MINUTES OF A SPECIAL MEETING
BOARD OF REGENTS OF THE UNIVERSITY OF OKLAHOMA
SATURDAY, MARCH 17, 1973

A special meeting of the Board of Regents of the University of Oklahoma was held in the Oklahoma Memorial Union, Dining Room 1, at the University of Oklahoma, Norman, on Saturday, March 17, 1973, beginning at 2:00 p.m.

The following were present at the meeting: Regent Huston Huffman, President of the Board, presiding; Regents Jack H. Santee, Walter Neustadt, Jr., Mack M. Braly, Thomas R. Brett, Bob G. Mitchell, M.D., and Nancy J. Davies.

The following were also present at the meeting: Dr. Paul F. Sharp, President of the University; Mr. Joseph C. Ray, Acting Provost; Vice Presidents Dean, Eliel, Morris, Nordby, and White; and Mrs. Barbara H. James, Secretary of the Board of Regents.

Regent Huffman said the meeting was called for the purpose of considering the interim and preliminary report from Herman Smith Associates which was prepared at the request of the Regents to meet the requirements of the Senate Committee for Investigation and Study of Health Care Facilities in Oklahoma created by Senate Resolution 9. The Committee asked that proposed solutions be prepared by March 9, 1973, in order to allow sufficient time for consideration of the proposed solutions and drafting any new legislation which may become necessary in connection therewith. Herman Smith Associates asked that this interim report not be considered as their final report to the Regents and that it should be used only for the purposes indicated above. "This report is based upon our best judgments, assumptions and estimates within the constraints of available data and time provided for this highly complicated subject. The final report will be based upon more firm data and thorough analysis and study of all relevant information available from all sources connected with and concerned about the Center's future."

Regent Huffman said this Interim Report was delivered to the Governor and the legislative leaders this week.

The Interim Report, including an Introduction, An Overview of the Problems, Immediate Solutions, and Appendix IV are as follows:

FOREWORD

Herman Smith Associates/Hospital Consultants first made a proposal to the University of Oklahoma on October 6, 1972 to assist the University with a "reorganization of the governance and fiscal support of the University of Oklahoma Hospitals," and the "design and installation of a fiscal management system for the University of Oklahoma Health Sciences Center." In a communication dated October 18, 1972, authorizing us to proceed with this study, the President of the Board of Regents expanded the study by stating it was "the concensus of the Board that you should furnish us with your observations regarding the total governance of the Center."

On November 20, 1972, we informed the Board of Regents that "because of the existing managerial vacuum, the administrative and fiscal affairs of the Hospitals are in serious disarray." This situation made it impossible for us to function effectively in the role of consultants as we originally proposed. An alternate proposal was then made that "Herman Smith Associates assist the University with managerial and planning services for a period of approximately 90 to 120 days beginning November 20, 1972." This proposal was accepted by the Board of Regents on that date.

As documented in bi-monthly progress reports, the management and fiscal affairs of the University of Oklahoma Hospitals have been effectively stabilized through the efforts of our firm with substantial assistance from the staff and resources of the University of Oklahoma. On February 22, 1973, the Regents' committee on the Health Sciences Center directed us to begin to prepare recommendations for both immediate and long-range solutions to the problems of finance, management, governance, and development of services and physical facilities that affect the Health Sciences Center, these for presentation on March 9, 1973 to the Oklahoma State Senate Special Investigating Committee on Health Care Facilities. This report outlines our preliminary recommendations (with alternative courses of action) in full realization of the critical decisions that face the Thirty-fourth Legislature of the State of Oklahoma concerning:

a. supplemental appropriations for the current fiscal year 1972-1973 to maintain the University of Oklahoma Health Sciences Center in operation;

b. what is required in the 1973-1974 budget for the University of Oklahoma to operate the Health Sciences Center;

c. what capital funds will be required to operate the essential components of the Health Sciences Center and to open the Everett Building, along with an analysis of what funds will be required to operate the Everett Building in the months ahead as well as in fiscal year 1973-1974;

d. the management stability of the University of Oklahoma Hospitals relative to the effective application of funds appropriated for both operations and capital development;

e. sound long-range solutions to assure everyone concerned that every alternative course is under consideration to resolve the critical issues now facing the Health Sciences Center as they relate to management, finance, service programs and physical planning.

f. A resolution to the crucial issue of how best to finance and provide care and treatment to the medically indigent of the state of Oklahoma.

As a matter of record, we wish to again state the risks involved in "instant planning" as they relate to judgments based on insufficient time to analyze the unprecedented national changes that have taken, and are taking, place in financing the training of health manpower and provision of health care services. This problem is particularly acute in health science centers, such as the University of Oklahoma. Its immediate and long-range impact is virtually impossible to predict at this time, except through the judgment of the Health Sciences Center faculty, who have done everything in their power to provide the University administration and consultants with their judgment on these matters that will affect the provision of health care to Oklahoma for decades to come.

Compounding the problem is the fact that there is no one function or activity that can be totally isolated from the others; therefore, instant, fragmented solutions to highly interrelated problems will not help anyone, but will in fact be a disservice to the entire State.

With these sobering considerations, we have marshalled the resources of our firm over the past two weeks to provide the best advice and experience we can offer at this point regarding the future effects of current, proposed actions. We believe there is one major conclusion on which we can all agree, and that is that, regardless of what historic information and data was being applied to the matter of how health manpower and resources would be provided, it is no longer dependable or relevant--we are in a completely new era where there simply are no road maps or guidelines. The best we can hope for is that, of all the alternatives available to the State and University of Oklahoma, there must be some better than others; and the purpose of this report is to assist everyone involved in choosing those alternatives that are in the best interests of Oklahoma.

March 17, 1973 12058

AN OVERVIEW OF THE PROBLEMS

A. Structure of Governance and Financing of the University of Oklahoma

Compared with the hundreds of planning manhours devoted to most distinguished community hospitals having only a fraction of the problems facing a university campus teaching hospital, the brief time and attention the University Hospitals can elicit from a board of regents faced with the problems of a vast university community is unacceptable in today's critical assessment of health care delivery.

However, the larger problem, in our opinion, begins with the total governance of the University of Oklahoma.

The role of the Oklahoma State Legislature, and its deep concern for the prudent expenditure of the resources of the State of Oklahoma; the role of the Oklahoma State Regents for Higher Education, with their mission of coordinating the functions, programs, standards and financing of higher education; the role of the University of Oklahoma Board of Regents in University operation and management; and the role of the University of Oklahoma Health Sciences Center as a "constituent agency in the State System" predictably all lead to conflicts regarding accountability, governance, financing, and attitudes toward one another. Our impressions over the past few months have been that each one of these bodies sincerely believes it knows what is best for the people of Oklahoma. The resulting conflict and competitiveness has understandably led the citizens of Oklahoma into truly confused and dismayed attitudes toward "education" and its governance and financing. To be certain, there have been significant elements of mismanagement, particularly as revealed in our mission in the Health Sciences Center. Unfortunately, this clouds the broader and more responsible issue of the overlapping roles of governing bodies.

We would hope that the current disarray in the Health Sciences Center will strongly motivate the State Legislature, through its appropriate committees, the State Regents for Higher Education, the University of Oklahoma Board of Regents, and the Governor's Office, to seriously and conscientiously reexamine the basis of authority and responsibility for each governing body and the process of communication and decision-making. Most faculty members at the Health Sciences Center have been demoralized and dismayed by previous mandates to develop needed programs of instruction for which they were required to provide the leadership necessary to secure financial support. Now they are criticized, if not vilified, as financial support is removed with little or no forewarning, leaving the faculty in the posture of being the mismanagers, when in fact, it was the decision-making process of the legislative and educational leadership that prompted them to develop these programs in the first instance. Inevitably this process will compromise or drive away the committed and competent faculty leaving only the opportunists who will move to wherever the money is, or those who will accept any degree of compromise which may have little to do with what is good for Oklahoma.

B. Identification of Major Problems of the University of Oklahoma Health Sciences Center

1. "Operating and managing the University of Oklahoma" with generalized mandates and directives concerning functions, programs and standards and with unpredictable long-range resources, the role of University of Oklahoma Regents is ineffective and perfunctory. (In charge of what?)

2. Nationally, there is serious controversy over the number and types of health facilities the country requires, as well as the quality and quantity of health manpower needed to serve the public. Lack of agreement on any public policy for health has forced academic health centers to become ambivalent about their role and to reevaluate their data base and philosophy toward the production of health manpower as well as their responsibility for health-care delivery. The data base upon which decisions were made in the past is no longer acceptable, and states are now forced to reevaluate their own priorities and reallocate financial resources. Among the most serious problems the new era brings is whether the schools of the health professions will train only for local needs in contrast to contributing to a regional or national health manpower pool. This immediately raises the issues of quality and excellence as they relate to image, quality of students admitted, size of school, and "why not let someone else do it for Oklahoma." (See B. - Programming Page 20)

3. Isolation of the University of Oklahoma Health Sciences Center as a "constituent agency" in the State System, rather than a fully integrated part of the University of Oklahoma is inexplicable and unfortunate. This situation was further compounded by the University of Oklahoma Board of Regents action of June 25, 1970, which states: "The Vice President for Medical Center Affairs has authority and responsibility for all programs and operations of the Medical Center, including budgeting and related fiscal affairs." Thus, in order to insure the implementation of this organizational relationship, it was recommended to the Regents that the title of the Vice President for Medical Center Affairs and Director of the Medical Center be changed to Executive Vice President for the Medical Center Affairs and Director of the Medical Center.

