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I. EXECUTIVE SUMMARY

A. Purpose

In July of 2005, The Lewin Group was engaged to develop a strategic plan and unified approach to the coordination and delivery of health care services to the medically indigent population of Tulsa County and the surrounding metropolitan area. The final strategic planning for safety-net services report needed to present a “road-map” that would in the long-term lead to measurable improvements in health care outcomes for Tulsa residents.

There was an expressed desire that the plan:

- build upon studies and analyses already completed;
- incorporate best practices for health care service delivery, governance, financing and health care improvement strategies; and
- articulate the role(s) necessary for stakeholders including policy makers, hospitals, the Community Hospitals Authority, foundations, and others to implement the strategic plan.

B. Approach

The Lewin Group’s approach built upon work completed to date by numerous participants, included significant stakeholder input and support, and reflected the Tulsa community’s capacity to oversee and manage the resulting safety-net program(s). Specific activities included:

- Conducting over 30 stakeholder interviews, one-on-one or in groups;
- Synthesizing numerous studies and analyses conducted by a variety of Tulsa organizations and stakeholder groups;
- Conducting additional analyses on capacity, demand, and costs of care for the uninsured;
- Vetting preliminary recommendations with stakeholders; and
- Finalizing the strategic plan.

C. Situation Assessment Findings

The first step in the planning process was to conduct a situation assessment to understand Tulsa area health care needs, problems and capacities. Our findings confirmed what is well known among Tulsa health care stakeholders: Tulsa faces many challenges in its delivery, financing and organization that limit its ability to successfully meet the needs of safety-net populations.

**Health Care Delivery.** Indigent patients in the region face a significant number of unmet needs and gaps. These patients have difficulty accessing primary, diagnostic and specialty care and thus rely on hospital emergency rooms as their primary entry into the health care system. The lack of available medical homes for many indigent patients, coupled with a community wide
lack of focus on prevention and coordinated treatment of chronic conditions, contributes to deteriorating health status throughout Tulsa, particularly for low-income residents.

**Financing.** The region and the State do not have sufficient, dedicated funding to assure that health care needs of the indigent are met. No hospital in the Tulsa region currently receives Medicaid Disproportionate Share Hospital (DSH) funds due to the formula for qualifying for DSH. Enhancements to Medicaid payment rates and efforts to expand insurance coverage only recently have been implemented. The Community Hospital Authority (CHA) is not authorized to receive and expend State appropriations. This leads to a lack of dedicated primary and specialty care for these patients, and to cost-shifting to all consumers. It also appears that not all avenues for financing have been effectively explored and/or implemented, especially as it relates to seeking public sources of financing in the way of grants and/or local support. Finally, there is clearly an insufficient level of participation in the support financing of indigent care by health care stakeholders, including physicians as well as policy makers and taxpayers.

**Organization.** There currently is no central authority responsible for coordinating and monitoring services for indigent patients specifically in the Tulsa region. The programs that do exist are state-wide or are planned and implemented by local providers on an independent basis. Community leaders have no single point of authority or accountability for the sufficiency and quality of indigent care throughout the region. Effective strategies require coordination and collaboration, particularly in the management of limited resources. These factors combined also have undermined the ability to attract stable financing from a variety of sources, both public and private. Addressing poor health status couple with enhancing access and funding for the uninsured requires a coordinated and unified approach.

These problems have been well recognized by stakeholders in Tulsa and led to the development of this strategic plan. Tulsa foundations have voiced concern regarding the problems faced by Tulsa residents, have supported the development of this strategic plan, and are interested in contributing to the solution over the long term.

**D. Strategic Plan Goals**

Driven from the situation assessment findings, strategic plan goals drive the development of improved health care delivery and financing for Tulsa residents.

<table>
<thead>
<tr>
<th>Strategic Plan Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase availability of services needed by indigent patients</td>
</tr>
<tr>
<td>• Enhance access to care for indigent patients</td>
</tr>
<tr>
<td>o Geographic</td>
</tr>
<tr>
<td>o Financial</td>
</tr>
<tr>
<td>• Reduce inappropriate utilization</td>
</tr>
<tr>
<td>• Improve health status and outcomes</td>
</tr>
<tr>
<td>• Stabilize and enhance financial performance of indigent care providers</td>
</tr>
<tr>
<td>• Maximize resources for indigent (and Medicaid) care</td>
</tr>
</tbody>
</table>
E. Recommended Strategies

Achieving the strategic plan goals can be accomplished by the implementation of a number of strategies and tactics detailed below.

1. Develop a Strong, Well-Coordinated Ambulatory Care Safety-Net System for the Indigent

   a. Rationale

   The development of a vibrant, well-coordinated ambulatory care network will serve as the cornerstone of a system that effectively meets the needs of Tulsa area residents. An ambulatory care network, coupled with a strong medical infrastructure and care coordination between sites, can reduce inappropriate emergency department use and hospitalizations while also contributing to improved health outcomes and population health status. Successful development of an ambulatory care network would be the sum of improved leveraging of existing resources with the development of new ambulatory care capacity to close any need gap.

   b. Tactics

   We considered a number of options to expand ambulatory capacity including Federally Qualified Health Centers (FQHC), hospital affiliated urgi-care centers, medical school/hospital collaborative HealthPlex development, as well as school health clinic expansion.

   The recommended tactics for expanding ambulatory care capacity for the medically underserved in Tulsa includes:

   • Support current plans to expand FQHC capacity by Morton Health Center and the newly funded FQHC. This includes the need for hospitals and the medical schools to provide contractual services for the FQHCs for diagnostic support as well as administrative assistance, where needed. Given that it is likely that it will take anywhere from 2-3 years for these two FQHCs to fully stabilize and provide needed primary care service expansions in addition to the current difficulties with securing new start funding, we do not believe that in the short-turn it is prudent to pursue developing a network of additional FQHCs as the primary vehicle to expand ambulatory capacity.

   • Establish two new full-service HealthPlex facilities affiliated with local hospitals and medical schools that offer comprehensive outpatient care to complement Tulsa’s current FQHC expansion strategy and collaborate with local hospitals and other providers. The new HealthPlex facilities, located in the Northwest and Northeast areas of Tulsa would facilitate access to care for medically underserved populations that reside in those areas and currently account for most local inappropriate ED use. The strategy thus represents a direct intervention and resource designed to enhance access to urgent, emergent, specialty, and related care for these populations, and would include triage and care management resources on site.

   The HealthPlexes as contemplated would each be approximately 60,000-80,000 square feet in size, serve 50-75,000 patient visits annually and combine current technology with
an array of integrated services that will allow patients to be referred to and seen in the most appropriate treatment setting. In addition to primary and preventive care services, each HealthPlex would offering specialty and urgent care, and maintain an outpatient pharmacy, diagnostic imaging and laboratory services and physician offices. Patients requiring tertiary care would be referred to affiliated hospitals. Our recommendation calls for collaboration between an area hospital and a medical school for each of two HealthPlexes, with the medical schools providing the primary and specialty care.

