prevents cost data from being used to set prospective prices); and (3) the cost report provided the data base for payment systems modifications, adjustments, exceptions, and analysis. At the same time, board members felt that the benefits of the cost report could be enhanced if the report itself was modified and reduced to retain primarily the items necessary for prospective payment system design, execution, and evaluation.

ACTION: It was moved, seconded, and carried that the AAMC should advocate retention of an appropriately modified, less burdensome Medicare cost report.

IX. Regional Seminars on Prospective Payment and Physician Reimbursement

Dr. Cooper joined the Board meeting to discuss this agenda item. He indicated that Donald Young, MD and Truman Esmond did a fine job in presenting the new Medicare legislation on prospective payment for hospitals and physician reimbursement under TEFRA at the Council of Deans Spring Meeting. However, in the time allocated they covered more material than could be absorbed effectively. It became apparent in subsequent discussions, particularly at the Southern Deans Meeting, that the Deans would welcome the opportunity to review the legislation and its implications in greater depth. They also recognized the value of getting this information to key departmental chairmen, and having the opportunity to engage in discussion with them and directors of closely affiliated hospitals. Thus, the AAMC staff has developed a proposal that a specially designed seminar be made available on a regional basis to the dean and four of his colleagues, hopefully at least two departmental chairmen, and at least one hospital director from a major affiliated hospital.

Each two day seminar will provide a detailed discussion of the current provisions of the DRG-based prospective payment system, alert participants to important management consequences and provide examples of the monitoring and control systems that some institutions are beginning to implement. The seminar will also address issues related to the recently issued hospital-based physician regulations and the forthcoming teaching physician regulations. Dr. Cooper pointed out that there are a great many seminars directed at hospital directors and the unique AAMC contribution would be to provide an environment where the dean, departmental chairman and the hospital director could have a joint learning experience. No action was taken but there was a general consensus on the part of the Board members that this was an excellent idea.

X. National Residency Matching Program (Trends in Graduate Medical Education)

Dr. Cooper discussed this topic briefly. He noted that an increasing number of residency program directors have begun to skirt the national matching program and/or place excessive requirements on students applying for residency positions (e.g., certain specialty programs are calling for early decisions). These actions, he emphasized, have contributed to a reduction in overall GME positions available. He then alerted the Board that several matching plans have been developed independent of the NRMP and that the AAMC was considering the establishment of a task force to convince program directors to use the single uniform match and call attention to those who compete for and sign up students outside the NRMP.

Dr. Cooper explained that in the mid-1970's, the number of positions offered in the match and the number of U.S. graduates maintained a ratio of 2:1. He stated that this ratio is getting close to unity in the current year and has created a great deal of concern among the deans. He noted that other issues highlighted at the Deans Spring Meeting in relation to residency training were the lack of primary care/ambulatory care teaching opportunities and the need to identify new sources of revenue to support programs.

XI. The President's Commission for the Study of Ethics in Medicine and Biomedical and Behavioral Research: AAMC Support for Renewal

The authority for the President's Commission for the Study of Ethics in Medicine and Biomedical and Behavioral Research expired on March 31, 1982, but Senator Edward Kennedy is attempting to renew its authority through fiscal year 1986. Dr. Thomas Kennedy told the Board that the Senator had requested the AAMC's support for this effort. Dr. Kennedy referred the Board to page 29 of the Executive Council agenda for background information on the issue. He informed Board members that Senator Kennedy's proposal had already received support in Congress without being introduced as a bill.

Mr. King stated he favored the Kennedy proposal because current ethical medical questions, such as the "Baby Doe" issue, will continue to be a problem. Dr. Rabkin concurred, suggesting that the Commission was a body from which one could expect a more thoughtful approach than that exhibited by HHS in issuing its "Baby Doe" regulation. Mr. Robinson stated that the AHA probably would support the bill, but it was waiting to hear the arguments of hospital directors opposed to the Commission.

Dr. Kennedy described the problems he foresaw with renewing the Commission, which were: (1) the executive director has been difficult to deal with; (2) the enthusiasm of the current Commission members is waning; (3) recent appointments to the Commission have been disruptive; and (4) in the absence of a specific set of issues to address, the Commission appears to be a body in search of a problem. In response to Dr. Kennedy's concerns Dr. Foreman suggested that the Association ought to support the concept of a national independent body to examine ethical issues. This suggestion met with general approval. No further action was taken.

XII. Legislative Update

Dr. Kennedy and Ms. McGrane presented an overview on activities related to NIH Budget and Renewal legislation and Animal Welfare bills now in Congress. They noted that the proposed FY 1984 NIH budget is approximately $4,077 million, some $73 million more than the previous year. Because the Administration desired 5,000 new and competing renewal research grants, the NIH has redistributed about $141 million to these grants from other programs such as

centers, clinical trials, and biomedical research support grants. The AAMC and 127 other organizations have called for a minimum $487 million increase in the FY 1984 NIH appropriation in order to adequately maintain current programs and provide $33 million for growth.

Dr. Kennedy reported that for the third time since 1979, the Congress has embarked on yet another effort to reach consensus on legislation renewing a number of expiring authorities for the NIH. As in the past, the House and Senate have adopted very divergent approaches: the Senate bill sponsored by Senator Orrin Hatch, albeit with important exceptions that seem to grow at every stage of the legislative process, provides for a simple reauthorization of expiring authorities; the House version, introduced by Rep. Henry Waxman, includes in addition to necessary renewals, a host of disease-specific "baubles", managerial directives and a major recodification of Title IV of the Public Health Service Act.

Dr. Kennedy noted that Rep. Waxman was using his bill as a vehicle to offer favors to his colleagues in the House, while the Senate sponsors have been a great deal more statesmanlike. He explained that Rep. Madigan had approached the AAMC for support of a counterproposal by him in the House that would call for a simple reauthorization. However, Mr. Madigan's bill could be defeated in the Health Subcommittee which Mr. Waxman chairs and which is well stacked in his favor. He believed chances were somewhat better in the full Committee, but that it would be difficult at best.

Animal welfare legislation has been introduced by several members of Congress. Rep. Walgren was successful in his efforts to append animal welfare amendments to the House NIH renewal legislation. These amendments pose significant problems and the AAMC opposed them. Rep. Madigan offered a substitute amendment which would require a comprehensive 18-month study of current animal welfare activiites by the National Academy of Sciences. At present, the amendment and the similar legislation introduced in the Senate by Senator Hatch have been supported by the AAMC. Senator Dole has also sponsored a bill which presents considerable problems.

XIII. Regulation on "Nondiscrimination on the Basis of Handicap"

Dr. Knapp described the highly emotional atmosphere surrounding the issuance of these regulations dealing with the withholding of nutrition or medical treatment from critically ill infants. He asked Ms. Seline to describe the problems with the rule and what had transpired since its issuance. Ms. Seline referred the Board to page 32 of the Executive Council agenda for background information on the issuance of the rule. She then informed the Board that after the agenda item had been prepared, the AHA, the Hospital Association of New York State, and Strong Memorial Hospital had filed suit in the Federal District Court in New York They raised similar issues to those in the AAP, NACHRI suit,

summarized in the agenda, and requested a temporary restraining order. The New York judge issued the TRO. Then on April 14, the District Court judge in Washington struck down the rule in a decision that is applicable nationwide. His decision was based soley on HHS' failure to follow normal procedures in issuing and implementing the rule; however, he used strong language in denouncing the rule's substance.

The Board briefly discussed this item. Several members expressed concern over the manner in which HHS intruded into the practice of medicine and the involvement of individuals with little knowledge of the issue.

ACTION: It was moved, seconded, and carried that it be recommended that the Executive Council instruct the Association to write a letter to HHS in response to this rule.

XIV. Department of Teaching Hospitals Activities and Initiatives

Dr. Knapp indicated that during the past three years there has been particular emphasis on the issues of diagnostic case mix and hospital payment methods. Five publications have resulted from this effort. Attention to this subject will remain high; however, data gathering and publication efforts will not be pursued with the same intensity. The time is appropriate for a review of the department's project activities. The first set of items concerns the matter of educational programs or seminars on case mix prospective payment. Dr. Knapp indicated that for the time being this issue was covered in Dr. Cooper's report on the seminars being designed for the dean, department chairmen, and teaching hospital colleagues. Given the limited amount of time available, he suggested that this item be placed on the June agenda for review once again, but that the matter of medical education costs in teaching hospitals be discussed briefly in the time available. There was considerable discussion of the various ways to think about the costs of graduate medical education. The point was made several times that in some services and at the higher levels of graduate medical education, the service provided by the resident more than compensated for the stipend the resident was paid. In other words, in the absence of the resident, other physician, nursing or allied health manpower would have to be hired to provide the service. At the same time it was recognized that the extent to which this conclusion may be reached depends on the level of the house officer and the extent to which medical students are involved in the provision of the service. The overall cost picture depends on the mix of programs and involvement of undergraduate medical students as well as the mix of first year and senior level house officers.