   It is our judgment that this action placed the President of the University in the position of ceremonial head of the University of Oklahoma Health Sciences Center and further confused the accountability of the University of Oklahoma Health Sciences Center. By exercising this expediency, the University of Oklahoma abdicated its responsibility for the schools of the health professions for which it is now paying a severe price.

4. The above actions were undoubtedly influenced by the aura of economic freedom the Health Sciences Center had developed through substantial federal funding.

The undue dependence on federal funding has left the University of Oklahoma in a situation similar to most other academic health centers in the nation, with no evidence of sufficient backup resources or alternatives except to reduce and close programs. Moreover, there appears to be little sympathy or compassion from the governing or legislative bodies that participated in this laissez-faire atmosphere of the past decade as modest substitute funding in the form of federal revenue sharing money is received. One would often hear great concern expressed over the percentage of "soft" money supporting health sciences, but no one addressed himself to acceptable courses of action that could be taken if and when public policy and public monies turned against the health delivery system. (Capitation grants, to a degree, have minimized the impact on schools of medicine, dentistry, and osteopathy in contrast to schools of public health, nursing and the allied health professions being left almost totally exposed to financial insolvency.)

5. Some major aspects of the "Master Planning Responsibility" for the Health Sciences Center was delegated to an umbrella planning agency, "The Health Sciences Center Foundation, Inc.". This group addressed itself to planning "The Oklahoma Health Center" of which the University of Oklahoma "Health Sciences Center" is a major element. The foundation's "Development Plan" has had a significant impact on the University of Oklahoma. It is apparent that the "foundation's" planning concepts, process and efforts do not have a sufficient understanding by the University of Oklahoma Regents, University-wide administration, State Regents or the Legislature to gain their full support. Unfortunately, this has further complicated the planning and decision-making process at the Health Sciences Center to a substantial degree.

6. As a result, the University of Oklahoma Health Sciences Center administration has, in recent years, been crisis oriented; has been on the defensive, and has lost a degree of credibility regardless of what factors precipitated the current situation. Although this is the characteristic posture of the entire health-care field at this time, it appears more exaggerated in Oklahoma.

   The character of administrative leadership in the Health Sciences Center may best be depicted by:

   a. The Center's identification as a "constituent agency" in the State System which thereby permitted it to essentially ignore the parent University until it was in trouble. Parenthetically, there is basic disagreement whether it was the parent University or the Center that ignored the other, or whether it was the University that was overly permissive with one of the "constituent agencies" under its control.

   b. The leadership came, used up the environment--or was used up by the environment--and left (three vice presidents in four years).

   c. A growing and permeating lack of confidence in, or confusion about the decision-making led to "traditional management by committee to avoid risk or exposure", with little evidence that these activities

were productive. Most appear to have led nowhere except to the conviction of many faculty members that there are no established mechanisms for reliable communication and for faculty governance to assist with major decisions for the University of Oklahoma Health Sciences Center.

d. Because problems never were resolved, an attitude of defeat and lack of urgency set in with the philosophy that--somehow it will work out--it always has before, and no one knows what's going on anyway.

e. There have developed a multitude of unrelated individual solutions, plans, and planners, both internally and externally, which must be classified as the most serious, disquieting and potentially destructive problem affecting the entire University of Oklahoma at this moment.

C. Specific Manisfestations

1. Unrealistic planning in relation to resources and lack of an appreciation of the relationships required to achieve a distinguished health sciences center --"a two hundred million dollar dream or a two hundred million dollar delusion?"

2. No evidence of feasible alternative courses of action if overall plan could not be effected.

3. Lack of understanding of what constitutes workable and acceptable joint venture agreements and arrangements for the delegation of graduate and undergraduate health education and support facilities. This is particularly acute as it relates to affiliation agreements. (See Facility Programming and Planning III-D, Page 22.)

4. Obscure and ill-defined relationships between the Health Sciences Center and the parent University, leading to a fiscal crisis that seriously threatens the very existence of the Center.

5. Equally obscure relationships between the administrations of the Health Sciences Center and the University of Oklahoma Hospitals with regard to respective roles, resources, management and control, all of which has resulted in the lack of direction, decisions, identity, and mutual respect and confidence.

6. Lack of coordination as a result of the inseparability of roles of Clinical Chiefs of the University Hospitals and of departmental chairmen in the School of Medicine, has led to fragmented planning and decision making. The two groups appear to have been working independently on common problems, but within the context of their own respective spheres of interest, without uniformity of priorities, and in a void of common information upon which to make decisions. (This is a chronic problem common to every academic health center in the nation and is seldom satisfactorily resolved as long as the teaching hospital remains an integral part of the academic health science center.)

7. Fiscal Planning

a. A myriad of funding mechanisms, however successful individually, resulted in fiscal insolvency. These included:

1) State Appropriations

2) Student Fees

3) Overhead or Indirect Costs for Grants and Contracts
(Arrived at by a complicated cost formula)

4) Sales and Services of Departments
(Wide variety of contractual arrangements with outside organizations, such as hospitals, State Department of Health, State Department of Mental Health and others).

5) Hospital Patient Services
(Complicated cost reimbursement formulas with third party payers, such as: D.I.S.R.S., Blue Cross, Medicare, Medicaid, Champus, other third party insurers and individuals.)

6) Food Service Operations

7) Gifts, Grants and Contracts
(Wide variety of relationships, accounting requirements and restrictions related to these sources of funds. Special reports required for each.)

8) Professional Fees
(Primarily applies to the College of Medicine but, to a lesser degree, is applicable to Colleges of Health and Dentistry.)

9) Support of Faculty and Supporting Staff from Affiliated Hospitals and Foundations
(Veterans Administration Hospital provides approximately $1,500,000 in support. Oklahoma Medical Research Foundation also provides significant support. All of this is outside of the program planning and budgeting process because these organizations pay these funds directly for services.)

10) Auxiliaries
(Computing Center, Plant operations, and others.)
State appropriations and revolving fund accounting require the Health Sciences Center to be on a cash basis instead of an accrual basis. This complicates the accounting system because it requires duplicate records to be maintained for the purpose of obtaining appropriate reimbursement for services in the same manner as other hospitals operated in accordance with business accounting principles.

b. Unpredictability and lack of control over uncompensated costs for the medically indigent--an untenable legislative mandate toward which the University of Oklahoma has remained unbelievably passive--has dragged the fiscal management of the University into disrepute.

c. Unpredictable effect of professional fees, grants, contracts, gifts, and other sources of funds on fiscal planning.

d. A short-sighted attitude regarding federal funding available to the Health Sciences Center and failure to direct the attention of governing and legislative bodies toward the necessity for a retrenchment plan in the event the method or amount of federal funding should be altered.

e. A patchwork of relationships to develop appropriate funding for many departmental operations, which in some instances required almost a full-time commitment by the Dean or Departmental Chairman to secure his own financial support in order to operate a department or college mandated by the governing bodies. Interestingly enough, this type of "self" financing required to create a department or college, and properly fund it, was interpreted negatively by many who read the "Richardson Report" as irresponsible fiscal management. Frankly, this measure of extra effort, if properly meshed into properly planned development, is ordinarily the subject of considerable praise.

f. Absence of an accounting system specifically designed for patient care activities with little relationship to organizational assignments, and providing no effective method for control or accountability of expenditures or revenue. This resulted in:

1) Unmanageable accounts receivable;

2) Critical reduction in cash flow affecting the entire Health Sciences Center's fiscal solvency;

3) Freezes on salaries, travel, and other expenditures;

4) Restrictions on capital funds;

5) General deterioration of personnel effectiveness, physical plant, and other resources necessary to maintain an acceptable quality of patient care and an appropriate teaching environment (bridging on malpractive).

D. Inevitable Results

1. A lack of confidence in management, resulting in numerous investigations, studies, special committees, consultants, etc.

2. Under the above structure of governance and financing, solutions relating

to the financing and overall planning of patient care facilities have been less than desirable or have failed.

3. Some feel that if "prudent" management had been exercised, none of the above would have occurred. This charge can neither be supported nor refuted except subjectively. Unfortunately, there has been enough evidence of mismanagement that the latter is generally accepted and blown out of proportion. In many ways the Health Sciences Center, and in particular the Medical School, has operated very successfully in spite of the "system". Those departments that independently took maximum advantage of governmental or other funding mechanisms are criticized for their entrepreneurial attitudes when such funding, from outside the system, has virtually dried up except for those available in the form of federal revenue sharing funds now being made available to the system.

   We would remind everyone that the School of Medicine has assumed one of the greater teaching commitments of any medical school in the country, and yet ranks in the lowest quartile of costs for training medical students. The quality of these students and their training certainly ranks high above the lowest quartile, leaving many wondering why the problems which are now surfacing did not arise earlier.

IMMEDIATE SOLUTIONS

A. Immediate financial and organizational stability of the University of Oklahoma Hospitals and Health Sciences Center for the current fiscal year 1972-73.

1. Through the combined efforts of the University of Oklahoma staff and its consultants, the cash flow deficit in the current fiscal year, 1972-73, is now estimated at $1,732,726 including the retention of cash reserves (see separately submitted Appendix I-March 1, 1973 letter to Governor Hall from John Dean, Vice President, University Relations). This is a reduction of approximately $1.3 million from the original estimated deficit of $3 million submitted in an earlier communication to Governor Hall dated December 14, 1972 (Also shown in Appendix I.).