- Expand University of Oklahoma’s (OU) successful school-based health center model. Expanding this model to additional local school districts, coupled with expanding hours of operation at each school health center to a minimum of eight hours daily, appears to be a strategy that should meaningfully reduce inappropriate ED use and hospitalizations by children and provide the types of primary and preventive services that have contributed to improved health status in other communities.

- Establish county-wide, contractually-based and protocol-driven patient referral linkages between hospital EDs, FQHC’s, HealthPlex sites, other clinics and urgent care centers to reduce fragmentation of care.

- Implement a web-based system to coordinate patient referrals from EDs to urgent care centers and community-based clinics, coupled with use of common IT and data reporting systems and integrating patient medical records to follow patients across sites of care.

- Integrate the current 211 system operated by the Community Services Council with a 24/7 telephone nurse triage clinical care referral system (that can be housed at HealthPlex sites) to provide both counseling and referral services county-wide.

2. **Implement Community Wide Programs that Improve Health Care Outcomes**

Rationale:

Research from the University of Oklahoma indicates that Oklahomans’ poor health status as compared to the nation is mostly due to cultural health values and beliefs that are “ingrained in the behaviors of Oklahomans.”

We recommend that one or more Tulsa providers develop and implement a large scale care management programs that have been proven successful at influencing lifestyle and behavior patterns that contribute to major health issues facing residents of Tulsa.

While lifestyle and behavior patterns are the largest determinant of health care status, access to medical services is another determinant of health outcomes that can also be positively and proactively influenced by reducing financial and informational barriers to care.

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Tactics:

- Consider development of a pilot Chronic Disease Program, as has been developed successfully in communities across the country. Chronic disease programs aim to improve a patient’s ability to manage chronic disease, improve the level of care clients receive and decrease the costs of care through improved self-management, including reducing inappropriate ED visits. Essential program components include advanced information tracking and accounting, decision support and protocols for clinicians, and self-management programs. A unique aspect of the program is the use of health coaches who are lay workers (paraprofessionals) from the neighborhood. They function as case managers, tracking patients, making home visits, and educating them on their diseases, medications, etc. Training community residents to perform home visits is less expensive than using health professionals.

- The medically indigent often experience financial barriers that significantly limit their ability to appropriately access the safety-net health care system for their outpatient needs. We recommend that Tulsa develop a standardized uncompensated care policy across outpatient primary and specialty care safety-net providers and conduct a standardized review of eligibility for reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency. We also recommend that consideration be given to the development of a regional ombudsmen to help safety-net consumers access and navigate the system and to assist with key financial counseling issues.

3. **Consider Creation of a “Virtual” Safety-Net to Achieve Safety-Net Hospital Benefits**

**Rationale:**

In recent months much discussion in Tulsa has focused on the fact that Tulsa does not have a public or private safety-net hospital and as uncompensated care is distributed among Tulsa providers, none of the hospitals meet the threshold uncompensated volume and case-mix requirement to qualify for Medicaid DSH payments (an important indigent care funding source).

**Tactic:**

While an analysis assessing the feasibility of a safety-net hospital was beyond the scope of this engagement, we have determined that the size of the uninsured/underinsured population (approximately 300,000) would require a hospital with anywhere from 150-200 med/surg beds. In addition, a safety-net hospital would need to meet all of its associated attributes: geographic proximity to the medically indigent, comprehensive primary and specialty clinics, full affiliation with a comprehensive medical school, discounted charity care policies and cultural competency. At the current time no Tulsa hospital meets all of these requirements, and it would be extremely costly to pursue this strategy.

While the issues are not insurmountable, we believe that in the short term resources should be devoted to creating a “virtual” safety-net by defining the essential roles that current
stakeholders should play to meet the desired vision of measurably strengthening the Tulsa safety-net delivery system.

Our view is that while important, getting access to DSH dollars should not be the driving force beyond the need for a safety-net hospital, and we provide several suggestions regarding DSH opportunities in the funding section of this document.

That being said, in the long-term, if there is consensus among stakeholders that a safety-net hospital strategy should be pursued, a detailed programmatic, bed and ambulatory care assessment and financial feasibility study needs to occur.

4. **Support the Strengthening and Coordination of Graduate Medical Education Training**

**Rationale:**

University of Oklahoma (OU) at Tulsa and Oklahoma State University (OSU) are important resources and providers of care for safety-net populations. However, graduate medical education in Tulsa faces major challenges that limit their effectiveness and support of indigent care delivery:

- Neither school is comprehensive in scope and both lack the array of subspecialty training fellowships and residencies provided at more comprehensive medical schools. As a result, neither school is substantially able to provide needed specialty care to community residents in both inpatient and outpatient settings.

- Both OU-Tulsa and OSU face unique funding challenges. The University of Oklahoma in Oklahoma City receives significantly more funding to manage its Medicaid patients than OSU or OU-Tulsa. As general OU funding flows through Oklahoma City, OU-Tulsa has had less direct access to funds. At the same time, there is currently considerable unrest regarding the future of OSU’s teaching program at Tulsa Regional Medical Center.

- There is currently a lack of collaboration among the two medical schools. While each school has plans to enhance its provision of care to the medically indigent, considerable opportunities have been missed due to the lack of more thoughtful and comprehensive graduate medical education planning and implementation to address needed service delivery gaps.

**Tactic:**

The Tulsa community could benefit from the development of a comprehensive strategic plan for medical education that supports the provision of community-based clinical care. Areas of focus should include:

- Identifying short and long-term residency training needs both in primary and specialty care and create slots to increase match rates;
• Developing incentives for joint planning by the two medical schools to design and deliver a more appropriate system of care, including increasing the focus on culturally appropriate outreach, case management and diagnostic care; and

• Developing incentives for the medical schools to jointly develop new residency training programs to facilitate service provision and increase the supply of physicians to the region.

5. **Implement Discounted Prescription Drug Program**

**Rationale:**

Medication assistance programs have been implemented around the country with the goal of giving the uninsured increased access to health care so that they can better manage their illnesses and reduce morbidity. Central to this strategy is the ability for patients to visit physicians regularly to help them understand and manage their condition. Access to low-cost or free prescription drugs has also been shown to improve medication compliance, reduce hospitalization rates, and decrease the number of emergency room visits. The combination of access to care and prescription drugs can therefore be significant in improving the overall health status of uninsured populations.

**Tactic:**

- Consider implementing a clinic-based medication assistance program at the Bedlam Clinic, and other sites to be determined. The clinic-based program provides prescriptions by purchasing medications at deeply discounted prices, by completing and dispensing individual manufacturer assistance program applications, and by administering bulk donation programs.

6. **Support Insure Oklahoma Initiative**

**Rationale:**

Insure Oklahoma (O-EPIC) represents a major initiative for the State that, if successful, will expand coverage and attract substantial federal funding. Patients and providers would benefit from initiatives that help encourage adoption and implementation of the program.