It was also pointed out that the issue of "allowability" of the cost would in the long run probably not be the issue. The issue would be, given the payment levels for various types of services, can enough revenue be generated to support the educational function where educational support is deemed to be needed. With the advent of HMO's, preferred provider organizations and other alternative forms of financing, the question will be whether enough net revenue can be generated to support education, and is educational support the proper use of this net revenue. There was a consensus that this issue should be a major item for discussion at the June Board meeting and should be the first item to be discussed under any review of departmental activities.

XV. Adjournment

The meeting was adjourned at 12:50pm.

COTH Membership Requirements

At its April meeting, the COTH Administrative Board asked staff to review Council membership criteria to ensure (1) a clear and consistent distinction is being made when applicants are categorized as corresponding or full members and (2) that corresponding membership in the name of a non-hospital entity such as a consortium is not being used to avoid participation as a full Council member. In addition, the Board sought information on hospitals which appeared to qualify for full membership but which had never elected to join the Council. This report presents background information on COTH membership and discusses each of the issues raised by the Board.

BACKGROUND

The Council of Teaching Hospitals was organized within the Association of American Medical Colleges in 1965 to provide representation and services related to the special needs, concerns and opportunities facing major teaching hospitals. Originally limited to a single class of "full" teaching hospital members, corresponding membership was added in the mid-70's to provide hospitals with small medical education programs and other medical education entities with an opportunity to receive AAMC mailings and participate in open COTH meetings.

Under present membership practices, full teaching hospital membership is limited to not-for-profit -- IRS 501(C)(3) -- and publicly-owned hospitals which sponsor, or significantly participate in, at least four approved, active residency programs. At least two of the approved residency programs must be in the following specialty areas: internal medicine, surgery, obstetrics-gynecology, pediatrics, family practice, and psychiatry. Other considerations evaluated in determining a hospital's participation in medical education activities are:

- the availability and activity of undergraduate clerkships;
- the presence of full-time chiefs of service or director of medical education;
- the number of internship and residency positions in relation to bed size, the proportion (in full-time equivalents) which are filled, and the proportion which are filled by foreign medical graduates;
- the significance of the hospital's educational programs to the affiliated medical school and the degree of the medical school's involvement in them; and
- the significance of the hospital's financial support for medical education.

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

Teaching hospital members receive the full range of AAMC and Council services and publications. In addition, their COTH representatives are eligible to participate in the AAMC's governance, organization, and committee structure. For the year 1983-1984, teaching hospital membership dues are $2,275. Dues increase annually based on the increase in the cost of living index.

Non-profit and governmental hospital and medical education organizations (e.g., consortia, foundations, federations) not eligible for teaching hospital membership may apply for corresponding membership. Corresponding members are

eligible to attend all open AAMC meetings and to receive the following publications: COTH Report; President's Weekly Activities Report; Assembly Memoranda; COTH, CAS, and COD Memoranda; Journal of Medical Education; Survey of Housestaff Policy; COTH Executive Salary Survey; and other periodic publications and surveys. Corresponding membership dues are presently $770 per year. Dues are increased annually to reflect changes in the cost of living index. Hospitals which are eligible for teaching hospital membership are not eligible for corresponding membership.

The Administrative Board of the Council of Teaching Hospitals is responsible for evaluating membership applications to determine whether the applicant is eligible for teaching hospital or corresponding membership. Completed applications -- which must include a copy of the hospital-medical school affiliation agreement and the dean's letter of recommendation -- are reviewed at the Board's quarterly meetings.

Differentiating Types of COTH Members

COTH is organized within the AAMC so that its full members reflect the following characteristics:

- members are hospitals organized to provide both patient care services and clinical education for undergraduate and graduate medical students,
- members belong as corporate organizations rather than as individuals, and
- members have major educational commitments as reflected by the size and scope of the clerkships and residencies provided and the formal affiliation with an accredited U.S. medical school.

The first two characteristics are easily operationalized into membership criteria. The third, the major teaching hospital dimension, is more difficult, especially because the operational criteria for this dimension generally separates full and corresponding members. Using the 1983 COTH Membership Directory, Tables 1 and 2 provide an empirical description of the present, full COTH members having small numbers of residency programs or residents. Table 1, which shows general hospitals, shows that three present members report less than the minimum of four programs:

- VA Medical Center — 2 programs
  Clarksburg, West Virginia
- Iowa Methodist Hospital — 3 programs
  Des Moines, Iowa
- Ball Memorial Hospital — 3 programs
  Muncie, Indiana

Under present membership criteria, each of these hospitals should be re-classified as a corresponding member. When the data on number of residents is examined, seven additional hospitals are found to have less than 30 FTE residents:

- Hospital of the Good Samaritan — 6 residents, 10 programs
  Los Angeles, California
- Jewish Hospital — 8 residents, 4 programs
  Louisville, Kentucky

- VA Medical Center, San Francisco, California — 10 residents, 17 programs
- Riverside Hospital, Riverside, California — 21 residents, 8 programs
- St. Mary's Hospital, Rochester, New York — 24 residents, 5 programs
- VA Medical Center, West Roxbury, Massachusetts — 25 residents, 11 programs
- Tuscon Medical Center, Tuscon, Arizona — 26 residents, 11 programs

While some of these seven hospitals may have incorrectly reported the number of residents, given the number of programs, Subgroup C in Table 1 shows six COTH members with four or more residencies have less than 30 residents while 18 members with at least four programs have between 30 and 40 residents. This distribution suggests that criteria for full COTH membership could be expanded to require a minimum of either 21 or 30 FTE residents. This would provide the Board with an additional quantitative yardstick for use in determining general hospitals with major educational commitments.

Table 2 shows COTH member specialty hospitals with fewer than 4 residencies. While the Board is authorized to make exceptions for specialty hospitals, the presence of 9 residents at Schwab Rehabilitation and 12 residents at Women and Infant's Hospital in Providence would appear to require specific consideration if a minimum number of residents is set as a membership criterion.

Staff Recommendation

In order to help promote a commonality of interest among hospitals with full membership in the Council of Teaching Hospitals, it is recommended that hospitals with fewer than 30 residents be classified as corresponding members.

It is further recommended that staff annually validate the data on general hospitals with full membership reporting fewer than 4 residencies or 30 residents. If the hospital cannot show 4 or more programs or 30 or more residents, it is recommended that the hospital be reclassified as a corresponding member.

Consortia as Members

In the past decade, many hospitals have established multi-unit systems, consortia, and associations in efforts to adapt to the changing hospital environment. Under the present COTH membership criteria, a group of hospitals each presently eligible for full membership could minimize their dues by joining as a system, consortia, or association. Not only would fewer entities pay dues, but the non-hospital nature of the applicant entity would result in its classification as a corresponding member.

In addition to the reduction in dues revenue, membership in the name of a non-hospital entity alters the relationship between the AAMC and the nation's teaching hospitals. Currently, AAMC staff have direct access to hospital executives because the hospital is the member and the CEO is generally the institutional representative. If hospitals joined as groups, membership services and staff requests would flow via the new entity to the hospital. Staff believe this would dramatically reduce the effectiveness and usefulness of the Council.

Staff Recommendation

In light of the Council's purpose to serve the needs of hospitals and the adverse impacts group membership could raise, it is recommended that corresponding membership for multi-hospital systems, consortia, foundations, and associations be granted only when each hospital qualifying for full membership within the entity has joined as an individual member.

It is further recommended that the Southwestern Michigan Area Health Education Center which joined as a corresponding member in 1978 and which includes at least two non-member hospitals in Kalamazoo be allowed to continue its corresponding membership. "Grandfather" status should also be considered for the Tulsa Medical Education Foundation which joined in April, 1983.

Potentially Eligible Non-Members

Table 3 contains a list of non-member general hospitals listed in the ACGME's 1983/1984 Directory of Residency Programs which meet two criteria: medical school affiliation and at least four residency programs including two from the COTH-required six. For each hospital the number of operating beds is shown. Where a hospital has only a limited or graduate affiliation, that relationship is identified. It should be recognized, however, that not all of the listed hospitals probably have the necessary signed affiliation agreement with a college of medicine.

With the exception of a small number of public hospitals and two university hospitals (Tulane and Tennessee at Knoxville) the list appears to include primarily community hospitals expected to have relatively small residency programs. Any effort to recruit new members from the listed hospitals should concentrate on the few major institutions included in the list.

Table 1

COTH General Hospitals with Small Residencies

Subgroup A: Sponsor or participate in 4 or fewer residencies with a total of less than 40 FTE residents.

Hospital	Number of Reported Programs	Residents
VA Medical Center, Clarksburg, WV	2	6
Jewish Hospital, Louisville	4	8
Frankford Hospital, Philadelphia	4	36

Subgroup B: Sponsor or participate in 4 or fewer residencies with a total of at least 40 residents.

Iowa Methodist Hospital	3	35
Ball Memorial Hospital, Muncie	3	48
Miriam Hospital, Providence	4	40
Worcester City Hospital	4	47
Berkshire Medical Center	4	51
United Health Services, Johnson City	4	52
Jersey Shore Medical Center	4	62
St. John's Mercy, St. Louis	4	87
Franklin Square, Baltimore	4	95

Subgroup C: Sponsor or participate in more than 4 residencies having a total of less than 40 residents.