Documentation for the need of $1,732,726 is included in Appendix I and the reductions from those approximations made in December 1972 are attributable for the most part to the consultants' intense efforts in reorganizing and managing the entire billing and collection activity at the University of Oklahoma Hospitals and improving opportunities for reimbursement. There are also many other reasons why the financial picture has improved, namely a wide range of fiscal and administrative reforms which have taken place at the Hospital over the past four months (see separately submitted Appendix III, concerning these activities).

It must also be understood that these reductions were derived by maintaining a freeze on virtually all salaries, travel, and other related expenditures. This is particularly critical as it relates to labor relations with lower salaried employees, as wages have been frozen for more than a year. However, in view of the total situation, everyone involved has extended himself to the utmost to hold the line in this fiscal year with the hope that a solution to the total problem will include competitive wage guidelines, which are essential if there is to be a new era of management and competency in the Health Sciences Center.

We believe that, to a large degree, fiscal and administrative responsibility is being achieved at this time in the University Hospitals and that in a matter of months we will be able to assure even the "greatest of doubters" that fundamental and lasting changes have been made that will place this institution in the role of leadership it deserves in the State of Oklahoma as one of its finest health care facilities. Therefore, we strongly recommend that an interim appropriation of $1,732,726 be immediately allocated to the Health Sciences Center, $777,626 for operations; and $955,100 for activation of the Everett Tower, based on a 120-day activation period as discussed in Appendix I. (This step requires University Regents, State Regents, and State Legislative and Executive action.)

However, this recommendation is not intended to lull anyone into a false sense of security concerning the cost of operations beyond this fiscal year. The reduction in operating needs for FY 1972-73 has resulted primarily from collection of overdue receivables and realization of other one-time sources of

income. Therefore, before granting this supplemental appropriation required to finish fiscal year 1972-73, it should be fully understood that needs for fiscal year 1973-74 and thereafter will be substantially higher as more fully discussed later in this report. Frankly, the supplemental appropriation is recommended in order to gain the necessary time within which to work out permanent solutions and to avoid the obvious impact of closing the Center in June of this year.

2. The recommendations to the legislature concerning a supplemental appropriation of $777,626 for the operation of the Health Sciences Center through June 30, 1973, is based on the absolute minimal course of action, which does not introduce any new programs, concepts, or expenditures except those that are essential to maintain existing service, education, and research commitments through this fiscal year.

   The rationale for this decision is our belief that there will be no supplemental appropriations beyond those for survival until a total plan is agreed upon with the legislature and state regents to resolve the current problems and arrive at long-term solutions involving finance, facilities, services, programs and management.

   Relations with the faculty and personnel, specifically concerning their futures, is the most critical problem that the University of Oklahoma administration has to deal with during this delicate period, and we again remind and caution those on the outside that the situation within the Health Sciences Center of the University of Oklahoma is "extremely brittle if not volatile" at this time.

3. We do not feel that Herman Smith Associates has sufficient knowledge or insight of what is the most appropriate governance, nor do we have the expertise to choose the most appropriate courses of action to achieve the most appropriate governance, for the entire University as it relates to the Oklahoma State Regents for Higher Education and the Oklahoma State Legislature. However, we must again emphasize the importance of an immediate strong supporting and understandable University organization to which the University Hospitals can relate. We concur wholeheartedly with a representative group of chiefs of the clinical services at University Hospitals and the newly appointed hospital administrator in their statement that "the University Hospital needs a board of trustees which will:

   - be the locus for role, program, and facility definition
   - articulate broad policy formulation
   - relate the institutions to the community and the state
   - bring the talent, expertise and judgment of successful leaders from the business, industrial and, most important, the managerial community into the intricate decision-making process of what is one of the most complex organizations in the State of Oklahoma."

   We also concur with this group's opinion that "high competence and response capabilities, unfettered by intricate organizational and inter-personal relationships, and uninhibited by archaic and arbitrary rules and regulations, are essential to meet the demands placed upon a short-term, acute-care campus teaching hospital which is expected to respond immediately and efficiently

to the unique and emergent situations as a service enterprise. To be buried in the organizational morass of an academic-health sciences center and treated as a laboratory for students of the health professions is an inappropriate and untenable posture for a modern hospital under unprecedented pressures from outside elements on which it depends for its ability to operate." As the consultants have said on many occasions in the past, we believe a hospital left in this posture, with the constant demands thrust upon it to be responsive and responsible, is programmed for disaster.

4. We further recommend that the University Hospitals must be held strictly accountable for management of its financial resources and cash flow and be given every possible support to become an immediate separate entity, in full control of all of its vital components, within the University of Oklahoma. Under "Long-Range Solutions," we will be discussing various alternatives for the Hospitals' long-range role, programs, and governance, oriented to strengthen its identity and allow it to take full advantage of every possible functional and programmatic inter-relationship in the Health Sciences Center.

   Until this can be achieved, the University has begun to separate organizationally, fiscally, and functionally the Hospital from the Health Sciences Center and make it directly accountable to the Regents of the University of Oklahoma through the President of the University (and his appropriate line and staff organization) similar to other colleges and major elements of the University of Oklahoma. Equally important is the reinitiation of the "Joint Conference Committee of the Medical Staff" to meet regularly with appropriate members of the Regents and University-wide administration to address itself exclusively to the "Hospitals Problems and Mission."

   The issue of governance, however, has both short and long range implications, since regardless of the degree to which University Hospitals can manage their affairs, they are still university hospitals, and therefore, dependent on an effective Health Sciences Center administration. Thus it should be made clear that the interim solutions we have recommended for the University Hospitals assume an equally strong administrative structure in the Health Sciences Center as it relates to the University of Oklahoma. Regardless of the historical reasons, the authority and responsibility of the Health Sciences Center, the Legislature, State Regents, and the University Regents have been obscure, ill-defined, and inadequate to the complexity of the task. We do not believe that anyone involved or concerned with the present crisis would condone or support a continuation of the present organizational structure of the Health Sciences Center and the confusion that it generates. To rectify this situation, the Health Sciences Center is beginning to relate to the University of Oklahoma as an integral part of the University and is already being reorganized along functional lines rather than that of a "separate entity" or "constituent agency." We recommend that the current position of Executive Vice President and Director of the Health Sciences Center be changed to that of Vice President for the Health Sciences, responsible to the president for the development and coordination of academic programs. Other functional vice presidents and administrative officers would have authority for non-academic matters.

   The next step to implement this new organizational structure is the successful demonstration of centralized support services on the Norman Campus that can be effectively integrated with those on the Health Sciences Center Campus in

Oklahoma City. It is apparent that some of these services can be integrated immediately, whereas some will take several months or even years. In some instances it will be necessary to essentially maintain satellite services with minimum integration because of the unique demands of each campus.

Clear cut mechanisms for internal communications and program development must be developed to insure that programs and recommendations for change are fully reviewed by the faculty of the Health Sciences Center for the purpose of insuring proper exercise of judgment and responsiveness required for the care and treatment of patients.

Obviously, this is an extensive and complex process that will require considerable study to determine what degree of integration is feasible and in the best interest of the Health Sciences Center. Fiscal separation may continue to contribute to functional separation and competitiveness between campuses and undoubtedly continue to inhibit or mask the advantages of having one integrated university community. The 22 mile access continues to be a significant barrier that many talk about overcoming, but little is apparently done to expedite communications. Activities should begin immediately to examine every possible component to break down the artificial barriers and image of two distinct campuses whose relationships have depended on a partial and expedient integration rather than a total concept that everyone concerned can understand. If the system of faculty governance and faculty participation is acceptable to, and has worked on, the Norman Campus, then there appears to be little reason why it should not be tried at the Health Sciences Center.

In relation to the Hospitals, we see this integration as being less complicated than the Health Sciences Center, and immediately responsible to the administration of the University of Oklahoma. This integration will also help focus the University of Oklahoma resources on the critical issue of how best to govern patient care facilities in academic health centers in the decade ahead. This subject will be discussed in considerably more detail in the section on Long Range Solutions. (This step will require Regents and administrative action.)

5. The consultants have prepared proforma operating budgets for Fiscal Year 1973-74 (See Appendix IV).

    a. One of the proforma budgets in the Appendix IV provides for the full activation of the Everett Tower, maintaining previously planned programs at their present levels for Children's Memorial Hospital and the current operational plan for the original buildings in the University Hospital--a total complement of 478 beds and full scale operation of ambulatory and supporting services. It also provides for bringing the qualifications of personnel who are directly related to patient care up to community standards. It should be noted that this budget attempts to take into consideration all expense and revenue as well as deductions from revenue according to our best judgment but cannot at this time measure the potential impact of Public Law 92-603 (HR1) on the University Hospitals which has a potentially devastating impact on the care and treatment of all the medically indigent adults in Oklahoma. Under these assumptions, the State Legislature would be expected to provide a significant,

if not prohibitive, appropriation, although some of the expense is a one time, catch up allocation to the hospitals. In addition, a contingency fund will be required as a back-up to the above appropriation to assure reasonable and prompt payment for unpredictable exposure under Public Law 92-603 (HR1) unless it is changed prior to July 1, 1973.

This proforma budget is based on treating the Hospital as a separate financial entity under the University of Oklahoma. The escalating factors in the budget over previous years have had to do with:

(1) activation of Everett Tower,

(2) the inefficiencies inherent in running three separate hospitals,

(3) a strict accounting and proper allocation to Children's Memorial Hospital, as stipulated in Public Law 20. "All monies be deposited in the Revolving Funds of the University Hospitals, and shall be used for general operating expenses of the Children's Memorial Hospital for those patients treated in Children's."

