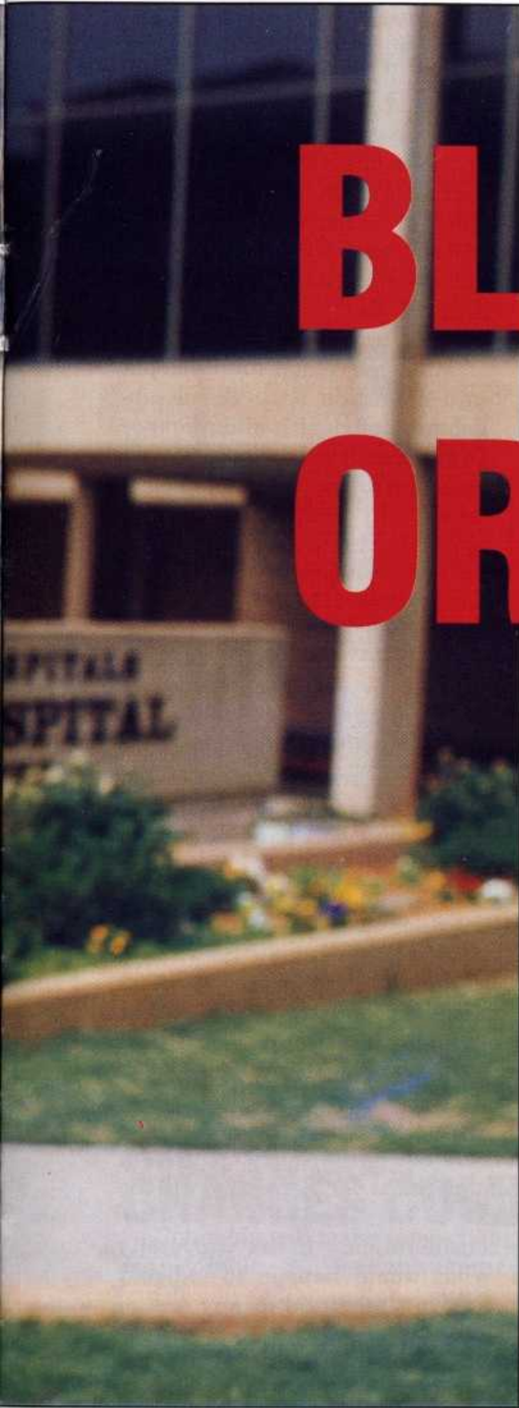
Robert Taylor



As chief negotiator for the merger of University Hospital and Children's Hospital of Oklahoma with Columbia HCA, OU Dean of Medicine Jerry Vannatta views the action as vital to the survival of medical education in the state.

The Rescue of University Hospitals:

BLESSING OR SELLOUT?

The controversial merger with Columbia HCA has a staunch defender in OU's dean of medicine. ■ BY JUDITH WALL

OU Health Sciences Center Public Affairs

In many ways, University Hospital and Children's Hospital of Oklahoma are the most important hospitals in the state of Oklahoma. Consider these facts:

■ Most of the state's physicians have been trained at the two teaching hospitals, which also serve as training sites for students from the OU colleges of Nursing, Pharmacy and Allied Health.

■ Fully one-half of the state's indigent citizens are cared for in the University Hospitals.

■ Half of the revenue of the OU College of Medicine is generated by faculty members who practice in the two hospitals.

■ Physicians from across the state and region often send their most critically ill patients to the hospitals to be cared for by OU faculty physicians.

By the mid-1990s, however, these pivotal institutions were facing an uncertain future. Following the failure of the Clinton national health-care bill, rapid changes in the nation's health-care industry brought an end to the funding structure under which the two state-owned hospitals had operated since the 1970s. As a result, University Hospitals had become an intolerable drain on the state budget.

A plan to save the hospitals put forward by Columbia HCA proved to be quite controversial, however, especially when the news broke last year that the corporation was under investigation for defrauding the government. *Continued*

Several citizen groups were against turning over the management of the state's not-for-profit teaching hospitals to a for-profit corporation that already operated more than 340 hospitals nationwide. Concerns were raised about the fate of indigent patients and the hospitals' teaching mission. Could some other way be found to save the hospitals?