St. Mary's, Rochester NY	5	24
Mary Imogene Basset, Cooperstown	5	32
Roger Williams, Providence	5	34
Stamford Hospital, CT	5	38
Wake County, NC	6	30
St. Francis, Tulsa	6	33
VA Medical Center, Des Moines	6	34
Methodist, Dallas	7	33
Emanuel, Portland	7	33
Hamot, Erie	7	34
Riverside Hospital, CA	8	21
Crawford Long, Atlanta	9	35
VA Medical Center, White River Junction	9	37
Harrisburg Hospital	9	39
VA Medical Center, Shreveport	9	39
Hospital of Good Samaritan, Los Angeles	10	6
St. Luke's, Milwaukee	10	31
Episcopal Hospital, Philadelphia	10	32
VA Medical Center, West Roxbury	11	25
Tuscon Medical Center	11	26
Public Health Hospital, Seattle	12	30
Presbyterian, Dallas	12	33
Madison General	14	32
VA Medical Center, San Francisco	17	10

Table 2

COTH Specialty Hospitals with Three or Fewer Residencies

Hospital	Number of Reported Programs	Residents
Schwab Rehabilitation Hospital, Chicago	1	9
St. Margaret's Hospital for Women, Boston	1	19
Hospital for Special Surgery	1	40
Western Psychiatric, Pittsburgh	1	55
Women and Infants, Providence	3	12

Table 3

List of General Hospitals which are Potential COTH Full Members

Alabama		
	Carraway Methodist Medical Center Birmingham	617 beds
	Cooper Green Hospital Birmingham	191 beds
	Lloyd Noland Hospital Fairfield	309 beds
Arizona		
	Kino Community Hospital Tuscon	213 beds
California		
	David Grant USAF Medical Center Travis Air Force Base	290 beds
	Kaiser Foundation Hospital Fontana	479 beds Limited Affiliation
	Kaiser Foundation Hospital Los Angeles	584 beds Limited Affiliation
	White Memorial Medical Center Los Angeles	377 beds
	Highland General Hospital Oakland	270 beds Graduate Affiliation
	Kaiser-Permanente Medical Center Oakland	263 beds Limited Affiliation
	Naval Regional Medical Center Oakland	276 beds
	Kaiser Foundation Hospital Sacramento	306 beds
	San Bernadino County Medical Center San Bernadino	315 beds
	Naval Regional Medical Center San Diego, California	614 beds
	Letterman Army Medical Center San Francisco	380 beds
	San Francisco General Hospital San Francisco	445 beds

St. Mary's Hospital and Medical Center San Francisco	525 beds
Santa Clara Valley Medical Center San Jose	427 beds
Santa Barbara Cottage Hospital Santa Barbara	465 beds Limited Affiliation
Kaiser Permanente Medical Center Santa Clara	329 beds Limited Affiliation
San Joaquin General Hospital Stockton	233 beds Limited Affiliation
Colorado	
Fitzsimons Army Medical Center Denver	554 beds
Denver General Hospital Denver	310 beds
Rose Medical Center Denver	400 beds
St. Joseph Hospital Denver	551 beds Limited Affiliation
Delaware	
VA Medical Center Wilmington	336 beds
District of Columbia	
Providence Hospital Washington	355 beds Limited Affiliation
Walter Reed Army Medical Center Washington	962 beds
Florida	
St. Vincent's Medical Center Jacksonville	518 beds Limited Affiliation
Orlando Regional Medical Center Orlando	1004 beds Limited Affiliation
Baptist Hospital Pensacola	520 beds Limited Affiliation
Sacred Heart Hospital Pensacola	339 beds Limited Affiliation
University Hospitals and Clinics Pensacola	128 beds Limited Affiliation

Georgia	
Georgia Baptist Medical Center Atlanta	525 beds Limited Affiliation
University Hospitals Augusta (not Talmadge Memorial)	693 beds
Eisenhower Army Medical Center Fort Gordon	759 beds
Memorial Medical Center Savannah	465 beds
Hawaii	
Kaiser Foundation Hospital Honolulu	166 beds
Kuakini Medical Center Honolulu	250 beds
Queens Medical Center Honolulu	506 beds
St. Francis Hospital Honolulu	308 beds
Tripler Army Medical Center Honolulu	560 beds
Illinois	
Columbus Hospital Chicago	530 beds Graduate Affiliation
Frank Cunco Memorial Hospitals Chicago	186 beds Limited Affiliation
Louis A. Weiss Memorial Hospital Chicago	372 beds
Ravensworth Hospital Medical Center Chicago	462 beds
St. Francis Hospital Evanston	469 beds
Indiana	
St. Joseph Hospital Fort Wayne	414 beds Limited Affiliation
St. Vincent Hospital Indianapolis	605 beds
Kentucky	
NKC, Inc. (Norton-Childrens) Louisville	553 beds

Louisiana	
Earl K. Long Memorial Hospital Baton Rouge	217 beds
South Louisiana Medical Center Houma	213 beds
University Medical Center Lafayette	205 beds
Conway Memorial Hospital Monroe	183 beds
Tulane Medical Center Hospital New Orleans	284 beds
Long Memorial Hospital Pineville	183 beds
Maryland	
Greater Baltimore Medical Center Baltimore	407 beds Limited Affiliation
Mercy Hospital Baltimore	350 beds
South Baltimore General Hospital Baltimore	496 beds
St. Agnes Hospital Baltimore	462 beds
Naval Hospital Bethesda	500 beds
Prince George's County General Cheverly	716 beds
Massachusetts	
Boston City Hospital Boston	436 beds
Cambridge Hospital Cambridge	182 beds
Michigan	
McLaren Hospital Flint	469 beds
Borgess Hospital Kalamazoo	473 beds
Bronson Methodist Hospital Kalamazoo	478 beds
Ingham Medical Center Lansing	262 beds

St. Lawrence Hospital Lansing	226 beds
Pontiac General Hospital Pontiac	380 beds
William Beaumont Hospital Royal Oak	926 beds
Saginaw General Hospital Saginaw	392 beds
Mississippi	
U.S. Air Force Medical Center Keesler AFB	325 beds
Missouri	
St. Louis City Hospital St. Louis	550 beds
St. Louis County Hospital St. Louis	200 beds
Nebraska	
Bishop Clarkson Memorial Hospital Omaha	524 beds
New Jersey	
Jersey City Medical Center Jersey City	608 beds
St. Peter's Medical Center New Brunswick	420 beds
United Hospitals Medical Center Newark	538 beds
New York	
St. Peter's Hospital Albany	437 beds
Mercy Hospital Buffalo	433 beds
Metropolitan Hospital New York City	621 beds
New York Infirmary/Beekman New York City	360 beds Graduate Affiliation
Coney Island Hospital New York City (Brooklyn)	473 beds Limited Affiliation
La Guardia Hospital New York City	302 beds
Lincoln Hospital New York City (Bronx)	534 beds

Lutheran Medical Center New York City (Brooklyn)	532 beds Graduate Affiliation
Staten Island Hospital New York City	422 beds Limited Affiliation
Wyckoff Heights Hospital New York City	437 beds Graduate Affiliation
South Nassau Communities Hospital Oceanside	401 beds
Ellis Hospital Schenectady	478 beds
Crouse-Irving Memorial Hospital Syracuse	490 beds
St. Joseph's Hospital Syracuse	422 beds
North Carolina	
Durham County General Hospital Durham	483 beds
Pitt County Memorial Hospital Greenville	496 beds
North Dakota	
Dakota Hospital Fargo	183 beds
St. Luke's Hospital Fargo	464 beds
United Hospital Grand Forks	261 beds
Ohio	
Jewish Hospital Cincinnati	616 beds
St. Vincent Charity Hospital Cleveland	422 beds
Mt. Carmel Hospital Columbus	747 beds
Mercy Hospital Toledo	350 beds
Riverside Hospital Toledo	270 beds Limited Affiliation
St. Vincent's Hospital Toledo	723 beds

Toledo Hospital Toledo	785 beds
U.S. Air Force Medical Center Wright-Patterson AFB	350 beds
Oklahoma	
Presbyterian Hospital Oklahoma	407 beds Graduate Affiliation
St. Anthony Hospital Oklahoma City	684 beds Graduate Affiliation
Hillcrest Medical Center Tulsa	646 beds
St. John's Medical Center Tulsa	752 beds
Oregon	
Good Samaritan Portland	539 beds
St. Vincent's Hospital Portland	451 beds
Pennsylvania	
Abington Memorial Hospital Abington	469 beds
Allentown Hospital Allentown	318 beds Limited Affiliation
Sacred Heart Hospital Allentown	205 beds Limited Affiliation
St. Luke's Hospital Bethlehem	440 beds
St. Vincent Health Center Erie	605 beds
Polyclinic Hospital Harrisburg	556 beds
Shadyside Hospital Pittsburgh	464 beds Limited Affiliation
Reading Hospital Reading	622 beds
South Carolina	
Charleston Memorial Hospital Charleston	154 beds
Richland Memorial Hospital Columbia	611 beds