This assumption is based on the fact that Senate Bill No. 20 will not be repealed and will be strictly adhered to, according to law. If Senate Bill No. 20 is repealed, the impact on the patient census under age 21 in the Health Sciences Center is impossible to calculate (but undoubtedly would be significant). This would escalate the proforma budget considerably if these patients were to be referred away from the Health Sciences Center to statewide resources with full reimbursement from DISRS.

(4) the increased costs of making personnel standards competitive with areawide hospitals,

(5) anticipated down time as a result of activating Everett and providing essential remodeling with fire protection for the present University Hospitals and Children's.

(6) the inability to raise rates and/or cost above the Phase III six percent (6%) guidelines,

(7) the increase in uncompensated costs as total costs go up as the result of all of the above.

This budget does not deal with any major capital development or expense, which will be discussed separately under Functional Planning but it does include what we consider to be a modest capital budget to keep the present facilities in safe and acceptable operation.

b. The consultants prepared several proforma budgets scaling down the present operations of the University Hospitals to a break-even budget to determine the impact it would have on maintaining an acceptable

environment for service and teaching for the Health Sciences Center. Basic to this approach is the assumption that the University Hospitals will be reimbursed at reasonable cost or bill charges from some appropriate agency or governmental jurisdiction in the State of Oklahoma. This is based on our firm belief and recommendation that the University of Oklahoma Regents can no longer be mandated to provide uncompensated medical care services supported at the expense of students of the health profession and sacrificing the quality of their educational programs due to these unpredictable costs. Also, the Regents cannot be mandated to provide substandard medical care for the people of Oklahoma, in some cases bridging upon malpractice by legislative or administrative edict or historical precedence because of the lack of proper and appropriate reimbursement. Under these assumptions, the University Hospital would not be required to admit and treat any patient, similar to other hospitals in Oklahoma except under emergency conditions, without a guarantee of payment for services rendered after taking into consideration a reasonable percentage for uncollectable accounts and charity discounts.

The only other manner to approach a break-even budget would be to scale the hospital down in an attempt to operate only the Everett Tower as a private referral hospital for surgery, obstetrics and gynecology deferring all other responsibilities to community hospitals throughout the State of Oklahoma and developing appropriate affiliation programs for all in-patient and out-patient-emergency services except those that could be accommodated in the Everett Tower with scaledown supporting services to support only a 214 bed limited general hospital. This exercise proved fruitless both from the standpoint of its ability to function as a viable patient-care facility, as well as economically because of fixed costs that are unavoidable if the hospitals are to remain in business.

The only other obvious approach to a break-even budget for the University of Oklahoma hospitals is to shut down all patient-care services which at this time undoubtedly could effectively close out the Medical School and seriously impede other schools of the health professions from continuing at its present site.

The fundamental issue relating to any cutbacks from the first approach is the question of where and why the University Hospitals would retreat without a continuing and accelerating disintegration of patient-care services that will eventually close the institution by default with predictable and unfortunate crisis in regard to the care and treatment of patients and training of students.

Therefore, we see only three viable alternatives to the future of the University Hospitals:

(1) An immediate recognition of the problem, and action regarding the compensation for the medically indigent and the completion of a full-service hospital, or

(2) A plan of action that recognizes and provides for a new governance, financial structure and physical facilities under a new corporate structure that can be achieved in a reasonable period of time and presented to the 1974 Legislature (under this approach we believe it might be possible to hold at least a core of personnel and medical staff in place based on evidence and commitments that there is a viable solution coming), or

(3) Phase the hospital out of business with appropriate alternative affiliation plans without total destruction of the schools of the health professions and the huge investment the State of Oklahoma has in the Health Sciences Center at this time and the significant stake it has in its future if Oklahoma is to have health manpower for the generations ahead.

(See III, Solutions - Long-Term regarding governance, financing and functional planning for the University of Oklahoma Hospitals.)

6. We recommend the transfer of ownership and control of Children's Memorial Hospital to the State Welfare Commission, effective 7/1/73. This should be carefully worked out to insure both the Commission and the University that their best interests are protected and maximum utilization of the facilities is achieved. The specific details for such a transfer require careful negotiation by both parties, but fundamental to any such agreement would be the following if the interests of both the University of Oklahoma and the Welfare Commission are to be maximized:

a. That the legislature provide a means to attain the capital funds to replace the present physical plant of Children's Memorial Hospital.

b. That functional planning efforts are such that every effort is made to avoid any duplication of resources to provide the people of Oklahoma with highest quality of health care achievable within the University of Oklahoma Health Sciences Center at the lowest possible cost. This includes sharing diagnostic, treatment and support facilities wherever feasible under purchased service agreements and sharing construction costs wherever future sharing can achieve quality care and teaching at the lowest cost.

c. That the Legislature create a Board of Directors for the Children's Memorial Hospital consisting of appropriate state officials, University of Oklahoma Regents, and appropriate officials of the University of Oklahoma (deans and administrative officers) for the purpose of formulating a policy for hospital operations, buffering the DISRS from inappropriate or unjustified demands and/or criticism, and relating the hospital to the community in such a manner as to alleviate a "welfare hospital image" in contrast to a Children's Hospital for "all children of the State of Oklahoma and the surrounding region".

d. That the management and provision of professional services is contracted for through the University of Oklahoma College of Medicine

and other appropriate schools of the health professions.

e. That management arrangements effect maximum coordination and unification between the overall direction of the University Hospitals and Children's Memorial Hospital.

f. That every reasonable effort is made to reduce conflict between the Hospital as operated by DISRS and the College of Medicine and Schools of Health Professions in regard to jurisdiction over the care and treatment of adolescent and young adult age groups, to insure that they are assigned to the most appropriate facility available, based on what is best for the patient.

Arrangements that do not at least insure the above would undoubtedly in the long run prove unfortunate to everyone involved. On the other hand, we are confident that the above recommendation has every possibility of providing the State of Oklahoma with the finest health care services for children in this region of the United States. We would hope that appropriate legislation could be enacted during this legislative session to insure that the above arrangements can be accomplished at the earliest possible date.

On this assumption, the break-even budget for the fiscal year 1973-74 (Appendix IV) is presented with the Children's Hospital broken out. However, it includes appropriate reflection of contractual agreements with the University and other institutions for necessary services within the Center. Either Children's Memorial Hospital will have to purchase these services from some other components of the Health Sciences Center or the Health Sciences Center will have to purchase them from Children's Memorial Hospital until such time as a new facility could be constructed.

The reasons for this recommendation are directly related to

(1) Maintaining the unique productive partnership "between DISRS, the College of Medicine and Department of Pediatrics,

(2) Maintaining a comprehensive health program for children in the State of Oklahoma that would otherwise be fragmented unless it is possible to maintain a "critical mass" of patients in one outstanding facility,

(3) Providing the most dependable source of funding for patient care to the University of Oklahoma Health Sciences Center. (We are confident that, regardless of what happens to medical assistance funding on a national basis, support for Children's services will be forthcoming in Oklahoma.),

(4) A new Children's Hospital would have the best possibility of gaining approval via general obligation bonds if this method is used to replace the hospital..

Of all the major problems facing the University Hospitals, the replacement and funding of Children's Memorial Hospitals by these actions appear to be the most achievable goal in the immediate future. (This step requires University Regents, State Regents, and Legislative action.)

7. It is assumed that, under a full-scale operating budget based on appropriations presented in Appendix IV, there would be no need for a separate educational subsidy. The extra cost normally associated with teaching hospitals has been provided for in this estimate, and the supply of teaching patients would be at least at the level of the previous year.

   If a breakeven operation were to be developed based on full reimbursement for reasonable costs, it would be necessary to isolate the additional costs associated with teaching programs, and there would have to be a special appropriation for the University of Oklahoma medical school budget to provide for patients who would be admitted specifically for the purpose of teaching and research. This would be allocated on a line item basis to the appropriate departments of the University of Oklahoma. It is assumed these monies would be appropriated within the constraints and resources of the funds available to the University of Oklahoma for fiscal 1973-1974 to carry on an adequate level of teaching and research during a period of transition from a "state hospital to care for the medically indigent of Oklahoma" to that of a more appropriate "Regional Tertiary Specialized Referral Center." This change would be consistent with the role and programs discussed later for a modern, responsive campus teaching hospital to meet the demands of Oklahoma in the present and future decades.

8. Financial assistance for current and future Capital Development Programs will be deferred and taken up under "Long Range Solutions".

   Originally, it appeared feasible to ask for interim capital financing for those programs that require immediate resolution. It is now apparent that, in all probability, there will not be any capital funds allocated or expended for the Health Sciences Center until a "Total Plan" for financing the physical development is agreed upon by the Legislature, State Regents, University Regents, and key administrative officers representing all of these bodies during this Legislative session.

   It is also apparent to the consultants that no additional capital funds will be made available until interim operating budgets are resolved and the 1973-74 budget is approved. The reason for this is as follows:

   Unless there are sufficient operating funds to appropriately manage present and future commitments, it would be irresponsible to appropriate capital funds until the operation of facilities is realistically funded. An example of this is that it would be impossible to recruit a sufficient number of individuals to activate the Everett Tower until such time as personnel policies are upgraded and sufficient lead time is allowed to recruit and train upwards of 240 personnel in order to open the Everett Tower. Until this is accomplished, it would appear unrealistic to initiate the purchase of any equipment and have it stand idle until a realistic budget is adopted to operate the facility at an appropriate level to insure a reasonable chance of success.