**Tactics:**

- Name a champion, like Tulsa Chamber of Commerce, to promote Insure Oklahoma;
- Support development of a regional campaign to build awareness about the program;
- Implement specific policies and procedures at all patient care delivery sites to encourage employers and individuals to participate in the program; and
- Consider offering of incentives to encourage adoption.
F. Estimated Major Strategic Initiative Costs

The table below summarizes the estimated costs of each initiative based on the assumptions highlighted below the table. Note that due to lack of the specifics regarding the operational configuration of a freestanding or virtual safety-net hospital, an estimate for this is not provided.

### Estimated Capital and Operating Costs of Strategic Initiatives

<table>
<thead>
<tr>
<th>Strategic Initiative</th>
<th>Fixed Capital Costs</th>
<th>Ongoing Annual Operating Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction of Two HealthPlexes</td>
<td>$44,700,000</td>
<td>$6,300,000</td>
</tr>
<tr>
<td>Expansion of School-based Health Centers</td>
<td>0</td>
<td>250,000</td>
</tr>
<tr>
<td>Implement Community Referral Network</td>
<td>300,000</td>
<td>360,000</td>
</tr>
<tr>
<td>Implement Disease Management Program</td>
<td>300,000</td>
<td>600,000</td>
</tr>
<tr>
<td>Support the Strengthening and Coordination of GME Training</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discounted Prescription Drug Program</td>
<td>300,000</td>
<td>10,800,000</td>
</tr>
<tr>
<td>Support Insure Oklahoma</td>
<td>250,000</td>
<td>2,250,000</td>
</tr>
<tr>
<td>Strengthen Governance and Organizational Accountability</td>
<td>300,000</td>
<td>500,000</td>
</tr>
<tr>
<td>Total</td>
<td>$46,150,000</td>
<td>$21,060,000</td>
</tr>
</tbody>
</table>

The key assumptions for each initiative include:

- **Construction of Two HealthPlexes** - The capital and operating costs of two new HealthPlexes assumes one HealthPlex will be a smaller, less comprehensive 60,000 square foot facility (Scenario 1) and one will be a larger 100,000 square foot facility offering a more comprehensive range of services (Scenerio 4). Estimated annual operating costs are reported net of revenue and assume 20% unreimbursed cost of uncompensated care.

- **Expansion of School-based Health Centers (SBHCs)** - Assumes expansion to five SBHCs. Each expansion site assumes a $250,000 annual operating budget and 20% unreimbursed cost of uncompensated care.

- **Implement Community 24/7 Nurse Telephone Triage Referral Network** - Assumes $300,000 in capital-related implementation costs, and a fully operational annual operating budget of $360,000.

- **Implement Disease Management Program** -Assumes $300,000 in implementation costs, and an annual operating budget of $600,000.

- **Support the Strengthening and Coordination of GME Training** -Assumes existing provider revenues match costs for this initiative.

- **Support Insure Oklahoma Initiative** - Assumes $250,000 in awareness building campaign. Assumes private sources of funds provide premium assistance for half of employer
share (25% of $200 monthly premium) for 7,500 covered lives. Ongoing operating cost will vary based on the number of enrollees, the monthly premium, and the level of assistance, e.g., the annual cost for 10,000 enrollees in a plan with a $250 average monthly premium for which assistance is provide for half of employer and employee share (40%) would be $6 million.

- **Strengthen Governance and Organization Accountability** - Assumes $300,000 in implementation costs, and an annual operating budget of $500,000.

### G. Recommended Governance and Authority Structure

The problems identified in the Situation Assessment require the intervention of “an Authority with Authority” in Tulsa – one that is empowered to act in an independent and meaningful fashion to serve as the locus for joint planning, implementation and coordination of services in the Tulsa region. Such empowerment would effect real change and improve the delivery and financing of health care for the indigent in the area.

Legislation that created the Community Hospitals Authority states clearly that the Authority cannot issue bonds, employ personnel, or acquire any real property – and that CHA cannot receive state appropriations (except those it is entitled to through the Medicaid program as administered by OHCA). The legislation also states that “in the event a program is enacted whereby hospitals are reimbursed for the cost, or a portion thereof, of providing indigent health care, the Legislature shall insure that reimbursement shall be made to all hospitals statewide with the exception of the University of Oklahoma Medical Center based on each hospital’s indigent care caseload as it relates to the total amount of indigent care provided by all hospitals other than the University of Oklahoma Medical Center.”

Many other communities across the country, have successfully implemented an organizational structure to support the coordination and strengthening of care for the indigent. We believe that now is the appropriate time to create such an organization to serve the residents of Tulsa.

Thus, we recommend the creation of an expanded Tulsa Healthcare Authority. In addition to the significant benefits to be realized from greater collaboration among organizations that currently play important but incomplete roles in the provision of services for the indigent, such an authority could achieve the following benefits achieved in other communities:

- The authority would broaden community-based participation and collaboration beyond the local hospital community;
- The Authority would provide a forum to enhance collaboration between the Medical Schools and Tulsa’s growing FQHCs that offer significant medical and supportive social and human services to the communities they serve;
- Structure would provide needed support to existing and newly funded FQHCs;
- Provides a possible vehicle for generating local tax support, and;
- Provides a vehicle for sharing and coordinating important programs/infrastructure (e.g. case management) and for setting policy (e.g., EMR participation and standards).
Consideration should also be given to creating a separate 501(c)3 organization that would serve as the conduit for private funding including philanthropic dollars, and would have greater flexibility with respect to governing roles and responsibilities, as compared to the governmental authority model. The 501 (c) 3 could either be created as a second organization that would interact with but function separate from the THA, or only be considered in the event that legislative changes required to create an effective Authority are not approved.

PROPOSED ENHANCEMENTS TO AUTHORITIES ROLES AND POWERS

<table>
<thead>
<tr>
<th>REFOCUS AND EXPAND MISSION:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refocus mission to clearly focus on planning and coordinating services for delivery of indigent care. Supporting GME and securing funding should clearly and solely be related to achieving this primary mission.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>EXPAND BOARD COMPOSITION:</th>
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<tbody>
<tr>
<td>Modify the Board membership to include a larger Board (13 -15 members) that is more inclusive of greater community perspectives. It is suggested that four to six additional members be added to reflect community views. Members must be results-oriented, energetic and in positions of leadership that will allow for the promotion of solutions.</td>
</tr>
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<table>
<thead>
<tr>
<th>EXPAND AUTHORITY ROLE:</th>
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<tbody>
<tr>
<td>Authority requires broader powers and greater coordination role to truly effect positive change. Expanded powers would include:</td>
</tr>
<tr>
<td>➢ Establish direction and priorities for authority and workgroups (see below)</td>
</tr>
<tr>
<td>➢ Hire and supervise Authority staff</td>
</tr>
<tr>
<td>➢ Make annual recommendations to governmental authorities (City/County/State) for needed changes in safety-net delivery and/or financing</td>
</tr>
<tr>
<td>➢ Implement programs to finance and serve indigent populations</td>
</tr>
<tr>
<td>➢ Accept and utilize governmental appropriations in furtherance of the CHA mission</td>
</tr>
<tr>
<td>➢ Establish contractual standards, policies and procedures</td>
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</tbody>
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<table>
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<tr>
<th>REQUIRE CREATION OF FORMAL WORKGROUPS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All levels of stakeholders should have a role and be vested in the outcome of planning and implementation activities. Create formal workgroups/ advisory boards representing:</td>
</tr>
<tr>
<td>➢ <strong>Provider Services</strong> will implement process assuring participation from all segments of the provider community in the planning and implementation of the strategic plan as it relates to the provider community</td>
</tr>
<tr>
<td>➢ <strong>Community Health Services</strong> will focus on supporting and strengthening collaborative community health efforts within the Tulsa MSA</td>
</tr>
<tr>
<td>➢ <strong>Access and Care Coordination</strong> will focus on care coordination of primary and specialist services within the Tulsa region to enhance access to care, and improve health care outcomes including developing a measuring system to track progress in access to care and progress made toward better health care outcomes</td>
</tr>
<tr>
<td>➢ <strong>Monitoring and Measurement</strong> will advance the tracking and regular reporting to the public of specific metrics, documenting both community benefits and progress made toward achieving health care improvements.</td>
</tr>
</tbody>
</table>
ESTABLISH STAFFING/BUDGET AND INDEPENDENT SPACE:
The independence of the Authority, in its administration and mandates is imperative. Create a small, paid, support staff to support ongoing administration, marketing and research. House the staff in a geographically neutral environment – perhaps co-located with a local foundation.