VA Medical Center Columbia	460 beds
South Dakota	
Sioux Valley Hospital Sioux Falls	488 beds
Tennessee	
University Hospital Knoxville	484 beds
Baptist Hospital Nashville	724 beds Graduate Affiliation
Metropolitan Nashville General Hospital Nashville	179 beds Limited Affiliation
St. Thomas Hospital Nashville	571 beds Limited Affiliation
Texas	
Central Texas Medical Foundation Austin	319 beds Limited Affiliation
Thomason General Hospital El Paso	288 beds
Texas Tech Health Center El Paso	1164 beds
Beaumont Army Medical Center El Paso	465 beds
John Peter Smith Hospital Fort Worth	357 beds Limited Affiliation
Jefferson Davis Hospital Houston	737 beds
St. Joseph Hospital Houston	887 beds
Brooke Army Medical Center San Antonio	692 beds
Olin Teaque Veterans Center Temple	587 beds
Utah	
Holy Cross Hospital Salt Lake City	343 beds Limited Affiliation
VA Medical Center Salt Lake City	404 beds

Virginia	
Arlington Hospital Arlington	350 beds
DePaul Hospital Norfolk	402 beds
Naval Regional Medical Center Portsmouth	524 beds
Roanoke Memorial Hospital Roanoke	675 beds
Washington	
Swedish Hospital Medical Center Seattle	653 beds
Virginia Mason Hospital Seattle	321 beds
Sacred Heart Medical Center Spokane	518 beds
Madigan Army Medical Center Tacoma	340 beds
West Virginia	
St. Mary's Hospital Huntington	440 beds
Wisconsin	
La Crosse Lutheran Hospital La Crosse	447 beds Limited Affiliation
St. Mary's Hospital Madison	440 beds
St. Joseph's Hospital Marshfield	524 beds Limited Affiliation

MEMBERSHIP APPLICATIONS

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

HOSPITAL	STAFF RECOMMENDATION
Baptist Medical Centers Birmingham, Alabama	Full Membership
The Germantown Hospital and Medical Center Philadelphia, Pennsylvania	Corresponding Membership
St. Joseph Medical Center Wichita, Kansas	Full Membership

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: Baptist Medical Centers

Hospital Address: (Street) 3201-4th Ave. South

(City) Birmingham (State) Alabama (Zip) 35222

(Area Code)/Telephone Number: (205) 322-9320

Name of Hospital's Chief Executive Officer: Emmett Johnson

Title of Hospital's Chief Executive Officer: President

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

for BMC-Montclair & BMC-Princeton combined

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	1,115*	Admissions:	40,008
Average Daily Census:	877	Visits: Emergency Room:	42,119
Total Live Births:	2,161	Visits: Outpatient or Clinic:	3,612**

* For fiscal year 1981-82 the hospitals actually had 916 beds in use. The expansion programs at both hospitals added 199 licensed beds, but these were not occupied until November & December, 1982.

** One clinic at each hospital for use of medical & surgical residents only.

B. Financial Data

Total Operating Expenses: $ 101,541,076

Total Payroll Expenses: $ 47,160,362

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 1,298,300
Supervising Faculty: $ 349,000

C. Staffing Data

Number of Personnel: Full-Time: 3,475
Part-Time: 721

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 280
With Medical School Faculty Appointments: 149

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

NONE

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

I. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	16	62	Elective
Surgery	13	60	Required
Ob-Gyn	3	34	Required
Pediatrics	0	0	------
Family Practice	0	0	------
Psychiatry	1	0	Elective
Other: Pathology	1	2	Elective
Radiology	2	17	Elective

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible	4	3	1	1982
Medicine	24	21	1	1972
Surgery	14	14	0	1969
Ob-Gyn	0			
Pediatrics	0			
Family Practice	0			
Psychiatry	0			
Other:				
Path A & C	5	5	0	1944
Diag. Rad.	8	8	0	1959
Total (Excl Flexible)	51			

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: Univ. of Ala. School of Medicine

Dean of Affiliated Medical School: James A. Pittman, Jr., M.D.

Information Submitted by: (Name) John M. Packard, M.D.

(Title) Director of Medical Education

Signature of Hospital's Chief Executive Officer:

Emmett Johnson (Date) May 4, 1983

Emmett Johnson
President

SUPPLEMENTARY STATEMENT
FOR
AAMC APPLICATION

The Birmingham Baptist Hospital, forerunner of the present Baptist Medical Centers multi-hospital system, opened its doors in 1922. Almost immediately a school of nursing and an internship were started and have continued with varying degrees of success over the ensuing sixty years. Additional educational programs in allied health, pastoral care and administration have been added, for a total of 900 students of various categories being trained last year.

This long tradition of education for the health professional has been one of the bases for the fine reputation we have enjoyed in the community, state and region. Our dedication to education was reaffirmed in 1982 when our Mission Statement was rewritten:

> "As a witness to the love of God through Jesus Christ, The Baptist Medical Centers seeks to improve the health status of the people and communities we serve by providing high quality health related services.
>
> "In fulfillment of this mission, we affirm that The Baptist Medical Centers:
>
> . . .
>
> "Will participate in and carry on educational and research activities supportive of the Mission and The Baptist Medical Centers."
>
> Etc.

Because the institution, The Baptist Medical Centers, has become a rather complex organization, it seems worthwhile to outline briefly its organizational structure, and that of the Department of Medical Education.

The Baptist Medical Centers is a voluntary not-for-profit, church-affiliated, multi-hospital system. The Birmingham Baptist Association elects the Board of Trustees, which sets policy and appoints the President, who is the Chief Executive Officer of the system.

The system includes two co-equal fully integrated teaching hospitals, Montclair and Princeton; one owned and two leased community hospitals and a management contract with a rehabilitation hospital; two ambulatory care centers; a high-rise apartment complex for the elderly and handicapped; a corporate headquarters which houses the corporate officers; and a general office building which houses the management information system, laundry, warehouse and other functions pertaining to the entire system.

The Department of Medical Education coordinates and provides budgetary and administrative support for all undergraduate, graduate and continuing medical education programs including the medical libraries at both hospitals. It is headed by the Director of Medical Education (DME) who reports directly to the President. The DME is an ex-officio member of both medical staff Executive Committees and chairs the Education

Committees at both teaching hospitals. Policy concerning all medical education programs is made by the Medical Education Council, which is chaired by the Director of Medical Education and composed of the President, the Executive Vice President for Finance, the Executive Vice Presidents from both teaching hospitals, the Program Directors and the Chief Residents of all residency programs. The Medical Education Council meets quarterly.

Resources for educational purposes, including space, personnel and financial support, are allocated centrally according to written institutional policies.

Undergraduate medical education has been provided by the Baptist Medical Centers for at least ten years. At any one time, twelve to eighteen third and fourth year medical students are assigned for electives or clerkships (surgery and OB/GYN) at the Baptist Medical Centers. Most are students from the University of Alabama School of Medicine, but occasional students from other medical schools choose electives with us. The elective in cardiology at BMC-Princeton has been selected as the best elective in a community hospital by the graduating seniors at the University of Alabama School of Medicine for the past six years.

Our residency programs consume most of our resources. An operational system involving the residency program directors has been developed based on institutional policies for the selection of the teaching staff, the selection of residents, the appointment of residency physicians among the accredited programs, the addition of new or deletion of current residency programs, and for the supervision, evaluation and advancement or dismissal of residents. We have had a written policy assuring due process for the residents for over five years.

We also undertake a periodic analysis of each program based on the following factors:

1. The resident's evaluation at the end of each rotation of the rotation itself and of the attending physicians.
2. The faculty evaluations of the residents.
3. The evaluation of the program at the semi-annual faculty meetings.
4. The subjective impressions of the Program Directors and the Director of Medical Education based on discussions with colleagues at the various national meetings of Program Directors, Association of American Medical Colleges and the Association of Hospital Medical Education.
5. The evaluation of the results of the In-Training and American Specialty Board Exams.
6. Discussions at the quarterly meetings of the Medical Education Council.
7. The period surveys by the Accreditation Council on Graduate Medical Education, and its predecessor, the Liaison Committee on Graduate Medical Education. (None of our residency programs has been put on probation nor approval withdrawn in the past fifteen years.)

We are considering ways to formalize this periodic analysis of each program in order to involve the administration to a greater extent,

and to provide written comments and evaluations. This may involve inviting Program Directors from other hospitals to make consultation visits between the formal surveys carried out by the ACGME.

Continuing medical education for the medical staffs of our major and affiliated hospitals is a rewarding (and time-consuming) part of the medical education program.

Both BMC-Montclair and BMC-Princeton have been accredited by the Medical Association of the State of Alabama for granting Category I credit for continuing medical education programs, according to the criteria for the Physicians Recognition Award of the American Medical Association. Over nine hundred conferences were given last year by our teaching staff supplemented by visiting faculty, and were attended by over 14,000 health professionals.

Support for our medical education programs should be judged not only by the budget, personnel and facilities provided by the institution, but also by the strong support on the part of the medical staffs. Over 230 of the active and associate medical staff members, out of a total of 280, have applied for and been selected as voluntary faculty. Two-thirds of these have faculty appointments at the University of Alabama School of Medicine. A considerable number were full-time medical school faculty members before entering private practice.