Or perhaps they did not need to be saved. After all, Oklahoma City had twice as many hospital beds as it needed. Why not distribute the faculty and students throughout the city's other hospitals?

After considerable public debate, an agreement was signed in February 1998 that turned over the management of University Hospitals to Columbia HCA, which already owned nearby Presbyterian Hospital. The agreement survived a legal challenge from Common Cause, which claimed the agreement constituted an unconstitutional gift of state assets to a corporation. Yet, the controversy continues. Was the merger really necessary?

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Dr. Jerry Vannatta, dean of the OU College of Medicine, was the University's chief negotiator for the merger. In the months following the signing of the joint operating agreement with Columbia, he has become its chief defender, speaking to any group that will have him.

The Pre-Med Club on the Norman campus recently invited him to discuss the merger. Most of the club's members hope to attend the OU College of Medicine. They knew about the controversy. Was the merger a good or bad thing for the college?

A good thing, Vannatta insists. The merger was needed to save the two teaching hospitals, the OU College of Medicine and the entire OU Health Sciences Center.

He explains to the pre-med students that the hospital merger saga began in 1992—after tremendous national debate—with the failure of the Clinton health-care bill. The U.S. business sector, which pays the nation's bill for health care, played a major role in that debate. The United States could not continue to compete internationally with 14 percent of its gross national product going into health care.

"That meant that 14 percent of the price tag for every automobile and everything else made in the United States went to health care," Vannatta points out. "In Germany, that figure was 8 percent; it was only 7 percent in Japan."

In great part, the American public and Congress agreed with American business that the bill for health care was too high. With the defeat of Clinton's plan, which threatened to further increase that cost, the solution put forward to reduce health-care costs was "managed competition."

"No one knew exactly what managed competition was or how we were going to accomplish it, but it became the rallying cry," Vannatta says. "Everyone was going to compete for health-care dollars, and we were going to manage that competition in some magical way that would make the cost come down."

Managed competition was put into operation with the establishment of Health Maintenance Organizations, a concept that appealed to the Oklahoma Legislature. In 1992, the state was appropriating $1.2 billion of its $8 billion budget for Medicaid, which covers health-care costs for children and pregnant women on welfare. Some states already had put their Medicaid programs into HMOs, and the Oklahoma Legislature decided to follow suit. It voted to bring down the cost of Medicaid by putting the program up for bid.

In Oklahoma, Medicaid patients were cared for at the University Hospitals by University physicians, Vannatta explains. This creative arrangement — the brainchild of the late Lloyd Rader, who headed the Oklahoma Department of Public Health and Human Services—generated 40 percent of the funding for the medical school and the two teaching hospitals. When that arrangement ended, the two hospitals and the medical school were left in dire straits.

"If the teaching hospitals failed, the medical school would be threatened," Vannatta continues. "And the medical school is the cornerstone of the entire OU Health Sciences Center. Except perhaps for dentistry, all the colleges would be at risk."

There was another consideration. If the University Hospitals were closed, what would happen to indigent patients, those who are without Medicaid or any sort of health coverage?

When the legislature realized the implications of its decision to turn Medicaid patients over to HMOs, it hired consultants. The Health Sciences Center also hired consultants.

"Everyone agreed that the hospitals were in trouble," Vannatta says.

Eventually, with consultant reports in hand, state and University officials agreed that the hospitals needed a capital partner in order to survive. In 1994, the legislature passed a bill instructing the Oklahoma Hospital Authority, the University Hospitals' governance board, to find such a partner.

The Hospital Authority sent requests for proposals nationwide, with the hope of achieving three major goals: maintaining a hospital presence at the Health Sciences

Center, continuing indigent health care and keeping education programs in the College of Medicine financially solvent.

The authority received four proposals. Only the proposal from Columbia HCA addressed all three goals. The Hospital Authority and the University began negotiations with Columbia in July 1995.