H. Implementation Requirements

Success of the recommended strategies and tactics as described will require diligence and implementation in three key areas: funding, legislation and roles and responsibilities of stakeholders.

Each implementation area is described briefly below:

1. Funding

In the near-term we recommend three different sources of funding to support the cost of the care provided to the safety-net population: 1) a modified DSH mechanism; 2) foundation resources; and 3) Insure Oklahoma.

- Medicaid DSH dollars are statutorily defined as funds intended for the cost of under funded Medicaid care and uncompensated care for the uninsured. Given the minimal levels of Medicaid DSH funding Oklahoma receives, it is poised to benefit from enhanced funding. Furthermore, an enhanced mechanism, for which there are precedents in other states, would permit the state (and Tulsa) to allocate funding beyond inpatient hospital care (e.g., ambulatory and clinic services), and to other providers in the state (e.g., Tulsa area hospitals).

- Local area foundations indicated a willingness to fund area health initiatives provided that there is a clear plan with specified goals in place. The lack of a region-wide vision with specified goals has impeded the ability of local organizations to attract private philanthropy. Furthermore, foundations are likely to seed local initiatives as they can readily monitor their impact in the community.

- Insure Oklahoma provides substantial financial assistance to the working uninsured, and has already gained approval at the federal level. Oklahoma has a high proportion of working uninsured, and the program is structured so that beneficiaries may obtain health benefits for members in the household (i.e., spouse and dependents). Furthermore, beneficiaries have access to over nine different commercial health plans which offer comprehensive benefits, similar to the insured who benefit from employer-sponsored coverage.

- As a long-term indigent care financing mechanism, the authority (or state) could implement a levy/surcharge on health care organizations. While such an initiative takes time to mandate, it provides a dedicated pool of funding that can be distributed based on a methodology that quantifies uncompensated care. It also provides a way to shift funds to providers who are providing a disproportionate amount of uncompensated care.
2. Legislation

This strategic plan also contemplates the following legislative agenda:

- Legislation that assures HealthPlexs can be licensed as part of hospital(s) without barriers.
- Resolution (and legislative support) to prevent any further deterioration in Oklahoma's Federal Medical Assistance Percentage (FMAP). Scheduled declines in FMAP – from over 70 percent to 68 percent – significantly affect the federal funds that flow to Oklahoma through the Medicaid program and reduce the “yield” associated with matching funds from state or other regionally-generated sources.
- Implementation of an updated DSH formula that expands the number of hospitals eligible for funding: based either on (a) the total quantity of charity and Medicaid services they provide, or (b) a mechanism that explicitly recognizes outpatient charity and outpatient Medicaid care.
- Legislation that creates an outpatient Medicaid DSH pool – so that funding provided to qualifying hospitals rewards hospitals that provide access to outpatient care and is less dependent or driven by inpatient utilizations.
- Legislation that makes the rate increases that Oklahoma providers recently received for Medicaid as permanent as possible.
- Legislation that enables the Community Hospitals Authority to assume the responsibilities recommended in this plan – including the ability to receive and expend appropriations from the State, from the University Hospitals Authority, or both.

3. Roles and Responsibilities

In recent years, Tulsa stakeholders have contributed much to improve the health care environment for the medically indigent. The major change that is recommended is that stakeholder planning and implementation occur in coordination with other efforts, rather than in isolation. In this manner, efforts can be leveraged to achieve the ultimate long-term goal of improved health care outcomes for Tulsa residents.

**Hospitals** should continue to coordinate high level inpatient services and collaboration via joint operating agreements with other providers (community physicians and both of the Tulsa medical schools) to strengthen the provision of health care and contribute to improved health care outcomes.

**Medical Schools** will continue to be looked upon to contribute valuable clinical and research resources. However, to be effective, great consideration should be given to collaborative planning and implementation of services to achieve desired health care status improvements and in order to bring additional GME resources into Tulsa.

**Foundations** will be looked to in support of the Tulsa Strategic Plan, specifically as it relates to providing seed money for innovative programs such as the Medication Assistance Program,
and the Chronic Disease Management Program, as well as providing needed one-time capital funding to meet new capacity requirements, such as development of the HealthPlex clinics.

The business community (via an organization such as the Tulsa Chamber of Commerce) should support the Insure Oklahoma Initiative in support of decreasing the number of uninsured in Tulsa.

Legislators will be asked to support the Tulsa Strategic Plan, particularly as it relates to bringing additional Federal and State funding to the Tulsa region.

I. Implementation Plan

The implementation plan presented below delineates the desired timeframe for completion of each recommended strategy and tactic across three components: delivery system strategies that enhance availability and access to care, governance and organizational strategies that improve the safety net system infrastructure and accountability and financing strategies to increases both the sources of funding and total dollars available to support the strengthening of Tulsa’s safety net delivery system.