Our research efforts thus far have been quite limited, but the Board of Trustees has recently given approval for the position of Director of Research, and we are currently recruiting a person of national reputation to stimulate more clinical research by our volunteer faculty.

A final word is in order concerning our relationships with the University of Alabama Medical Center in Birmingham (UAB) which was recently formalized in the attached affiliation agreement. Departmental letters of agreement have been in effect many years, as well as an affiliation agreement with the School of Community and Allied Health. As mentioned above, medical students are regularly assigned to the Baptist Medical Centers for electives and clerkships. Some of our residents also rotate to UAB for required or elective rotations, and a number of our volunteer faculty teach on a regular basis at UAB, while UAB faculty participate in lectures, consultations and teaching rounds. UAB's Lister Hill Library of the Health Sciences provides notable back-up for our two hospital medical libraries. The relationships between the School of Medicine and the Baptist Medical Centers has been cordial, enduring and mutually beneficial. Our formal affiliation agreement will strengthen these ties and ensure a continued association to the mutual benefit of the hospitals and the teaching program of the School of Medicine.

The University of Alabama in Birmingham
University of Alabama System Medical Education Program/Office of the Executive Dean
(205) 934-5391

University of Alabama School of Medicine / (205) 934-5391
College of Community Health Sciences, Tuscaloosa / (205) 348-7942
School of Primary Medical Care, Huntsville / (205) 539-7757

May 11, 1983

Richard Knapp, Ph.D.
Executive Director
Council of Teaching Hospitals
One Dupont Circle, N.W.
Washington, D.C. 20036

Dear Dr. Knapp:

The undersigned, as Dean of the University of Alabama School of Medicine, UAB, has reviewed the application of the Baptist Medical Centers for membership in the Council of Teaching Hospitals--Association of American Medical Colleges. The data and information, as they relate to the School of Medicine and our relationships, are accurate and factual.

Over the past several years, prior to the development of our recent formal affiliation agreement, the Baptist Medical Centers, through a number of informal arrangements with our various departmental chairmen, had developed a substantial number of cooperative programs in undergraduate and graduate medical education. Through these arrangements, the Centers have provided clinical experiences for our residents in some specialties that are not available in our University Hospital or in our other affiliated hospitals. Our residents will now have these experiences through our formal affiliation agreement. Further, the Centers have provided both elective and required clerkships annually for a substantial number of our junior and senior medical students.

In summary, the Baptist Medical Centers are community hospitals of widely recognized excellent teaching programs in undergraduate and graduate medical education and other health professions. It is my opinion that the applicant fully meets the criteria for COTH membership and that approval of this application will add excellent teaching hospital members to the Alabama membership of the Council.

Sincerely,

James A. Pittman, Jr., M.D.
Dean
University of Alabama
School of Medicine

University Station / Birmingham, Alabama 35294

COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: The Germantown Hospital and Medical Center

Hospital Address: (Street) One Penn Boulevard

(City) Philadelphia (State) Pennsylvania (Zip) 19144

(Area Code)/Telephone Number: (215) 951-8000

Name of Hospital's Chief Executive Officer: Mr. Joseph F. Farrell

Title of Hospital's Chief Executive Officer: President

II. HOSPITAL OPERATING DATA (for the most recently completed fiscal year) ended: 6/30/82

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	282	Admissions:	8,597
Average Daily Census:	218	Visits: Emergency Room:	25,210
Total Live Births:	361	Visits: Outpatient or Clinic:	50,101

B. Financial Data

Total Operating Expenses: $ 35,951,812.

Total Payroll Expenses: $ 21,092,255.

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 720,000.
Supervising Faculty: $ 50,000.

C. Staffing Data

Number of Personnel: Full-Time: 808
Part-Time: 266

Number of Physicians:

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

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

None

Does the hospital have a full-time salaried Director of Medical Education?: None

I. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education *

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	12	12	Required
Surgery	5	5	Required
Ob-Gyn			
Pediatrics			
Family Practice	5	5	Required
Psychiatry			
Other: Renal	2	2	Elective
Emergency Medicine	2	2	Required

*Students rotate from Temple University Medicine

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine	10	10		*
Surgery	4	4		*
Ob-Gyn	3	3		*
Pediatrics				
Family Practice				
Psychiatry				
Other:				
Radiology	4	2	2	1952
Pathology	1	1		**
Orthopaedic Surgery	2	2		***
Radiology	1-2	1-2		*
TOTAL	25-26			

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

*Through alliliation with Temple University School of Medicine
**Through affiliation with The Medical College of Pennsylvania
***Through affiliation with The Hospital of the University of Pennsylvania

IV. SUPPLEMENTARY INFORMATION

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

*See Attachment I

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: Temple University School of Medicine

Dean of Affiliated Medical School: Leo M. Henikoff, M.D.

Information Submitted by: (Name) Mr. J. Donald Caccia

(Title) Vice President

Signature of Hospital's Chief Executive Officer:

J. D. Caccia (Date) 1/28/83

The Germantown Hospital and Medical Center
ONE PENN BOULEVARD ■ PHILADELPHIA, PENNSYLVANIA 19144

ATTACHMENT #1

January 5, 1983

SUPPLEMENT TO THE COUNCIL OF TEACHING HOSPITALS APPLICATION

Item IV

Since 1874 when the first "resident doctor" came to The Germantown Hospital, this institution has been actively and intimately involved in the education of medical practitioners. The role of the Hospital as an educational institution has, of necessity, changed over the years to meet the varying needs of the physicians in training, the Hospital's desire to intergrate both patient care and educational activities and the perceptions of the community at large concerning medical education. Training programs have run a full course from the late 1800's through the 1980's, from freestanding "residency" programs prior to the advent of the various specialty boards, through freestanding fully approved residency programs, to the extensive training programs through affiliations with medical schools and universities. Some brief highlights of this rich history and tradition will serve to demonstrate the Hospital's past and continuing commitment to the education and training of young physicians.

In 1874 two positions were created at The Germantown Hospital for "resident physicians." In this context, the physicians were "residents" since their responsibility was for inpatient care in the Hospital. These two physicians, under the direction of a medical director, served a sort of "apprenticeship" in medicine and following a two year period, were eligible for their licensing examination.

In 1895 these "resident physician" posts became more and more popular and at the turn of the century, the Hospital's requirements for a "resident physician" included that he pass his State Licensing Examination before appointment at the Hospital. Also, at this time, the "residency" was formalized as a distinct educational unit at The Germantown Hospital. Throughout subsequent years, the number of resident physicians increased until, in 1918, six such positions existed at the Hospital and at this time the name was officially changed from "resident physician" to "intern." In light of the changing medical climate and following an inspection of its educational program by the State Bureau of Medical Licensure, the Hospital created two new positions, "Chief Resident - Medicine" and "Chief Resident - Surgery." These Chief Resident Physicians would be available to supervise the training and care rendered by the interns which now numbered nine. This change, reflecting the specialization of educational programs at the time, proved to be successful in maintaining the popularity of the Hospital's training programs.

It was not until 1936 that the Hospital's educational efforts took another significant step forward. At that time, the Hospital employed its first true resident physician, i.e., a licensed medical doctor entering a clearly defined program of postgraduate study in a particular disease speciality. This first resident was in the area of pulmonary disease and through the efforts of his supervising physician, the true era of postgraduate residency programs was begun at the Hospital. By the start of World War II, The Germantown Hospital and Medical Center could boast fully approved residency training programs in Surgery, Internal Medicine, Obstetrics and Gynecology, Pathology, and Pulmonary Disease.

Immediately following the end of the war, 1946, the Hospital moved further adding two residency programs, Radiology and Pediatrics, fully approved and intergrated into its educational efforts. There were, then, freestanding postgraduate residency training programs in six specialties and one subspeciality.

In the early 1950's the Hospital reached its zenith of freestanding residency programs with seven, Urology being added by 1953. The medical education climate, however, was changing. In early 1949, the Hospital entered into an affiliation agreement with the Jefferson Medical College for the training of undergraduate medical students. Affiliation agreements with medical schools would prove to be the wave of the future for the involvement of community hospitals, such as Germantown, in both undergraduate and graduate medical education.

The Hospital continued with its freestanding residency programs through the 1950's and 1960's and it was not until the 1970's that formal affiliation with the Medical School of Temple University, the Hospital of the University of Pennsylvania, the Medical College of Pennsylvania that the Hospital's affiliated residency programs came into being. At the present time, through the major affiliation with Temple University, the Hospital provides postgraduate residency training in Internal Medicine, Surgery, Obstetrics and Gynecology, as well as undergraduate training for third and fourth year medical students. The affiliation agreement with the Hospital of the University of Pennsylvania provides residency training in Orthopaedic Surgery. The affiliation with the Medical College of Pennsylvania provides postgraduate training in Pathology. The Hospital continues to operate a freestanding residency program in Diagnostic Radiology.

The attached copy of the Hospital's 1980 Annual Report may provide further insight into the Hospital's commitment and interest in postgraduate medical education.