In summary, "a realistic financial structure" is being requested for the maintenance of an effective level of essential health care service, if sound judgments are made for the future role and scope of the University Hospitals as related to role, program, and capital development. Without this kind of assurance, it would only complicate matters to enlarge the existing problems while simultaneously trying to resolve long-range commitments and their appropriate financing, before the immediate problems of day-to-day operation are resolved.

We are fully cognizant of the frustrations and distress that these recommendations will cause to the many dedicated individuals who have been waiting for over a decade to improve their resources and ability to provide a high quality of patient care. On the other hand, we believe that everyone involved has learned a bitter lesson about expedient and short-sighted planning that led to the impasse we have reached today. We trust that the sobering threat of operating and capital bankruptcy that faces the University of Oklahoma Health Sciences Center will impress on everyone that there are no easy solutions to these intricate problems and subtle and often misunderstood cause and effect relationships.

March 17, 1973

UNIVERSITY OF OKLAHOMA HOSPITALS
COMPARATIVE STATEMENT OF INCOME AND EXPENSE
For Budget Year Ending June 30, 1974

	Actual For Fiscal Year Ended 6/30/72		Projected * For Fiscal Year Ended 6/30/73		Budget For Fiscal Year Ended 6/30/74	
	Amount	P/P/D	Amount	P/P/D	Amount	P/P/D
Revenue from Services to Patients						
Routine Inpatient	$ 5,594,020	52.91	$ 5,499,056	53.91	$ 7,930,032	63.7
Ancillary Inpatient	5,785,503	54.72	5,858,617	57.43	7,205,855	57.4
Outpatient	3,090,543	29.22	3,086,090	30.25	3,086,090	24.6
Total	14,470,066	136.85	14,443,763	141.59	18,221,977	145.2
Deductions from Revenue	4,929,814	46.62	5,418,616	53.12	6,075,906	48.4
Net Revenue	9,540,252	90.23	9,025,147	88.47	12,146,071	96.8
Other Revenue	23,153	.22	25,000	.25	25,000	.2
Total Revenue	9,563,405	90.45	9,050,147	88.72	12,171,071	97.0
Allocated Expense	13,233,342	125.15	13,599,445	133.31	21,496,602	171.4
Net (Loss)	$ (3,669,937)	(34.70)	$ (4,549,298)	(44.59)	$ (9,325,531)	(74.3)
Adult Patient Days		105,737		102,010		125,418

*Without Everett Tower and with increased room rates effective 3/1/73.

12075

UNIVERSITY OF OKLAHOMA HOSPITALS
SCHEDULE OF ALLOWANCES AND UNCOLLECTIBLE ACCOUNTS
FOR BUDGET YEAR ENDING JUNE 30, 1974

Allowances

Medicare		
Discount	$ 90,702	
Rate Loss	176,050	
Blue Cross - Rate Loss	52,338	
Employee Discount	63,874	
OB Package Plan	292,966	
Institutional	88,179	
CRC Discount	19,106	
Contractual Adjustments	37,624	
DPW Discount (10 day extentions)	1,676,422	
DPW Charity (10 day extentions denied)	740,665	
Charity	1,562,442	
Total Allowances	$ 4,800,368	$4,800,368

Uncollectible Accounts

Gross Revenue 1973-1974	$18,221,977	
Rate	7%	
	1,275,538	1,275,538
Total Allowances and Uncollectible Accounts		$6,075,906

(See 10.1 - 10.4 for discussion and explanation of Deductions from Revenue.)

UNIVERSITY OF OKLAHOMA HOSPITALS
SUMMARY OF ALLOCATIONS OF HEALTH SCIENCE DEPARTMENTS THAT PROVIDE SERVICES FOR THE UNIVERSITY HOSPITALS

(ACTUAL AMOUNTS FISCAL YEAR 1971-72)

Office - Vice-President	$ 55,062
Administrative Affairs	20,032
Controller	90,430
Materials Management	45,376
Cost and Audit Section	19,108
State Regents for Higher Education	10,569
University Administration	2,928
Life Insurance Clearing	1,240
Public Relations	12,691
Central Mail Service	10,096
Institutional Publications	4,099
University Council	3,369
Learning Resource Center	19,000
Retirement Supplement	7,782
Administrative and General Equipment Replace	338
Administrative and General Repair	2,942
Telephone Service	50,822
Personnel	108,172
Health Service	46,261
Security-Fire-Safety	104,688
Utilities	223,585
Management of Grounds	1
Bond Monies	16
Physical Plant Administration	32,300
Campus Architect	37,614
Medical Center Operations	85,468
Maintenance of Physical Facilities	358,560
Repair and Replacements	12,643
Architect Fees - Basic Science	310
Equipment Moveable - Basic Science	7,764
Housekeeping - Academic	109,072
Laboratory Medicine	684
Psychiatry	7,661
TOTAL	$1,490,683(1)

3/7/73

(1) Depending on a cost analysis study presently underway, this figure may be reduced approximately $630,000 in 1973-74

UNIVERSITY OF OKLAHOMA HOSPITALS
BUDGETED INCREASES OVER 72-73
PROJECTED EXPENSES

Projected Expenses for 1972-73	$13,599,445
INCREASES:	
Salaries	
Increases in salaries that are competitive with other hospitals in Oklahoma City (approximately 5%), plus a general 5% increase because of a 1 year freeze	1,035,208
New positions for Main Hospital to provide the quality of service desired by departmental analysis	1,704,921
New positions required to activate Everett Tower (244.2 FTE's)	1,320,000
I Fringe Benefits	
Increases in payroll taxes	295,716
Workmen's Compensation	56,670
Parking expense (equitable with other employees)	63,484
Group health and life insurance (competitive with other hospitals)	551,400
II Other Operating Expenses	
Volume increases of non-salaried expenses due to increase in patient days (Everett Tower impact)	795,940
Debt Service for Steam and Chilled Water Plant	503,208(1)
Increases in utilities and maintenance (Everett Tower a major portion)	438,452
Building maintenance and preventive maintenance Program (no renovation included)	771,700
Increases in Inventory for Everett Tower	29,100
Depreciation	331,358
TOTAL INCREASES	$7,897,157
TOTAL EXPENSE BUDGET for 478 beds including Childrens Hospital and Everett Tower	$21,496,602

(1) Debt service commenced 5-1-72. The amount is for total Health Science Center - a major portion will be for the Hospital. Amount unknown at this time until step down cost allocation is completed. 433,212 interest. 69,996 principal.

UNIVERSITY OF OKLAHOMA HOSPITALS
RENOVATION AND EQUIPMENT BUDGET
FISCAL YEAR 1973-74

RENOVATION

Est. 1. Remodeling to convert Rogers Building into an ambulatory care center	$800,000
Est. 2. Renovation to utilize original University Hospital Buildings (Old Main) while being replaced	$2 to 2.5 million
Est. 3. Renovation to bring CMH up to interim standard while being replaced	$880,000
Est. 4. Renovation to conform with fire standards and code deficiencies	$1.6 to 2,000,000
TOTAL RENOVATION	$5,280,000 to $6,180,000

continued on next page

I. EQUIPMENT

Department	AMOUNT
Social Work	$ 600.00
Medical Records	1,310.00
Administration	7,448.16
CMH Admitting	500.00
Pediatric Nursing	700.00
Physical Therapy	9,040.00
Respiratory Therapy	15,765.10
Management Services	1,903.13
Ped. - Hematology-Oncology Service	9,000.00
CMH Surgery	633.00
Pediatric-Urology	5,478.00
E.K.G.	26,733.00
Pediatrics	24,156.50
Housekeeping Services - Hospitals	7,874.00
Pulmonary Service	46,500.00
Medicine, Psychiatry and Emerg. Rm.	12,360.00
Pediatric Surgery	1,000.00
Gyn/OB Clinic	1,200.00
Surgery Clinic	2,045.00
Unit Management	2,875.00
Hospital Systems	1,225.00
Oral Surgery	10,100.00
Pharmacy	10,945.00
Phys. Ther.	1,395.00
X-ray	1,277,900.00
Cardiac Cath.	19,000.00
X-ray Ther.	31,000.00
Commun. Health	1,800.00
Labs - Blood Bank	8,760.90
Chemistry	25,147.00
Hematology - Urinalysis	11,750.00
Microbiology	350.00
Labs - Additional Eq.	175,000.00
Dietary	16,830.00
TOTAL EQUIPMENT	$1,768,323.79(1)

) This figure is unusually high because of deferred equipment purchases over past several years. This situation cannot continue. (normally 3.4% of expense budget)

March 17, 1973

UNIVERSITY OF OKLAHOMA HOSPITALS
COMPARATIVE STATEMENTS OF REVENUE AND EXPENSE
FISCAL YEAR ENDING JUNE 30, 1974

	"BUDGET" Inc. 478 beds (Old Main-E.T.-CMH)	CHILDREN'S HOSPITAL (Stand Alone)	EVERETT HOSPITAL (Stand Alone)
STATISTICS			
Average Beds open for service	478	106	214
Patient Days of Care	125,418	24,790	54,677
Percent Occupancy	71.9%	64.1%	70.0%
REVENUE AND EXPENSE			
Gross Revenue from Patients:			
Routine	7,930,000	1,567,000	3,457,000
Ancillary	7,206,000	1,202,000	3,142,000
Outpatient	3,086,000	520,000	1,045,000
	18,822,000	3,289,000	7,644,000
Less Allowance for:			
Doubtfull Accounts	1,276,000	230,000	535,000
Indigent Care	4,800,000	359,000	-0-
	6,076,000	589,000	535,000
	12,146,000	2,700,000	7,109,000
Other Revenue	25,000	4,000	8,000
	12,171,000	2,704,000	7,117,000
Allocated Expenses	21,497,000	5,230,000	10,504,000
Net Income or (Loss)	(9,326,000)(1)	(2,526,000)(1)	(3,387,000)(1)
Add Subsidy	(9,326,000)	(2,526,000)	(3,387,000)
Net	-0-	-0-	-0-
Revenue Per Patient Day	120.68	111.70	120.68
Cost Per Patient Day (IN-PATIENT ONLY)	146.80	190.00	173.00

(1) Assumes no rate increases will be approved over guidelines of 6%

12081

PATIENT ACCOUNTING SYSTEM

University Hospitals operate on a system of detailed charges for services rendered to patients, and ch test, service, or other item furnished to a patient is charged to the patient's account at standard es. Each department of the Hospital which furnishes patient service is covered by one or another section a master price list, wherein each service is described and its standard price specified.