<table>
<thead>
<tr>
<th>Immediate (within 1 to 3 years)</th>
<th>Short-Term (within 3-5 years)</th>
<th>Long-Term (5-10 years +)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delivery System</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish Joint Operation</td>
<td>Medical schools reach</td>
<td>OSU/OU develop joint</td>
</tr>
<tr>
<td>Agreement between one or</td>
<td>consensus on graduate</td>
<td>residency/fellowships in</td>
</tr>
<tr>
<td>more hospitals and OU</td>
<td>medical education</td>
<td>selected subspecialties,</td>
</tr>
<tr>
<td>and/or OSU to plan and build</td>
<td>training needs</td>
<td>thereby creating</td>
</tr>
<tr>
<td>two HealthPlex facilities</td>
<td>Foundation funds and</td>
<td>additional capacity</td>
</tr>
<tr>
<td>Support FQHC initiatives</td>
<td>establishes discount pharmacy</td>
<td>Expand 211 to include</td>
</tr>
<tr>
<td>already underway</td>
<td>program that would be</td>
<td>24/7 nurse triage</td>
</tr>
<tr>
<td>Pursue school health clinic</td>
<td>administered via the THA, and</td>
<td></td>
</tr>
<tr>
<td>expansions</td>
<td>established at the Bedlam</td>
<td></td>
</tr>
<tr>
<td>Integrate 24/7 telephone</td>
<td>Clinic and or the new Health</td>
<td></td>
</tr>
<tr>
<td>nurse triage referral system</td>
<td>Plex facilities</td>
<td></td>
</tr>
<tr>
<td>with current 211 system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One or more providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>develop community-wide</td>
<td></td>
<td></td>
</tr>
<tr>
<td>chronic disease case management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>program</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Governance/Structure</strong></td>
<td>THA, and workgroups issues</td>
<td>Further develop THA</td>
</tr>
<tr>
<td>Through legislative authority,</td>
<td>first Tulsa Indigent Care</td>
<td>capacity to attract</td>
</tr>
<tr>
<td>establish Tulsa Healthcare</td>
<td>Progress and Community Benefit</td>
<td>financing and monitor</td>
</tr>
<tr>
<td>Authority-CHA would be</td>
<td>Report</td>
<td>utilization.</td>
</tr>
<tr>
<td>restructured to create the THA)</td>
<td>that would plan and coordinate</td>
<td>Consider integrating /</td>
</tr>
<tr>
<td>that would plan and coordinate</td>
<td>indigent care delivery as</td>
<td>coordinate city and county</td>
</tr>
<tr>
<td>indigent care delivery as well</td>
<td>become the conduit for new</td>
<td>public health functions</td>
</tr>
<tr>
<td>become the conduit for new</td>
<td>sources of funding</td>
<td>under THA.</td>
</tr>
<tr>
<td>sources of funding</td>
<td>Establish Work Groups</td>
<td></td>
</tr>
<tr>
<td>Establish Work Groups</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financing</td>
<td>Immediate (within 1 to 3 years)</td>
<td>Short-Term (within 3-5 years)</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chamber of Commerce and providers actively support “Insure Oklahoma”</td>
<td>Foundations collectively establish Indigent Health Care Fund, the distribution of which would be managed by the THA. The continuance and use of these funds would be contingent upon receiving matching funds from other sources including local, state and federal dollars; with a preferred match rate of 2 to 1. Begin building political support for a regional revenue source for indigent care/public health</td>
<td>Consider further coverage enhancements via increasing Medicaid coverage and/or further expansions of employer coverage to low income employees.</td>
</tr>
</tbody>
</table>
II. PURPOSE

In July of 2005, The Lewin Group was engaged to develop a strategic plan and unified approach to the coordination and delivery of health care services to the medically indigent population of Tulsa County and the surrounding metropolitan area. The final strategic plan document needed to present a “road-map” that would in the long-term lead to measurable improvements in health care outcomes for Tulsa residents.

There was an expressed desire that the plan:

• build upon studies and analyses already completed;

• incorporate best practices for health care service delivery, governance, financing and health care improvement strategies; and

• articulate the role(s) necessary for stake-holders including policy makers, hospitals, the Community Hospitals Authority, foundations, and others to implement the strategic plan.
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III. APPROACH

The Lewin Group’s approach built upon work completed to date; included significant stakeholder input and support, and builds upon the Tulsa community’s capacity to oversee and manage the resulting safety-net program(s). Specific activities included:

- Conducting over 30 stakeholder interviews, one on one or in groups;
- Synthesizing numerous studies, analyses that have been conducted by a variety of Tulsa organizations and stakeholder groups;
- Conducting additional analyses on capacity, demand, and costs of care for the uninsured;
- Vetting preliminary recommendations with stakeholders; and
- Finalizing the strategic plan.
IV. SITUATION ASSESSMENT FINDINGS

This strategic plan was informed by a rich array of resource materials that describe both the health care environment in Tulsa and across Oklahoma. These resources, coupled with input from stakeholders, indicate that the Tulsa region is a community with unique challenges in health care delivery, organization and financing.

The first step in the planning process was to conduct a situation assessment to understand Tulsa area health care needs, problems and capacities. Our findings confirmed what is well known among Tulsa health care stakeholders. Tulsa faces many challenges in its delivery, financing and organization that limit its ability to successfully meet the needs of safety-net populations.

Health Care Delivery. Indigent patients in the region face a significant number of unmet needs and gaps. These patients have difficulty accessing primary, diagnostic and specialty care and thus rely on hospital emergency rooms as their primary entry into the health care system. The lack of available medical homes for many indigent patients, coupled with a community wide lack of focus on prevention and coordinated treatment of chronic conditions, contributes to deteriorating health status throughout Tulsa, particularly for low-income residents.

Financing. The region and the State do not have sufficient, dedicated funding to assure that health care needs of the indigent are met. No hospitals in the Tulsa region currently receive Medicaid Disproportionate Share Hospital (DSH) funds due to the formula for qualifying for DSH. Enhancements to Medicaid payment rates and efforts to expand insurance coverage only recently have been implemented. The Community Hospital Authority (CHA) is not authorized to receive and expend State appropriations. This leads to a lack of dedicated primary and specialty care for these patients, and to cost-shifting to all consumers. It also appears that not all avenues for financing have been effectively explored and/or implemented, especially as it relates to seeking public sources of financing in the way of grants and/or local support. Finally, there is clearly an insufficient level of participation in the support financing of indigent care by health care stakeholders, including physicians as well as policy makers and taxpayers.

Organization. There currently is no central authority responsible for coordinating and monitoring services for indigent patients in the Tulsa region. The programs that do exist are state-wide or are planned and implemented by local providers on an independent basis. Community leaders have no single point of authority or accountability for the sufficiency and quality of indigent care throughout the region. Effective strategies require coordination and collaboration, particularly in the management of limited resources. These factors combined also have undermined the ability to attract stable financing from a variety of sources, both public and private. Addressing poor health status couple with enhancing access and funding for the uninsured requires a coordinated and unified approach.

These problems have been well recognized by stakeholders in Tulsa and led to the development of this strategic plan. Tulsa foundations have voiced concern regarding the problems faced by Tulsa residents, have supported the development of this strategic plan, and are interested in contributing to the solution over the long term.
This section summarizes important background information that shaped and guided the development of recommendations in the strategic plan.

A. Demographics and Health Status

Key Findings: More than one-third of Tulsa County residents are uninsured or underinsured. Tulsa has dramatically higher adjusted death rates than the national average.