TEMPLE UNIVERSITY
OF THE COMMONWEALTH SYSTEM OF HIGHER EDUCATION
SCHOOL OF MEDICINE
TU-556-00
3400 NORTH BROAD STREET
PHILADELPHIA, PENNSYLVANIA 19140

LEO M. HENIKOFF, M.D.
Dean & Vice President
for Medical Affairs

January 24, 1983

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

Dear Dr. Knapp:

I am writing in support of membership on the Council of Teaching Hospitals of the AAMC for the Germantown Hospital and Medical Center in Philadelphia. Germantown has been a major teaching affiliate of Temple University School of Medicine over a long period of time. Currently the medical residency program is integrated, and students from our third and fourth year as well as other residents from Temple University Hospital rotate through the Germantown Hospital and Medical Center. The Department of Family Practice at Temple is responsible for operation of the outpatient clinics at Germantown which serve as a basis for clinical activities of our Institute on Aging as well.

These relationships are such that Germantown Hospital and Medical Center has a major commitment to the educational process and is truly a teaching institution that should properly be a member of the Council of Teaching Hospitals of the Association of American Medical Colleges. If I can be of further assistance in this process please let me know.

Best wishes in the new year.

Yours truly,

Leo M. Henikoff, M.D.

LMH/pb

bcc: Hugh Maker
Joseph Farrell

association of american medical colleges

May 5, 1983

Mr. Joseph F. Farrell
President
The Germantown Hospital and Medical Center
One Penn Boulevard
Philadelphia, Pennsylvania 19144

Dear Mr. Farrell:

At its April Meeting, the Administrative Board of the Council of Teaching Hospitals reviewed Germantown Hospital's application for membership in the Council. While the Board recognized the presence of required clerkships and 25 FTE residents, the Board also noted that the application showed:

- no full-time salaried Director of Medical Education,
- no full-time salaried chiefs of service, and
- only $50,000 in hospital costs for supervising faculty.

Because the supplemental statement included with the application did not address the way in which educational supervision and instruction is provided for clinical clerks and residents, the Board has tabled action on the application until such supplemental information is available. Therefore, if Germantown Hospital wishes to be considered further for Council membership, I request a comprehensive statement describing faculty resources, clinical supervision, and educational instruction by June 10, 1983.

Thank you.

Sincerely,

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

RMK/am

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

The Germantown Hospital and Medical Center
ONE PENN BOULEVARD ■ PHILADELPHIA, PENNSYLVANIA 19144

J. DONALD CACCIA
VICE-PRESIDENT

June 8, 1983

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

Dear Dr. Knapp,

The attached statement prepared in response to your, May 5, 1983, correspondence, addresses the concerns you expressed about The Germantown Hospital and Medical Center's application for membership in the Council of Teaching Hospitals. Should any further clarification be required, please let me know.

Thank you.

Sincerely,

J. Donald Caccia
Vice President

JDC:jmc

cc: Mr. Joseph F. Farrell, President
Mr. Hugh J. Maher, Executive Vice President

THE GERMANTOWN HOSPITAL AND MEDICAL CENTER

SUPPLEMENTARY STATEMENT

TO

APPLICATION FOR MEMBERSHIP - COUNCIL

OF TEACHING HOSPITALS

RESPONSE TO POINTS RAISED

1. "no full-time salaried Director of Medical Education": The Germantown Hospital and Medical Center has historically utilized the services of one of its attending medical staff members, on a volunteer rotating basis, to fill this function. The duties of this individual include, acting with the various department chairman as a liason with the Medical Schools with whom we are affiliated and coordinating the on-site activities, with the chief residents, of the residents and their attending supervisors. We are currently searching for an individual to fill this role on a full-time basis since the growth in our educational programs has greatly increased the responsibilities of this position.

2. "no full-time salaried chiefs of service": While the information requested and forwarded with the application show no full-time salaried positions the Hospital maintains individual contractual relationships with the Chairman of Surgery, Medicine, Radiology, Pathology, and Obstetrics and Gynecology which provides renumeration to these individuals for their participation and supervision of our teaching efforts.

3. "only $50,000.00 in hospital costs for supervising faculty": This figure represents dollars paid to our Medical School affiliates for faculty supervisor they provide, over an above that provided by Germantown. Total annual expenses for supervision, including this $50,000.00 is over $250,000.00 (includes dollars indicated in #2 above.)

FACULTY RESOURCES

Of one hundred and fifty active medical staff members at Germantown Hospital, forty-five hold faculty positions at either Temple University School of Medicine, University of Pennsylvania School of Medicine (Orthopedics), or the Medical College of Pennsylvania (Pathology) with the majority of these being at Temple, the Hospital's major affilate. In addition, faculty members from Temple, twenty-one, hold clinical appointments on the staff at Germantown. These faculty members share the teaching responsibilities at Germantown with Germantown physicians on a rotating basis by clinical specialty.

CLINICAL SUPERVISION

Every resident and medical student rotating through Germantown Hospital is assigned a service and clinical supervisor (attending staff) for the duration of his/her rotation. In Medicine a typical assignment consists of two medical students

CLINICAL SUPERVISION (CONTINUED)

and a resident to a service. Depending upon the service, case load and availability of supervising physicians, these groups of residents and students may be supervised by anywhere from one to four attending physicians. The attending physicians are responsible for the clinical supervision of those students and residents on a daily basis through clinical conferences and rounds. When an attending participates in the teaching program his role clinically is as a supervisor since order writing and case management are the responsibilities of the residents and students. Cases are reviewed daily by the attendings.

In Surgery and Obstetrics and Gynecology a similar procedure is followed, with residents and students being assigned various services with attending physicians providing supervision on at least a daily basis.

Orthopedics and Pathology, because of the small number of residents in each specialty (two and one respectively), are handled directly with the department chairman and service chief. In these cases (since there are no medical students) direct clinical supervision of the residents is the responsibility of individual chairman.

In Radiology, clinical supervision is provided to our own residents on a one to one basis with a member of our attending staff.

EDUCATIONAL INSTRUCTION

In addition to the educational activities provided in the direct clinical process numerous educational opportunities exist on a daily, weekly, and monthly basis.

Daily there is a Surgical Student and Resident Conference featuring case presentations and discussions, a weekly Surgical Oncology Conference and a weekly general surgical presentation. Attendance is required at these daily conferences and the weekly general surgical session for all students and residents on these surgical services.

In the Department of Medicine, the medical students and residents meet four days a week with attending physicians for morning report and students conference. Case presentations and specific clinical topics are discussed. In addition, a medical residents conference is held twice a week and involves a closed circuit television hookup between Temple and all affiliated institutions for the discussion of current topics. Also, via a television hookup, CPC and Grand Rounds are presented from Temple for all house and attending staff.

The resident ataff in Radiology has a daily conference with the entire attending staff for discussion of various case presentations and other topics as appropriate.

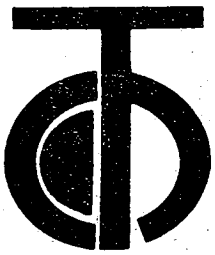
In addition to the above descriptions of educational instruction provided, there are several other sessions, both of a specific and general nature for the education of medical students and residents. Attached is a typical monthly schedule outlining the various programs and activities.

THE GERMANTOWN HOSPITAL AND MEDICAL CENTER

JUNE - 1983 - STAFF MEDICAL EDUCATION PROGRAM

DAILY	Mon thru Friday		Radiology Departmental Conference, Jay W. MacMoran, M.D.	
		8:00 AM	House Staff Invited	Radiology Conf. Room
DAILY	Mon thru Friday			
		2:00 PM	Surgical Student Conference	Surgical Conf. Room
WEEKLY		8:00 AM	Medical Residents Morning Report (Mon., Tues., Thurs., & Fri.)	Committee Dining Room
WEEKLY		8:00 AM	Medical Students Conference (Mon., Tues., Thurs., & Fri.)	3rd Fl. Founders' Bldg.
WEEKLY		12:00 PM	Medical Residents Conference (Mon. and Thurs.)	Auditorium
WEEKLY	Tue	12:00 PM	Neurology Conference, Stephen D. Silberstein, M.D. (Note 1)	Auditorium
WEEKLY	Wed	7:45 AM	Orthopedic Teaching Rounds, House Staff Invited	Floor 2 - South
WEEKLY	Wed	9:30 AM	CPC	Auditorium
WEEKLY	Wed	11:00 AM	Grand Rounds from Temple (Notes 1 and 2)	Auditorium
WEEKLY	Wed	3:00 PM	Surgical Conference - Oncology	Dr. Lerner's Office
WEEKLY	Thu	4:00 PM	Surgical Conference - Current Problems	Surgical Conf. Room
WEEKLY	Fri 3	11:45 AM	CONTINUING EDUCATION LUNCHEON (See Note 4)	Doctors' Dining Room
WEEKLY		12:15 PM	CONTINUING EDUCATION CONFERENCE, "ENT Update - 1983" Alan S. Berger, M.D., Department of Otolaryngology, The Germantown Hospital and Medical Center. (Note 1 and 2)	Auditorium
	Tue 7	4:00 PM	Surgical Conference - Orthopedics	Surgical Conf. Room
	Wed 8	12:30 PM	Departments of Internal Medicine and Family Practice Meeting.	Auditorium
WEEKLY	Fri 10	12:15 PM	CONTINUING EDUCATION CONFERENCE, Tumor Conference, "Principles and Clinical Aspects of Neutron Radiation Therapy", Melvyn Richter, M.D. Director, Department of Radiation Therapy, American Oncologic Hospital; Assistant Professor of Radiation Therapy, University of Pennsylvania School of Medicine. (see Notes 1, 2 and 4).	Auditorium
	Tue 14	8:00 AM	Ob/Gyn Department Meeting	Doctors' Dining Room
	Tue 14	4:00 PM	Surgical Conference - Urology	Surgical Conf. Room
WEEKLY	Fri 17	12:15 PM	CONTINUING EDUCATION CONFERENCE "Pathophysiology and Management of Angina Pectoris", Irving M. Herling, M.D., Director, Coronary Care Unit, Likoff Cardiovascular Inst. Hahnemann University Hosp. (See Notes 1,2 and 4)	
	Mon 20	8:00 AM	Neuroradiology Conference, (Combined with weekly Radiology Conference, (Note 1 and 2)	Radiology Conference Rm.
	Tue 21	4:00 PM	Surgical Conference - E.N.T.	Surgical Conf. Room
WEEKLY	Fri 24	12:15 PM	CONTINUING EDUCATION CONFERENCE, "Pulmonary Artery Hypertension", Eric Finkenstadt, M.D., Pulmonary Division, Hahnemann Hospital. (See Notes 1,2 and 4).	
	Mon 27	7:30 AM	Anesthesiology Conference (Note 3)	Recovery Room
	Tue 28	7:00 AM	Department of Surgery, MORBIDITY AND MORTALITY CONFERENCE.	Auditorium
	Tue 28	8:00 AM	Ob/Gyn Department Meeting	Doctors' Dining Room
	Tue 28	4:00 PM	Surgical Conference - Vascular	Surgical Conf. Room