An agreement that merged the management of Presbyterian and University Hospitals finally was reached two-and-a-half years later. Under the terms of the agreement, the state of Oklahoma would continue to own the two hospitals, with Presbyterian remaining an asset of Columbia HCA. In addition:

- A new board of governance consists of five members appointed by Columbia and five by the State of Oklahoma.
- Columbia will pay the Hospital Authority the first $9 million of revenue and keep the next $30 million. Revenue over $39 million will be split, with 70 percent going to Columbia and 30 percent to the Hospital Authority.
- Columbia will continue to provide $6.8 million in indigent care, which reflects the current level at Presbyterian, and also will provide indigent care equal to a minimum of 120 percent of the $26 million the state appropriates for indigent care.
- The College of Medicine will use all three hospitals for at least 90 percent of its inpatient and outpatient care.
- Columbia will furnish $40 million to be used for programs mutually agreed upon by the College of Medicine, the Hospital Authority and Columbia.
- OU maintains control of faculty appointments and curriculum and is the sole employer of all faculty and residents.

"We're all betting that Columbia can run those hospitals more efficiently than the state of Oklahoma," Vannatta says. "I think it's a good bet."

INEVITABLE CHANGES COMING

Columbia will make some changes, he points out. That is inevitable. All over the country, hospitals are closing wards and adding wellness and other programs to bring in revenue.

One noteworthy change already has occurred. The three hospitals now are spoken of collectively as University Health Partners, with the controversial Columbia name fading from view locally.

The fraud charges against Columbia in the midst of the negotiations were a cause of great concern. The company immediately fired its CEO, however, and backed away from a grow-at-all-costs philosophy. The new CEO is physician Tommy Frist, whom Vannatta refers to as "a patient-friendly kind of guy."

"Actually, the charges against Columbia changed the dynamics of the negotiations," Vannatta says. "With their company being dragged through the dirt on television and in the press, it gave us the upper hand."

Oklahoma was not alone in its teaching-hospital crisis, Vannatta says. Other academic health sciences centers are looking for similar mergers. Some already have taken place, each with their own set of problems. "In Boston, a Jewish hospital has merged with a Methodist hospital. They can't decide which holidays to give their employees."

He admits that one particularly delicate merger-related problem probably will not go away. With the Medicaid bonanza over at the OU Health Sciences Center and University Health Partners now competing more directly with other area hospitals, OU physicians will be in more direct competition with community physicians.

Part of the capital infusion from Columbia will be used to build a physician practice facility near the Health Sciences Center campus. Instead of difficult-to-find clinics spread across the vast health center campus, the proposed state-of-the-art facility will be easy to find and offer ample parking. Vannatta does not expect local physicians to be particularly thrilled about the new competitive environment.

One of the pre-med students in the audience asks, is Vanatta absolutely certain the merger will work?

"It seems like a good deal," Vannatta responds, "and without it the hospitals would have failed within the next few years. I believe the merger provides the OU Health Sciences Center with an environment that will allow it to continue to grow and do well.

"The bottom line was that we needed a place to educate medical students and provide health care for indigent people. The merger does that. If there was a better way to accomplish those things, we sure couldn't find it."

He concludes his Norman-campus visit with a philosophical overview of why the teaching hospitals had to be saved:

"The University Hospitals had to be saved because what is going on at the OU Health Sciences Center is what I call a biomedical enterprise. It has to do with an explosion in biomedical research. It has to do with taking care of patients in a high-tech environment, often using cutting-edge technology.

"Medical school physicians have more access to that cutting-edge technology because medical schools are where the cutting-edge kinds of people go. Medical school faculty members want some of their time to be dedicated to research so they can create new techniques and find better ways to fight disease. They want to be associated with very bright, talented, well-funded molecular biologists who can clone the gene that can produce the proteins they need to attach to a receptor that can bring down the blood pressure or do some other wonderful thing that will heal people.

"To be a successful academic physician, you have to be closely associated with successful academic molecular biologists. A symbiosis of geography is necessary to make that work. That's what you have at an academic health center.

"An academic health center cannot exist without teaching hospitals. We cannot teach students how to be physicians if we don't have patients. Patients are our library and our laboratory. Trying to get a medical education without being at the bedside and seeing patients is like trying to go to sea without a boat. It just won't work."