The Tulsa region (Tulsa MSA) supports a population base of approximately 861,000 people, and is comprised of seven counties – Creek, Okmulgee, Osage, Pawnee, Rogers, Tulsa, and Wagoner. About two-thirds, or 558,000 reside in Tulsa County. In 1999, approximately 12% of the population was at or below 100% of the federal poverty level (FPL) (Exhibit 1).²

### Exhibit 1
Tulsa MSA Demographics, 2000

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Tulsa MSA</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Race/Ethnicity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White (Non-Hispanic)</td>
<td>635,617</td>
<td>74%</td>
</tr>
<tr>
<td>Black (Non-Hispanic)</td>
<td>74,758</td>
<td>9%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td>39,594</td>
<td>5%</td>
</tr>
<tr>
<td>American Indian and Alaska Native</td>
<td>61,685</td>
<td>7%</td>
</tr>
<tr>
<td>Other</td>
<td>49,701</td>
<td>6%</td>
</tr>
<tr>
<td>Total</td>
<td>861,355</td>
<td>100%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 5 yrs</td>
<td>61,665</td>
<td>7%</td>
</tr>
<tr>
<td>5 to 17 yrs</td>
<td>168,390</td>
<td>20%</td>
</tr>
<tr>
<td>18 to 64 yrs</td>
<td>527,270</td>
<td>61%</td>
</tr>
<tr>
<td>65 yrs and over</td>
<td>104,030</td>
<td>12%</td>
</tr>
<tr>
<td>Total</td>
<td>861,355</td>
<td>11%</td>
</tr>
<tr>
<td>Income in 1999 below FPL</td>
<td>99,472</td>
<td>12%</td>
</tr>
</tbody>
</table>


Although the percentage of low income residents in Tulsa is consistent with many communities across the country, the Tulsa MSA has a higher safety-net population (defined as the number of uninsured and Medicaid beneficiaries) compared to the national average. The number of uninsured residents and Medicaid eligibles (approximately 322,000) represents 37% of the population base.³ This is similar to the proportion of uninsured and Medicaid recipients in Oklahoma, but is substantially higher than the national average (Exhibit 2).

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² A Health Policy Analysis of the Tulsa Total Metropolitan Area: Baseline Research in Support of a Regional Strategic Plan. Michael Lapolla, University of Oklahoma College of Public Health; April, 2005.

³ Ibid. United States source of health insurance derived from Lewin Health Benefits Simulation Model estimate; 2000.
More than one-third of Tulsa County residents fall into the safety-net cohort—it is estimated that 109,000 are uninsured, and 90,000 are covered by Medicaid—and are concentrated in the northwestern and southeastern parts of the county.4 An additional 123,000 uninsured and Medicaid beneficiaries reside in the suburban counties of the Tulsa MSA, namely Creek, Osage, and Rogers.

**It is this tremendous population of more than 300,000 persons that is of critical concern.**

A recent study by the United Health Foundation ranked Oklahoma 40th in overall health status among all states. Oklahoma ranked in the bottom quintile for several risk factors and health outcomes, including (state ranking in parenthesis):

- Lack of health insurance (47);
- Adequacy of prenatal care (47); and
- Total mortality (47)5.

The health status of Tulsa MSA residents mirrors that of the state but appears worse when other key indicators are examined. A compelling trend is the age-adjusted death rate (AADR). During the 1980s, the AADR in the United States declined—and this trend also was experienced for Oklahoma and Tulsa County residents. However, there was divergence in the 1990s. After 1990, the national average declined 11% while the Tulsa rate increased 3% (Exhibit 3). **Oklahoma is the only state whose Age-Adjusted Death Rate worsened during the 1990s.6**

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4 Ibid. Lewin analysis.

5 America’s Health: State Health Rankings. United Health Foundation; 2004.

Tulsa MSA AADRs were higher than national averages for all causes measured. As indicated in Exhibit 4, premature deaths in the Tulsa MSA were 21% higher than the national average. The higher than average rates of premature deaths was driven largely by deaths from respiratory and heart disease.\(^7\)

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\(^7\) Ibid.
Exhibit 5 shows the ordinal ranking of age-adjusted death rates for zip codes in the Tulsa MSA relative to the location of existing clinics. Areas shaded in red indicate the highest AADRs and those shaded green indicate the lowest.

**Exhibit 5**

**Tulsa MSA Age-Adjusted Death Rates**

**All Causes, 2003**

Within Tulsa County, zip codes with the highest mortality rates are concentrated in the northern part of the county. Zip codes in outlying counties also have relatively high mortality rates. Several zip codes in the region share characteristics in common:

- lack of clinics,
- high AADRs,
- lower income, and
- high rates of uninsured.

There appears to be correlation between poor health outcomes and the uninsurance rate. Clinics are concentrated in the central and western parts of the county, where mortality rates are lowest. Poor health outcomes, high poverty rates, and high uninsurance rates suggest the greatest need for access to health services.
### B. Tulsa’s Safety-Net Delivery System

**Key Findings:** Tulsa does not have an organized approach to meet the needs of the medically indigent.

Most communities/cities with significant populations and/or high numbers of uninsured and/or indigent populations have developed an organized delivery system to meet the needs of such populations. These communities usually have one or more of the following: 1) a public hospital; 2) a comprehensive medical school; 3) Medicaid DSH funding; 4) a hospital focused on safety-net patients; or 5) a strong network of Federally Qualified Health Centers (FQHCs). Tulsa lacks all five.

The need for an effective delivery and financing system for safety-net populations was notably described in the Institute of Medicine’s landmark study entitled, “America’s Safety Net, Intact but Endangered.”

> “America’s health care safety-net is a patchwork of providers, funding and programs tenuously held together by the power of demonstrated need, community support and political acumen.”

For many communities/cities, this has meant employing one or more of the following strategies:

- **The creation or designation of one or more hospitals as a “safety net” hospital with the stated mission of caring for all patients regardless of their ability to pay or insurance status.** Safety-net hospitals serve as a locus of activity, planning and expertise, devoting resources specifically to address the needs of the medically underserved. As of August 2003, 40 percent of National Association of Public Hospitals (NAPH) were directly operated by the state or local government. Fifty-three percent of NAPH members were organized as separate public entities. Most safety-net hospitals receive some form of public revenue through a variety of mechanisms and/or sources (described more fully under the Safety-net Delivery strategy section of this document). Tulsa currently does not have a designated safety-net hospital.

- **In many communities, medical schools, in collaboration with an academic medical center or public hospital are an important resource and provider of care for safety-net populations.** Medical schools, particularly comprehensive training programs, offer a range of faculty and primary, specialty and sub-specialty graduate medical education programs that either substantially complement the staff of a hospital or serve as the hospital’s medical staff. Communities with access to a comprehensive medical school benefit in that most medical schools, in support of resident training, provide primary and specialty care to community residents in both inpatient and outpatient settings. In addition, there are a variety of “medical education” dollars available to medical schools and/or hospitals that provide graduate medical education, that are often used to subsidize or offset the costs of serving the indigent. Tulsa has two medical schools,

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8 National Association of Public Hospitals, Common Governance Structures
Oklahoma University of Tulsa and the Oklahoma State University. However, neither offers a comprehensive array of subspecialty training fellowships and neither sponsors the breadth residency programs that are available at more comprehensive medical schools.