Note 1 This conference will be held weekly at this time and place.
Note 2 Credit given for Category I by AMA and PMS.
Note 3 Approved for 1 Credit Hour by the AANA.
Note 4 Continuing Education LUNCHEONS are held on Fridays at 11:45 AM in the Doctors' Dining Room and precede the CONTINUING EDUCATION CONFERENCE.



COUNCIL OF TEACHING HOSPITALS • ASSOCIATION OF AMERICAN MEDICAL COLLEGES

APPLICATION FOR MEMBERSHIP

Membership in the Council of Teaching Hospitals is limited to not-for-profit -- IRS 501(C)(3) -- and publicly owned hospitals having a documented affiliation agreement with a medical school accredited by the Liaison Committee on Medical Education.

INSTRUCTIONS: Complete all Sections (I-V) of this application.

Return the completed application, supplementary information (Section IV), and the supporting documents (Section V) to the:

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

I. HOSPITAL IDENTIFICATION

Hospital Name: St. Joseph Medical Center

Hospital Address: (Street) 3600 East Harry

(City) Wichita (State) Kansas (Zip) 67218

(Area Code)/Telephone Number: (316) 685-1111

Name of Hospital's Chief Executive Officer: Mother Mary Anne McNamara

Title of Hospital's Chief Executive Officer: Executive Director

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

A. Patient Service Data

Licensed Bed Capacity (Adult & Pediatric excluding newborn):	600	Admissions:	17,878
Average Daily Census:	415	Visits: Emergency Room:	36,804
Total Live Births:	1,253	Visits: Outpatient or Clinic:	164,527

B. Financial Data

Total Operating Expenses: $ 64,777,844

Total Payroll Expenses: $ 37,346,110

Hospital Expenses for:

House Staff Stipends & Fringe Benefits: $ 515,676
Supervising Faculty: $ 100,387

C. Staffing Data

Number of Personnel: Full-Time: 1,407
Part-Time: 451

Number of Physicians:

Appointed to the Hospital's Active Medical Staff: 399
With Medical School Faculty Appointments: 223

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

Radiology | Rehabilitation | Family Practice | Emergency Medicine

Pathology | Alcohol Treatment | OB Anesthesia |

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

III. MEDICAL EDUCATION DATA

A. Undergraduate Medical Education

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

Clinical Services Providing Clerkships	Number of Clerkships Offered	Number of Students Taking Clerkships	Are Clerkships Elective or Required
Medicine	1	2	Elective
Surgery			
Ob-Gyn			
Pediatrics	2	20	Elective
Family Practice	1	3	Elective
Psychiatry	3	30	Elective
Other: Radiology	1	4	Elective
Pathology	1	4	Elective

B. Graduate Medical Education

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

Type of Residency[1]	Positions Offered	Positions Filled by U.S. & Canadian Grads	Positions Filled by Foreign Medical Graduates	Date of Initial Accreditation of the Program[2]
First Year Flexible				
Medicine				
Surgery				
Ob-Gyn				
Pediatrics	1	-	-	Sept. 1975
FP-Salina	4	4	-	Feb. 1979
Family Practice-SJMC	22	22	-	May 1972
Psychiatry	8	2	2	June 1976
Other:				
Anesthesiology	12	10	-	Nov. 1977
Pathology	4	-	4	1955 SJMC July 1977 city-wide
TOTAL	51			

[1]As defined by the LCGME Directory of Approved Residencies. First Year Flexible = graduate program acceptable to two or more hospital program directors. First year residents in Categorical* and Categorical programs should be reported under the clinical service of the supervising program director.

[2]As accredited by the Council on Medical Education of the American Medical Association and/or the Liaison Committee on Graduate Medical Education.

IV. SUPPLEMENTARY INFORMATION

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

V. SUPPORTING DOCUMENTS

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

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

Name of Affiliated Medical School: University of Kansas School of Medicine-Wichita

Dean of Affiliated Medical School: William J. Reals MD

Information Submitted by: (Name) Lew W. Purinton MD

(Title) Vice President for Medical Education

Signature of Hospital's Chief Executive Officer:

Institute Treasurer Authorized (Date) May 23, 1983

St. Joseph Medical Center

3600 EAST HARRY STREET, WICHITA, KANSAS 67218

WICHITA'S CENTER FOR FAMILY HEALTH CARE

Department of Medical Education

Lew W. Purinton, M.D.
Vice President

May 13, 1983

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

Dear Doctor

In review of requirements for membership in the Council of Teaching Hospitals, it seems clear that St. Joseph Medical Center, Wichita, Kansas, now fulfills those requirements. As a result we are submitting our application for membership in COTH. Attached you will find several documents including a copy of the letter from William J. Reals MD, Dean, University of Kansas School of Medicine-Wichita, in support of our application, a Mission Statement from the Board of Trustees of St. Joseph Medical Center - dated, January 1983, the Master Agreement between The University of Kansas School of Medicine - Wichita and St. Joseph Medical Center with Exhibits A through D that relate to cooperative ventures between the medical center and the medical school in various areas of medical education.

Obviously, this documents the medical center's participation in residencies' programs involving family practice, psychiatry, anesthesiology and pathology. The medical center basically operates the family practice residency program, but has extended a management contract to the medical school. The medical school essentially controls the residency programs in psychiatry, anesthesiology, and pathology. St. Joseph participates in the psychiatry residency program by providing the training site for all of the first year residents and most of their second and third years in psychiatry. This then is the primary teaching hospital for the psychiatric residency program that is a city-wide university operated program. St. Joseph Medical Center participates in an equal manner with St. Francis Regional Medical Center and Wesley Medical Center in the training of anesthesiology residents. In regards to the pathology residency, it is operated by the medical school; however, each hospital recruits its own residents to the program.

I trust this brief letter of explanation, along with the attached materials will provide adequate explanation and information qualifying St. Joseph Medical Center for membership in the Council of Teaching Hospitals.

Sincerely

Lew W. Purinton MD
Vice President
Medical Education

LWPmn

Attachments

THE UNIVERSITY OF KANSAS

Office of the Dean
The University of Kansas School of Medicine-Wichita
1001 N. Minneapolis
Wichita, Kansas 67214
~~(316) 268-8221~~
(316) 261-2600

May 11, 1983

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

Dear Doctor:

This letter is written in support of the application of St. Joseph Medical Center, Wichita, Kansas, to become a member of COTH.

St. Joseph Medical Center is a 600-bed community hospital offering services in a broad variety medical specialties and sub-specialties. It is a principal teaching institution for The University of Kansas School of Medicine-Wichita and medical students, residents and postgraduate students have a variety of learning experiences within the institution as rotations in our curriculum.

St. Joseph sponsors or co-sponsors residency programs in Psychiatry, Family Medicine, Anesthesiology and Pathology. Negotiations are currently under way with this Medical School to institute a training site for our Internal Medicine program and contracts will be signed shortly to achieve that purpose.

St. Joseph Hospital has been involved in medical education at all levels since The University of Kansas School of Medicine began operating and is a valuable and important institution in our educational programs.

I am pleased to recommend St. Joseph Medical Center as a member of COTH and will be happy to answer any questions concerning the institution.