Charges for daily Hospital service (room charges) are made automatically as a part of the computer nsus procedures each night. All other charges are recorded from charge documents originating at rsing stations and completed by the service department. These charge documents are transmitted regu- ly via the Billing Office to the Data Processing Department for posting to patients' accounts and for venue accounting.

PATIENT REVENUE ACCOUNTING

Individual charges for service provided by Hospital departments for patients are posted daily and nmarized in monthly reports. Revenue of each department is analyzed according to the type of service vided, the type of patient for whom it was provided, and the type of payment or fiscal arrangement ich was established for the patient. All of the revenue analyses begin with tabulations at the ablished rates for the service, even though the actual payment may be reduced by special arrangement according to contractual agreements. In this way, productivity or output of any particular department n be viewed without the distortions which might arise from sudden or short term changes in these ancial arrangements.

DEDUCTIONS FROM REVENUE

The patient account which is established at admission or registration builds by the accumulation charges for services rendered during active treatment. The total at the time of discharge or comple- n of treatment is then the sum of gross patient revenue earned as a result of providing service for t patient and if all patients paid cash in full, it would equal the total cash receipts. Today, few tients pay cash, and fewer still pay in full; many deductions in revenue are recognized.

The largest group of such deductions, in dollar volume and in frequency, is known as contractual allowances. This class of entry makes up the difference between the total of established charges on a patient's account and the payment by some third party at a negotiated rate. In theory a negotiated per diem rate could exceed the sum of charges to a patient's account as often as the reverse, but in practice these rates are negotiated to apply during extended periods and are revised less frequently than the prices; also, some elements of cost presumably considered when setting the prices are excluded when negotiating the per diem rates. The following are specific examples of contractual allowances now in active use:

SERVICE CODE	BILLING DESCRIPTION
0002199	Medicare Discount: Reduction of the total billed charges to an amount equal to the approved Medicare coverage.
0002299	DPW Discount: The reduction of the first 10 days total charges to an amount equal to 10 times the per diem rate authorized by DISRS.
0002399	OB Package Plan: Reduction of the total charges to an amount assessed to the patient in advance of admission.
0003899	CRC Discount: Reduction of total charges to the amount covered by the Clinical Research Center per diem rate.

Another group of revenue deductions are known as discounts, reductions or some waiver of a portion of original charges for a specific group of individuals. Historically the earliest type of revenue deduction, discounts are more commonly offered to the Hospitals' own employees or other recognizable affiliates. In this particular case the reduction in revenue may be considered a form of fringe benefit, and could be chargeable as such through proper accounting procedures. The term "discount" is often generally applied to any deduction from revenue, even though it is proper only in the situation described here. The only discount transaction currently in use is:

SERVICE CODE	BILLING DESCRIPTION
0001999	Emp/Med Staff Disc: Is up to 20% of total inpatient charges, or up to 50% of total outpatient charges may be credited with this transaction; if insurance pays more than 80% of an inpatient account the discount is applied to the balance.

The last group of revenue deductions are the account adjustments. It is sometimes necessary to credit an account that is in dispute, when the dispute is well founded but a true correction cannot be determined. For example, an erroneous posting to a patient's account for a service which the patient did not receive and which was not ordered by the physician in the medical record; unless the original charge document which was posted in error can be found, an adjustment of the account must be made to correct the error without hope of determining the true liability. Adjustments on accounts may also be necessary to correct an original misclassification of the patient's financial abilities. A large volume of adjustments of this type have resulted from the rejections by DISRS of applications to extend coverage beyond 10 days; the indigent patient has been cared for, charges have accumulated and are determined after the fact to be uncollectible. While the below transactions are titled "Charity", it is not an accurate description of all the cases in which the transaction occurs; there is a hazard that this classification may be used incorrectly in cases which more properly would be considered uncollectible. Two Charity transactions now in use are as follows:

SERVICE CODE	BILLING DESCRIPTION
0002099	Charity DPW: The patient charges for stay in excess of 10 days without an approved extension of benefits.
0003499	Charity: Reduction of an account to allow for settlement, particularly for indigent patients not eligible for DISRS benefits.

March 17, 1973 12086

THE UNIVERSITY OF OKLAHOMA
MEDICAL CENTER
800 NORTHEAST THIRTEENTH STREET
OKLAHOMA CITY, OKLAHOMA 73104

March 6, 1973

MEMORANDUM

TO: DR. JEP DALSTON

FROM: WILLIAM E. NIX

SUBJECT: DETAIL BUDGET FOR PATIENT CARE, FISCAL YEAR 1973-74

After Fridays meeting of March 9, we plan to immediately take the basic budget as estimated for this meeting and begin refinement on a detailed basis. Herman Smith Associates working with Health Science Center and hospital staff must do the following:

1. Classify each position in the hospital by patient care, research and teaching categories.

2. Detail proper salary classifications for each position.

3. Evaluate proper staffing ratios for each department.

4. Analyze charges for services from the Health Science Center to the hospital and budget realistic amount in hospital accounts for payment of these services on a monthly accrual basis. Also, analyze charges to the Health Science Center by the hospital.

5. Review all department programs and budget for additions or deletions.

6. Develop an equipment budget.

7. Develop a capital program budget including renovation of patient care areas.

8. Carefully ascertain patient volumn for inpatients, emergency patients and clinic patients.

9. Retain an appraisal firm for the extension of lives of major movable equipment in order to increase reimbursement.

arch 17, 1973

12087

. Jep Dalston
irch 6, 1973

10. Detail non-salaried items by department.

11. Segregate costs using stepdown cost allocation methods to include both direct and indirect costs by the following categories:

(a) Inpatients, outpatients, emergency room.
(b) Hospital departments, nursing stations and individual clinic.
(c) Main hospital costs, Everett Tower costs and Children's costs.

12. Establish reporting formats using the FMS system as a prototype.

13. Use budget data for testing and familiarizing staff with the FMS system and begin using actual date begir ning July 1st.

14. Prepare a budget cash flow statement for 1973-74.

15. Define source of payments for 1973-74 budget, by patient category, including indigent care.

EN/ba

: Mr. Gerald Prillman
Mr. Gerald Gillman
Mr. Don Wilburn
Mr. Jack Dumas

President Sharp said the Task Force which was appointed representing the Regents and the administration of the University (Regents Huffman, Braly, and Mitchell, President Sharp, and Vice Presidents Eliel, Dean, and Nordby) recommends to the Board of Regents adoption of the Immediate Solutions proposed in the Herman Smith Associates Interim Report (shown on pages 12065 to 12074 of these minutes). In addition, the Task Force recommends the adoption of Appendix IV (shown on pages 12075 to 12087 of these minutes), with the one reservation that we will give further study to the items in Appendix IV concerning expenditures for capital improvements and capital equipment.

Regent Braly moved approval of the recommendations. All members voted AYE.

The following is an explanation of the actions of the Board:

1. A supplemental appropriation of $777,626 will be required to maintain operation of the Health Sciences Center and the University Hospitals at their present level of operation for the remainder of the fiscal year 1972-73. The amount of appropriation required is to be forwarded to the Governor of Oklahoma, the Speaker of the House of Representatives, the President Pro Tempore of the Senate, the Senate Committee for Investigation and Study of the Health Care Facilities in Oklahoma, and the Oklahoma State Regents for Higher Education.

2. An additional sum of $955,100, over a four month period of time, will be required to equip and prepare Everett Tower for operation. While the Regents wish to see the new facility opened as soon as possible, the activation of the Tower under the present circumstances would increase the operating deficit of University Hospitals and within present budget limitations increase the problem of providing sufficient operating funds. The request for these funds will be, therefore, contingent upon a final decision concerning the amount of state appropriations and the operating budget available for the coming fiscal year.

(NOTE: If sufficient operating funds are made available for fiscal year 1973-74, the operating budget for University Hospitals will be adjusted to eliminate duplication of utility expenses ($120,000) which were included in the requested supplemental appropriation planned for implementation March 1. The inclusion of funds for training and moving ($61,000), salaries for get-ready personnel ($140,000), and base stock inventory ($29,100) are necessary to include at any effective date of the opening of Everett Tower. The remaining $605,000 required to activate Everett Tower represents a capital expenditure and the purchase of equipment which must be obtained from revenue-sharing funds or HERO bond funds.