- Dating back to the 1960’s, the federal government began a program allocating federal resources directly to community-based organizations in order to develop and operate community-based health clinics in communities with few health options. These Federally Qualified Health Centers benefit from enhanced Medicaid and Medicare reimbursement, discounted drugs, and 330 grant funding to support the provision of care to the uninsured and provide other supportive services. Within the last five years, there has been renewed emphasis by the Federal government to expand the development of FQHCs in “high need” communities. This has resulted in a wave of new and expansion applications from communities across the country. In 2005, The CHA sponsored a study examining the Tulsa’s current FQHC status and opportunities to expand further. That study found that while there are opportunities to expand FQHC capacity in Tulsa, there are also a number of obstacles, including a lack of new start funding, and governance considerations that will continue to challenge Tulsa’s ability to rely on FQHC development as a primary capacity building strategy.

- Safety-net hospitals utilize a variety of funding sources to finance un-reimbursed care including the Medicaid and Medicare Disproportionate Share funding program. Medicaid and Medicare DSH payments compensate hospitals that serve a disproportionate number of uninsured and underinsured patients. In 2002, Medicaid DSH comprised 23% of the financing for safety-net hospitals (National Association of Public Hospitals member hospitals), with state/local subsidies of 39%, comprising the highest percentage of funding. To date, Oklahoma’s formula for qualifying hospitals for Medicaid DSH funds has been based on the minimum standards specified in federal law. No Tulsa hospitals have qualified to receive Medicaid DSH funds in recent years.

Thus Tulsa, unlike most communities of similar size, does not utilize and/or have access to any of the primary strategies used by most communities to deliver/fund safety-net care. (Exhibit 6).
Exhibit 6
Safety-net Characteristics of Selected Metropolitan Areas in the United States

<table>
<thead>
<tr>
<th></th>
<th>Public Hospital</th>
<th>Comprehensive Medical School</th>
<th>Medicaid DSH</th>
<th>Focused Hospital</th>
<th>State FQHC Emphasis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresno County</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Birmingham</td>
<td>State</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Honolulu</td>
<td>Public</td>
<td>Yes</td>
<td>Alternate</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Albany</td>
<td>University</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Tucson</td>
<td>University</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tulsa</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Syracuse</td>
<td>State</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Omaha</td>
<td>University</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>


1. Tulsa’s Safety Net: Capacity and Utilization of Inpatient, Emergency, Primary and Specialty Care Services

a. Inpatient Services

Key Findings: Most of Tulsa's major hospitals are at or close to capacity for inpatient care and the uninsured are admitted less frequently than the insured, suggesting a lack of access to care.

There are 15 acute general hospitals in the Tulsa MSA. However, the five full-service hospitals are all located within Tulsa County. The five hospitals are Saint Francis Hospital, St. John Medical Center, Hillcrest Medical Center, South Crest Hospital and Tulsa Regional Medical Center. Two of the hospitals are private, not-for-profit, and three are for-profit. None of the Tulsa hospitals are governed as a public or university hospital, nor do any of the hospitals receive public subsidies.

The Tulsa area is somewhat unique in that all Tulsa County hospitals belong to one of the four health care systems, and only a few smaller hospitals in outlying areas operate independently. This bodes well for implementing strategic change within the region, given that key decision makers are concentrated across few providers.
Data suggest that the region’s uninsured are admitted to Tulsa hospitals far less frequently (less than half) than the commercially insured (Exhibit 7).

![Exhibit 7](image)

**Exhibit 7**

**Hospital Admission Rate per 1,000 Tulsa County Residents by Payer**

While a significant proportion of these differences can be explained by the demographic characteristics of patients (e.g., the Medicare population is older, and women with Medicaid eligibility have comparatively high admissions rates for obstetrical care), access issues also appear to be affecting utilization rates for the uninsured. An analysis of actual versus expected inpatient utilization by the uninsured found that actual admissions to Tulsa County hospitals were about 30% less than expected based on The Lewin Group’s Health Benefits Simulation Model (Exhibit 8).

![Exhibit 8](image)

**Exhibit 8**

**Actual Versus Expected Admissions to Tulsa County Hospitals, 2004**

Source: Lapolla (2005), Lewin Health Benefits Simulation Model.
In terms of capacity, most Tulsa hospitals are within the normal occupancy range suggesting there is not an excess of beds, nor a great deal of available capacity to absorb additional patients. Note that three of five hospitals are at or above an average occupancy rate of 75%, meaning that these hospitals likely operate at or near capacity during peak times, and could not easily absorb additional patients (Exhibit 9).

**Exhibit 9**

**Staffed Bed Occupancy Rates**

**Tulsa County Hospitals**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Occupancy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hillcrest Medical Center</td>
<td>75%</td>
</tr>
<tr>
<td>Saint Francis Hospital</td>
<td>78%</td>
</tr>
<tr>
<td>Southcrest Hospital</td>
<td>53%</td>
</tr>
<tr>
<td>Saint John Medical Center</td>
<td>80%</td>
</tr>
<tr>
<td>Tulsa Regional Medical Center</td>
<td>62%</td>
</tr>
</tbody>
</table>

**Tulsa Average Occupancy**

Source: Lewin analysis, 2003 Medicare cost reports.

**b. Emergency Room Services**

**Key Findings:** Approximately 75% of all ER care could be rendered in a more appropriate, less costly setting.

Tulsa County hospitals accommodated over 201,000 emergency room visits by Tulsa MSA residents. Most of these (82%) were by residents of Tulsa County. Data analysis (Exhibit 10) suggests that the Medicaid recipients, as well as the uninsured, use the ER as their entry point into the delivery system.
A study of Tulsa’s emergency rooms indicates that a high proportion of ER visits could be seen in a more appropriate, less costly setting. The study found that 30% of ER visits were non-urgent and 43% were urgent (requiring attention in 48 hours or less). Applying this finding, it is estimated that 31,000 non-urgent and urgent ER visits could be treated in another care setting if the capacity were available and accessible. An even greater volume of redirected ER visits might be achieved if other patient groups also were targeted.

This study did not clarify the specific diagnoses and/or reasons for the inappropriate emergency department use. However, experience suggests that these reasons are likely to include a lack of a primary care provider (medical home), unavailability of a provider during evening or weekend hours, or lack of specialists available for diagnostic or treatment services.

Lewin’s Health Benefits Simulation Model also was applied to analyze health care utilization for Tulsa’s uninsured. The results of the model are compelling. The actual ER utilization by uninsured Tulsa County residents was nearly twice the expected volume (Exhibit 12). This is consistent with other findings that a large proportion of Tulsa area ER utilization should be shifted to less intensive and less costly setting.

![Exhibit 12](chart.png)

**Exhibit 12**
Actual Versus Expected ER Visits by Uninsured Tulsa County Residents, 2004

Source: Lapolla (2005), Lewin Health Benefits Simulation Model.

Most of the ER visits by the uninsured and Medicaid population originate from zip codes in the northwestern and southeastern parts of Tulsa County (Exhibit 13). These zip codes have higher poverty rates and the poorest health status outcomes in Tulsa County. These areas thus should be considered high priorities for creating new capacity and enhanced access to care.

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Exhibit 13
Medicaid and Uninsured Visits to Tulsa County ERs
by Zip Code, 2004


c. Primary and Specialty Ambulatory Services

Key Findings: There is a significant unmet need for both primary and specialty care; however the greatest current gap is the lack of specialty care for the indigent.