Sincerely,

William J. Reals, M.D.
Dean

bcc: Dr. Lew Purinton

STATEMENT OF SUPPORT FOR GRADUATE MEDICAL EDUCATION

St. Joseph Medical Center has been involved with graduate medical education since 1958 when it developed a Pathology residency training program. The Medical Center had an approved internship from 1941 to 1972. Since 1972, the Medical Center has had an approved program in Family Practice. We became one of the sponsoring institutions for the University of Kansas School of Medicine-Wichita in the following residency training programs: Pediatrics - 1975; Psychiatry - 1978; Anesthesiology - 1977.

The board of trustees of St. Joseph Medical Center and its administration has a long history of commitment to the education of physicians in graduate training and reaffirmed that commitment and dedication on 12 January 1983.

The reasons for this solid commitment are many, but include, improvement of patient care through resident participation, stimulation of our medical and nursing staff for better patient care, and encouragement of highly qualified physicians to participate in the care of our patients through staff membership.

Medical Center resources are allocated through an annual budgetary process accomplished through joint efforts of administration, program directors, vice president for medical education, our accounting and controller staff, UKSM-W officials, where applicable, hospital councel, personnel officer, and other related officials of the Medical Center. The board of trustees of St. Joseph Medical Center provides a final review and approval of the educational budget for graduate medical education. The Medical Center further has appointed the vice president for medical education to set as a full voting member of the board of trustees and to update the board regularly on graduate medical education programs.

Each program through its director cooperates with the vice president for medical education, the administrative staff of the Medical Center, the responsible individuals of the Medical School (UKSM-W) and selected residents in training in providing for teaching staff appointment and resident selection. Resident supervision, evaluation, advancement and dismissal policies are delegated to program directors and appropriate faculty with cooperation of appropriate UKSM-W officials and Medical Center's vice president for medical education. Due process is dealt with in our contract with St. Joseph Medical Center residents and was developed by hospital councel.

DEPARTMENT OF TEACHING HOSPITALS
ACTIVITIES AND INITIATIVES

During the past three years, the Department has focused particular emphasis on the issues of diagnostic case mix and hospital payment methods. Five publications have resulted from this effort:

- o Describing and Paying Hospitals: Developments in Patient Case Mix, May, 1980
- o The DRG Case Mix of a Sample of Teaching Hospitals: A Technical Report, December, 1981
- o The Disease Staging Case Mix of a Sample of Teaching Hospitals: A Technical Report, February, 1982
- o Selected Data for a Small Sample of Teaching Hospitals, October, 1982
- o A Description of Teaching Hospital Characteristics, December, 1982

Attention to the subject area will remain high, but data gathering and publication efforts will not be pursued with the same intensity.

The Department continues to develop and publish the COTH Report; COTH Directory of Educational Programs and Services; Executive Salary Survey; Housestaff Stipends, Benefits and Funding Survey; and the Survey of University-Owned Teaching Hospitals' Financial and General Operating Data. Plans are underway to expand the "university-owned" hospital survey.

The time is appropriate for a review of the Department's project activities. It would be helpful if the Board would review and discuss the following items as possible departmental initiatives.

This list should serve only as a point of departure for discussion. Suggestions and observations about all departmental activities are encouraged.

1. Medical Education Costs in Teaching Hospitals

In May, 1980, the Department of Teaching Hospitals published the Annotated Bibliography on Medical Education Costs in Teaching Hospitals which appears as a separate enclosure with this agenda material. The question of what useful contributions remain to be made in this area is a matter which requires attention.

- o Should additional studies of the impact of medical education costs on teaching hospitals be encouraged?

- What specific questions should be pursued?
- Are there ways of making better use of the work that has already been completed?
- The current AAMC position is that graduate medical education is a legitimate patient care cost. With increasing price/cost competition, is a new examination of this issue in order?

The questions set forth under the heading, "Unresolved Issues and Unanswered Questions," (P. 791) in the article following this agenda item are worth reviewing in this context.

2. Tracking the Financial Performance of Teaching Hospitals

New payment systems involving contracting, discounting, and per case payments are rapidly being implemented. The impact of these payment systems on teaching hospitals is an area which has not received systematic attention. To monitor these changes and compare different subgroups within the COTH membership, the AAMC could sponsor all of its non-federal members in the Financial Analysis Service (FAS) of the Healthcare Financial Management Association for a five year period. FAS uses audited financial statements to compute and display 29 standard financial ratios. A five year time series, 1982-1986, would permit comparisons among COTH subgroups (university-owned, primary affiliate, affiliated) and between COTH members and non-teaching hospitals.

3. Comparative Hospital Data

Increasingly, executives in COTH hospitals are interested in comparative data which could be used to assess their hospital's performance. When questioned about participation in the AHA's Monitrend, most callers say its usefulness is limited by inconsistent data collection and reporting practices. To assist COTH member hospitals, at least three options are available.

A. Improved Monitrend Comparability

If the basic Monitrend reports are useful to the membership but the weakness is the data, AAMC staff could establish a joint project with AHA staff and participating COTH hospitals to help obtain more uniform input data. This could be supplemented by meetings of COTH subscribers where hospitals could explain atypical organizational and financial characteristics that underlie data differences. In addition, and depending upon member interest, Monitrend staff might be willing to develop special reports and comparison groups (university-owned, primary affiliate, affiliated) for COTH members.

B. Expanding the Yale-New Haven Hospital Study

Yale-New Haven Hospital is presently undertaking its second collection and analysis of case mix data in university-owned and primary affiliated hospitals. The first study assisted Yale-New Haven in a presentation to the Connecticut Cost Commission and provided participating hospitals with comparative data on length of stay by DRG. The current study uses the new DRG's and additional cost information from the hospitals. Depending upon Yale-New Haven's interests, the AAMC could assist the hospital in establishing a center to gather and analyze comparative financial, operational, and utilization data for university-owned and primary affiliated hospitals.

C. Commercial Teaching Hospital Database

If a sufficient number of COTH members were interested and willing, the AAMC could form a joint venture with a commercial data processor to create and maintain uniform database information on teaching hospitals. Data included could be organized at the specific patient level, the operational departments, or both.

4. New Technology Clearinghouse

As COTH members introduce new technologies and services (e.g., NMR, PET scanners, bone marrow transplants), the hospital often prepares an internal report for adopting and/or planning the change. The AAMC could establish a clearinghouse on new projects/services which member hospitals could share. If sufficient interest exists, the clearinghouse could be expanded to include evaluation reports prepared by member hospitals for new services.

5. Insurance Access

As new payment and delivery arrangements develop, price sensitive insurers may be reluctant to provide beneficiaries with access to high cost teaching hospitals. The AAMC could identify services generally requiring care in major teaching hospitals, develop a directory of member hospitals performing minimum service thresholds in a specific service, and allow insurers to use a registered service mark on policies providing coverage for specialized services in teaching hospitals listed in the directory.

6. Impacts of Clinical Research on Hospitals

In the recent AAMC report on 33 COTH hospitals and in the report describing teaching hospitals, no adequate information on research activity in teaching hospitals was found. As a result, it is

difficult to describe the impacts of research on teaching hospitals. As both research agencies and third party payers face more constrained budgets, they may dispute which expenses should be paid by research or patient care dollars. The AAMC is in no position at this time to provide either general data on the cost impacts of research or methodologies individual hospitals could use to estimate research-related costs. A project to develop measures of research activity and methods for estimating their cost impacts could be developed.

7. Medicare Payment System Activities

With the enactment of the 1983 Social Security amendments, Medicare payment for inpatient services has been dramatically altered. The 14 pages of legislative language provide the Secretary with substantial discretion in implementing prospective payment. In addition, the list of mandated studies provides some indications of Congressional interest in related payment areas. The changing Medicare payment system and the implementation options provide the AAMC with several challenges in the months and and years ahead. For example, in implementing the Prospective Payment System, HCFA must address the following regulatory issues of concern to COTH members:

A. The rate of increase to use when adjusting old data for inflation;

B. The way in which residents are counted when computing the resident-to-bed adjustment;

C. The distinction between Part A physician costs allowed in the medical education passthrough and those physician costs for management and supervision which are included in the per case rate;

D. The definition of a "distinct part" unit for psychiatric and rehabilitation patients,

E. The length of stay and cost thresholds used to define outliers;

F. The definition of "marginal cost" to be used in paying outliers;

G. The separation of the urban wage indices into their central city and suburban components;

H. The method of payment for patients transferred to a second hospital;

I. The extensiveness of future cost reporting forms and procedures; and

J. The continued usefulness of input controls such as maximum allowable costs for drugs, reasonable compensation equivalents for physicians, and access to subcontractor books and records.

Moreover, in the years ahead, HCFA must be prepared to address additional revisions of the system, including:

A. The addition of case mix categories or systems more sensitive to severity of illness and intensity of care;

B. A methodology for incorporating capital costs into the per case payment;

C. A means of paying for hospital-based ambulatory care, both outpatient and emergency, on a prospective basis;

D. A prospective payment system for physicians' services provided to inpatients; and

E. Publicly available methodologies for computing payment adjustments for the indirect costs of medical education, national and regional referral centers, and hospitals serving large number of indigent and Medicare patients.

The resources required to fully address each of these issues exceed those presently available to the AAMC. Therefore, in recommending future activities for departmental action, the Administrative Board is requested to identify short and long term prospective payment issues of greatest concern to the membership.