(Since the pro forma operating budgets on page six of Appendix IV to the consultants' Interim Report are based on a full 12 month operation, they will also have to be adjusted to reflect only the period of time in which the Tower will be functioning according to the preceding paragraph.)

3. The action of the Regents creating the position of Executive Vice President for the Health Sciences Center and actions supporting or relating to this action are hereby rescinded and the position is redesignated as "Vice President for Health Sciences". This officer of the University shall be responsible for all academic programs and academic personnel at the Health Sciences Center. In addition, other specific administrative functions, such as administration and finance, University Relations and others, are assigned to the appropriate Vice President of the University.

4. The University Hospitals are to be separated organizationally, functionally and fiscally from the academic programs at the Health Sciences Center and the administration of the hospital is to be directly accountable to the Regents of the University through the President, similar to other colleges and major elements of the University.

5. The Regents will request that the Legislature and the State Regents take the necessary action to establish within the University separate budgeting and allocations for the University Hospitals and the Health Sciences Center.

6. The Regents request immediate action be sought, including enabling legislation, through appropriate channels to allow the State Welfare Commission to assume ownership, control and operation of Children's Memorial Hospital subject to the guidelines listed on pages 16 and 17 of the Interim Report (pages 12071-72 of these minutes).

7. An increase of $9.3 million will be requested for operation of the University Hospitals for fiscal year 1973-74. This figure includes $5.5 million for operating costs, including those associated with educational costs which are inherent in a teaching hospital, and $4.8 million for indigent care. If Children's Memorial Hospital is transferred to the State Welfare Commission, the request can be lowered to $6.8 million, including $4.4 million for indigent care.

These actions by the Regents are aimed specifically at insuring continued operations of the Health Sciences Center and University Hospitals for fiscal year 1973-74, and do not address the long-range recommended solutions included in Section III of the Herman Smith report.

The Regents directed the special Task Force on the Health Sciences Center to continue reviewing the long-range solutions and to be prepared to make recommendations on them within the next few months.

Regent Huffman asked Dr. Eliel if he would like to make any comments. Dr. Eliel said the immediate solutions just adopted represent very profound changes in the organization of the Center, its relationships, and the manner of operation of its Hospitals. He thinks the Task Force and the Regents have taken a very bold step but are providing the only solutions we see with the many problems we have in the Center. Dr. Eliel said the faculty and staff in the Center will address themselves to these solutions and he hopes that outside of the Center there will be an equally vigorous response to our recommendations.

Proposed Long-Range Solutions, on which the Regents took no action, were also included in the Interim Report, as shown on the following pages.

There being no further business the meeting adjourned at 2:20 p.m.

Barbara H. James
Secretary of the Board of Regents

Others present at all or part of the meeting:

Mr. Gerald H. Gillman, Associate Vice President for Health Sciences Center Administrative Affairs
Mr. Jack Cochran, Director of Public Relations
Mr. Steve Trollinger, The Daily Oklahoman
Ms. Kay Martin, United Press International
Ms. Mary Davis, The Tulsa World
Mr. J. D. Van Sickle, KOMA
Mr. Wally Zubriski, KOCO-TV
Mr. Paul Webber, KOCO-TV
Ms. Jo Myers, KGOU
Ms. Teresa Black, Mr.Dick Nelson, Mr. Steve Newman, WKY-TV
Mr. John Shur, The Norman Transcript, Associated Press
Mr. Dave McMillan, Mr. Roy Charles KWTV
Ms. Nancy Nunnelly, KTOK

PROPOSED SOLUTIONS - LONG RANGE

A. Governance

Having discussed the immediate courses of action regarding progress, stability, finance, management, and governance, we wish briefly to outline those matters we believe essential to the solution of long range problems.

Before presenting our thoughts on the long range solution to the governance, planning, and administrative structure of the University of Oklahoma Hospitals, it should be made clear that our interim solutions discussed above are dependent upon an equally strong decision-making administrative stucture that is believeable not only in the University but at all levels of State Government in the immediate future.

Because the issue of governance of the University of Oklahoma ranks among the highest priorities in the State of Oklahoma, it is our recommendation that the University of Oklahoma Board of Regents should place as its highest priority the task of preparing recommendations for the 1974 legislative session concerning the manner in which the governance of the University of Oklahoma can better communicate and relate to the agencies and legislative bodies of State Government. The Board's specific charge, as set forth by its governing authorities, should be sufficiently clear regarding the method and criteria whereby the Regents shall be held accountable for the "operations and management" of the total University of Oklahoma. We believe that, unless this is given immediate priority, initiative will be assumed by others with questionable results. As is implicit throughout this report, the governance and administrative structure of the University of Oklahoma, as it relates to who is in charge and the decision-making process, continues to be at issue.

If the sensitive and complex issues of hospital governance can be addressed separately and resolved, the long-term problem of governance of the University of Oklahoma may be considerably less complicated and controversial. In many ways, however, the missions of the two projects are inseparable and should remain the focus of the attention of the Board of Regents until they are resolved; or we predict with near certainty that the problems discussed in this report will recur with increasing intensity.

B. Programming

Regardless of what form the governance of the Health Sciences Center takes, and because of the serious under-financing, compounded by the major cutbacks in federal funds, program planning is fundamental to examination and reordering the former goals and objectives as they relate to:

- --the determination of needs of those responsible for the Health Sciences Center performance
- --a realistic recognition of the availability of resources, both public and private

--the setting of priorities and difficult, but inevitable, hard-headed choices inherent in the process of merger, reduction or, as expressed by the Regents Task Force with which the firm has been working, "elimination of programs and possibly colleges".

--the establishment of a plan of action providing the Board of Regents the best and most considered advice available on alternative courses of action, should program reduction become inevitable.

It is very apparent that the method by which the University of Oklahoma is reorganized on a functional basis will materially affect the manner in which this reprogramming will take place.

In a separately submitted Appendix II, four tables are presented relating to the impact of reducing Federal training grants and contracts which amount to approximately $1,202,000.00 through June 30, 1973, by an additional $805,000 on June 30, 1974. It is apparent from these preliminary figures that the domino effect that these cut backs will have on the entire Health Sciences Center demand the attention of the best talent available in and to the University of Oklahoma to minimize what is inevitably going to be a continual crisis over the next several years as it realtes to those schools not funded by capitation grants. There is an additional $300,000 of state grants that may be eliminated.

It would appear that the University's inability to fund the cost of medical care for the medically indigent in Oklahoma within academic appropriations is no longer even a matter of debate. If these funds are not redirected toward academic programs, there will be no one to care for the patients regardless of who underwrites the cost of the medically indigent.

C. Long Term Financing for Adult Care

1. It is apparent from earlier discussions that the State is faced with a substantial and escalating financial subsidy to the University Hospitals if it is to continue at least at its present operating level. This obviously is an unsatisfactory long-range solution, and therefore, we present the following alternatives which appear to be basic to any long-range solution of the fiscal solvency of the University of Oklahoma Health Sciences Center.

a) Direct, and properly fund, DISRS to reimburse the University Hospitals at "full cost" for the "Adult Medically Indigent". (To be defined)

b) Change governance from a state operated hospital to a nonprofit community corporation, or a separate state agency with its own board, in order to respond, compete, and address itself to the health care demands of the '70's and repeal the present legislation concerning the University of Oklahoma Medical Center in Sections 3306 and 3307 of Oklahoma Statutes in 1971, Title 70. If this proved feasible and successful, the Children's Memorial Hospital and other components of the Health Sciences Center could be placed under the control of the new corporation or agency, including:

1) Family Medicine Clinic
2) Child Study Center
3) Speech and Hearing Clinic
4) Dermatology Clinic
5) Youth Counseling and Child Development Center

This would place the responsibility directly upon the counties to care for the medically indigent who are not eligible for federal and state programs of medical assistance. It would also mean returning to the present political trend of local control and self-determination as the most efficient manner to expend resources, especially as it relates to welfare.

c) Revise the "Medical Assistance" legislation for the State of Oklahoma, placing the total responsibility for the medically indigent on the Department of Institutional, Social and Rehabilitative Services (similar to the Medical Program in California). This would provide complete free choice of vendor and one "level" of service for all citizens.

d) Transfer the University of Oklahoma patient care responsibilities to other clinical facilities by expanding the present affiliation agreements (see below).

e) Transfer entire clinical years of the College of Medicine to Tulsa but do not attempt two schools until one can be financed. (This would make the University of Oklahoma a two year school with the last two clinical years of training transferred to Tulsa.)

UNDER A, B, AND C ABOVE:

2. There must be a permanent separation of "educational costs" from uncompensated medical care that will forever preclude mingling of educational funds with the unpredictable and uncontrollable costs incurred in providing care to the medically indigent.

3. There must be an installation of a "financial management system" with a continual updating, capable of setting rates based on cost and rendering an identifiable bill for full costs for every patient served with reasonable expectation that the bill will be paid.

4. There must be a full scale financial feasibility study conducted on absolute identifiable operating and capital support after reprogramming of both academic and service programs are accomplished.

D. Facility Programming and Planning

Until the following alternatives are carefully studied and a major decision is reached, a Moratorium should be placed on all further development of University of Oklahoma health facilities at any stage of development except the Dental Clinical Science Building, the Bio-Medical Science Building, and the addition to the Basic Sciences Educational Building. The considerations during the Moratorium are as follows:

1. "Affiliation Agreements"

The consultants examined the University's present affiliation agreements and our assessment of the most efficient and realistic approach to maximum use of these community resources. At this time our appraisal of this important matter is that a campus-based University teaching hospital is an essential component of the set of clinical teaching resources at most state operated academic health centers.

The most noteable exception to this pattern is a number of distinguished private medical schools primarily in the East who use affiliated hospitals exclusively. However, these hospitals and communities grew up with these relationships and acceptance of University control as a "condition to medical staff membership"--an essential ingredient to a successful partnership. Some new medical schools are being planned on this model, which is considerably easier to accomplish if everyone involved from the outset (particularly the faculty) is recruited with full understanding and support of this concept.

It is recognized that the nature, role, location, and scope of the University teaching hospitals may vary significantly from campus to campus with many different factors influencing such determination. As a general guideline, universities are beginning to be more dependent on off-campus clinical teaching resources than in the past. Each school, both new and old, will develop over time in an unique set and mix of clinical teaching resources reflecting its curriculum and the particular circumstances of its own community. It will however maintain the goal of maximizing the use of community resources while at the same time providing enough of its own campus-based clinical facilities to maintain the necessary educational critical mass.

First, we believe the subject of affiliations is highly misunderstood, oversimplified and often misrepresented. We believe there are essential elements that have to be considered if affiliation agreements are a realistic solution to the training of undergraduate and graduate medical students. If the University of Oklahoma is to meet its responsibilities for maintaining and controlling a quality and level of education expected by department or colleges of the University we believe the essential ingredients in an affiliation agreement are as follows: (Hospitals involved must demonstrate the following)

1. Quality of hospital, including appropriate accreditation, approvals and membership, and organizations committed to education for the health professions.

2. Appropriate facilities, personnel, support services geared 24 hours a day to teaching and patient care.

3. A critical mass and variety of patients with appropriate medical problems to justify the establishment and expense of a major educational effort off campus.

4. The acceptance by the hospital of a substantial degree of <u>control</u> as it relates to the hospital environment, medical staff, patient management, and administrative policies.

5. The acceptance of dual responsibility and authority of appointments of both chiefs, faculty, and house staff and the university's complete control of the assignment of students and house staff without arbitrary restrictions by the hospital.

6. Significant financial obligations (mutual).

7. Research capabilities, including resources and a record of interest and commitment.

8. Evidence of other successful health educational programs related to the health sciences.

9. The ability of health professions schools to deal with stringent residency restrictions by various approving Boards related to all of the above.

10. University's ability to recruit a sufficient number of residents to make it efficient for both the University and the Hospital to become involved in the above commitments. (There are chronic shortages in key specialties which make it a necessity to hold residencies down to at least one hospital.)

11. Faculty resources and the realistic problems of dispersing the faculty throughout a wide geographical area in multiple hospitals and still maintaining the adequate supervision control necessary.

When one assesses all of these constraints and commitments it is difficult to understand how community resources are always said to be readily available when in fact they are not. Our assessment of Oklahoma indicates that the present affiliations that the University has are appropriate for its present resources. We are assuming that the present affiliated hospitals, and in particular the Veterans Administration, will continue to be major affiliated hospitals throughout the history of the medical school. The present Veterans Administration Hospital affiliation is ideal(if not crucial to the existance of the Health Sciences Center)in terms of the above stated criteria. The trend of integrating Veterans Administration Hospitals with the community will make this affiliation even more valuable to the University in future years.

2. An important question in the minds of those responsible for solutions to the dilemmas of the Health Sciences Center is the role of Presbyterian Medical Center. Although time did not allow more than a superficial review of the Presbyterian development programs, our preliminary conclusions are as follows. The present site upon which the Presbyterian Medical Center is being constructed is too far away to provide efficient physical interrelationships which might materially assist the University of Oklahoma hospitals. It is also apparent, after rather extensive discussions with the faculty of the University of Oklahoma College of Medicine, that to consider Presbyterian a major factor in teaching programs, would require control of departments and other conditions as outlined above in the discussion of affiliations. At the present time it appears that the Presbyterian Medical Center is comfortable with the present affiliation agreements. We would predict that, after an appropriate period of start-up, if the present affiliation agreements prove to be a problem to either institution they will be appropriately modified. Through frequent consultations and cooperative efforts, it may be possible to expand the present affiliation with Presbyterian Medical Center through sharing of programs, services and facilities. However, this route does not provide any

immediate relief or solution to the University of Oklahoma's financial and physical facility dilemma.

3. On the assumption that there will continue to be a University of Oklahoma hospital located at its present site, we visualize and believe its most appropriate role is that of a full-service hospital designed to serve as a tertiary specialized referral center with an appropriate mix of primary care services. The hospital would provice the full spectrum of service needed to maintain a "critical mass" of patients in order to properly carry out the missions of the various schools within the Health Sciences Center. This full-service hospital need not be under one roof and corporate structure, but meaningful functional and physical relationships must exist so it operates as a unit. In previous sections we have already alluded to alternative corporate structures and the fact that it had to be fiscally designed to be fully reimbursed and flexible to deal with the demands of the present health economy.

During the period we have addressed outselves to the future role of the University of Oklahoma, we have uncovered some basic differences in philosophies among key individuals concerning the appropriate patient composition of a university teaching hospital. There appear to be a number of individuals who still believe the welfare-indigent hospital model is still appropriate and possible as a future mode of of operation for the University of Oklahoma Hospitals. This has been somewhat revealing to the consultants as this philosophy is at odds with the philosophies of most academic health centers and the views of those now in key leadership positions. We would remind those involved that the concept of medical indigency changed significantly with social security legislation passed as early as 1952 providing "free choice of vendor". The concept of the medically indigent hospital (and its obvious implications) has been continually eroded for the past 25 years through a variety of social security and related health care legislation, making it a clear mandate of public policy that there should be one level (Mainstream) of health care provided locally for all citizens. The logical conclusion to 25 years of changing values will inevitably lead to national health care insurance replacing the myriad of medical care assistance programs and funding mechanisms that have become untenable to administer and finance. For Oklahoma to build the University Hospitals on a model of the past generation, in our opinion, is neither realistic nor possible, regardless of one's values or philosophies on this subject. The "Mainstream" concept has taken longer to arrive in this region of Oklahoma than elsewhere in the state and many places in the nation except in highly urban areas with problems that cannot be absorbed in community operated facilities. The laws and financing of health care preclude turning back. Moreover, we are uncertain why anybody would want to turn back.

Because of changing public values these are stormy, turbulent times for even the financially strong, well-endowed institutions. Never in the history of this country have hospitals been under the pressures that exist today. Regardless of what happens to hospitals over the nex several years, there is little question in our minds that university

teaching hospitals that are an integral part of a health sciences center, such as that at the University of Oklahoma, will survive. If there is to be adequate health manpower, these centers must be supported unless there is a revolutionary change in our value systems relating to health and life. It is our prediction that the present federal funds being cut off (the impact of the University of Oklahome Health Sciences Center is well over $20 million in capital matching grants and an unpredictable millions of dollars in training and contracts) will be back in another form (such as revenue sharing) and under another name once those responsible are satisfied that the "fat" has been trimmed away from 25 years of unprecidented funding in health care. Unfortunately, the inevitable result may be the cutting away of healthy tissue that may never regenerate.

Our advice, therefore, is that the University of Oklahoma Health Sciences Center must not become "unglued" during this critical period and must be allowed to preserve their best investments while discarding the non-essential programs. It is our belief that without patient care facilities there will be no Health Sciences Center, and therefore, it is academic to discuss closure of the hospitals or abdication of fiscal responsibilities to others with less ability to finance the Center than the State of Oklahoma.

The assets of the faculty and students of the caliber of those in the University of Oklahoma Health Sciences Center are virtually irreplacable. The physical resources to provide the appropriate teaching environment for the mission of the Health Sciences Center is salvageable. With the newly constructed Everett Tower ($12 million) ready to be activiated and a strong possibility of a new Children's Memorial Hospital which hopefully will be built under the leadership and operating support of DISRS, the nucleus of outstanding physical facilities are available. We strongly recommend an immediate reprogramming of the Center based on using all of the HERO bonds available and other resources of revenue available to the state to rehabilitate the Center at the earliest possible time. Every relationship should be explored and re-explored relating to sharing and joint services and extending affiliation agreements to keep capital and, most important, operating expenses at their absolute minimum.

We again reiterate, however, that we do not believe any of the above is feasible or advisable under the present governance, organization, role, and financial structure of the hospitals. It is apparent that the University of Oklahoma Regents and Administration have already tightened their belts and are taking a hard look at their resources and options and are anticipating appropriate cooperation and support from the people of Oklahoma and their legislative and executive representation.

FOLLOW-UP MECHANISMS

A. A financial management system will for the first time ever provide the University Regents and all other public bodies with sound fiscal information concerning the controls that have been lacking since the development of the University of Oklahoma

Hospitals.

B. We would recommend that there be a continual audit management system with detailed cost allocation, financial statements, and trending.

C. The present University Regents' Task Force on the Health Sciences Center should be reconstituted to include a representative from the Governor's Office, the Senate, the House, the State Regents and the Department of Institutions, Social and Rehabilitative Services. The new task force should continually monitor the above recommendations through the coming year so that appropriate and acceptable legislation can be prepared for the next legislative session to avoid the crisis and risks involved in this kind of "instant planning" to solve problems that have developed over a decade.