Through various analyses, Lewin was able to estimate the amount of unmet ambulatory services needs in the Tulsa region. Clinic capacity for the indigent in Tulsa County is comprised of five large providers, 10 free clinics, and a mobile clinic that serves nine locations. These programs principally provide primary and preventative services; however some sites also offer limited specialty and ancillary services, including:

- Pharmaceuticals;
- Laboratory services;
- X-ray, mammography, and other diagnostic radiology;
- Prenatal care services;
- Dental and vision; and
- Other limited specialty services.
Lewin analyzed self-reported data by the five largest Tulsa safety-net clinic operators (as measured by volume) (Exhibit 14). Most ambulatory care is sponsored by the two medical schools, OU and OSU, followed by Indian Health Care, and Planned Parenthood.13

**Exhibit 14**
Principal Safety-net Clinics, 2004

<table>
<thead>
<tr>
<th>Clinic Operator</th>
<th>Sites</th>
<th>Visits</th>
<th>Unduplicated Patients</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indian Health Care</td>
<td>2</td>
<td>58,369</td>
<td>9,450</td>
<td>74%</td>
</tr>
<tr>
<td>Morton Health Center</td>
<td>4</td>
<td>43,490</td>
<td>15,237</td>
<td>78%</td>
</tr>
<tr>
<td>Oklahoma State University</td>
<td>3</td>
<td>100,958</td>
<td>18,813</td>
<td>15%</td>
</tr>
<tr>
<td>Planned Parenthood</td>
<td>5</td>
<td>28,881</td>
<td>26,840</td>
<td>48%</td>
</tr>
<tr>
<td>University of Oklahoma</td>
<td>18</td>
<td>145,800</td>
<td>38,740</td>
<td>23%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32</td>
<td>377,498</td>
<td>109,080</td>
<td>40%</td>
</tr>
</tbody>
</table>

Source: Lewin analysis, Clinic records.

Tulsa currently has one Federally Qualified Health Center (FQHC), the Morton Health Center, which recently received significant funding to expand its services. Approval has also been granted for one new FQHC, Community Health Connection.

Oklahoma ranks 49th among all states in per capita FQHCs. Five recent FQHC approvals in Oklahoma, including the new site in Tulsa, do not improve that ranking.14

Characteristics of Tulsa’s existing ambulatory care delivery services for the safety-net include:

- The clinics served 377,498 patient visits, including dental care;
- The clinics provided care to 109,080 unique patients, an average of 3.5 visits (medical and dental) per person;
- The five largest sponsors operated clinics at 33 different sites in the Tulsa MSA;
- About 114 physicians, physician assistants (PA), and nurse practitioners (NP), staffed the clinic operations; and
- The majority of patients served in these clinics were covered either by Medicaid or were uninsured, with Indian Health Care and Morton proportionately providing services to the greatest proportion of uninsured.15

Lewin assessed information provided by other clinic operators that serve safety-net populations, including weekly operating schedules, services provided, and target population

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13 Volumes across all sites reflect medical and dental visits. Planned Parenthood volume reflects medical visits. Planned Parenthood provides a number of services, thus non-medical visits, e.g., Women, Infants, and Children (WIC) program encounters are not counted in the visit total. In addition, one of the five Planned Parenthood sites is a mobile unit. University of Oklahoma site and visit totals do not include Bedlam Clinic volumes.


15 Clinic utilization and financial data was self-reported by the individual sites and provided by Michael Lapolla.
(e.g., homeless, kids, languages spoken, etc). These operators included eight free clinics and a mobile van that services six locations.

Free clinic operators self reported annual visit volume. For sites not able to provide visit volumes, Lewin totaled the hours of each site to estimate the number of visits the clinics serve on an annual basis (Exhibit 15). We estimate that these clinics serve approximately 37,200 patient visits annually.16

### Exhibit 15

**Free Safety-net Clinics**

<table>
<thead>
<tr>
<th>Clinic Operator</th>
<th>Hours per Week</th>
<th>Annual Visits</th>
<th>Evenings</th>
<th>Weekends</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bedlam Clinic</td>
<td>8</td>
<td>3,200</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Broken Arrow Neighbors</td>
<td>1.5</td>
<td>800</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Cornerstone Medical*</td>
<td>2</td>
<td>850</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Good Samaritan Health Services</td>
<td>12</td>
<td>5,000</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Neighbor for Neighbor</td>
<td>20</td>
<td>10,000</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Neighbors Along the Line</td>
<td>2.5</td>
<td>950</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Osage Community Clinic</td>
<td>30</td>
<td>0</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tulsa County Social Services</td>
<td>10</td>
<td>500</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tulsa Day Center for the Homeless</td>
<td>10</td>
<td>10,000</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tulsa Dream Center*</td>
<td>6</td>
<td>2,500</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Xavier Medical Clinic</td>
<td>9</td>
<td>3,500</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>111</strong></td>
<td><strong>37,300</strong></td>
<td><strong>4</strong></td>
<td><strong>1</strong></td>
</tr>
</tbody>
</table>

Source: Lewin analysis, clinic internal records. * denotes estimate of annual volume at sites where visit totals were not available at the time

Based on our estimates of existing visits being provided, there appears to be a substantial unmet need for primary and specialty ambulatory services in the Tulsa area. To identify the potential “gap,” Lewin conducted an analysis that projected the expected volume of primary and specialty visits for the Tulsa uninsured population in comparison to the actual level of services being provided. Our health benefits simulation model projected that the uninsured with coverage (a proxy for the amount of care truly needed), would expect to generate about 347,000 visits.

Based on the data supplied to Lewin, uninsured visits at Tulsa clinics by Tulsa County residents approximated 139,000 visits. Based on our interviews and understanding of uninsured usage patterns, Lewin estimated that these clinics served about 75% of uninsured ambulatory visits, thus approximately 46,000 visits occurred in other settings, e.g., physician offices. In addition, Lewin added the non-emergent ER visits (31,199) that could be served in an alternative ambulatory setting. Deducting this from the expected volume represents the “gap” in the safety net, or the unmet need of primary and specialty visits, about 130,000 visits (Exhibit 16).

---

16 Cornerstone Medical and Tulsa Dream Center provide clinic services for 2 and 6 hours per week, respectively. Assuming 8 visits per hour yields about 850 and 2,500 annual visits at Cornerstone Medical and Tulsa Dream Center, respectively.
Of the 346,976 “expected visits”, about 40 percent (or 139,000) represents need for specialty care visits.17 Our assessment suggests available capacity of only about 43,000 specialty care visits for indigent patients, based on the following assessment.

Much of what is known about specialty care availability is anecdotal at best, as we were unable to document any hard statistics. However, all stakeholders noted the lack of available specialists to serve both the uninsured and Medicaid populations. One stakeholder noted, “we have to beg to get a physician to see a patient, and as soon as one does, he/she is immediately bombarded and overwhelmed with patients.”

Based on analysis of the services offered where the uninsured seek care, and the lack of specialty services accessible to the population, we estimate that 80% of patient visits are for primary care services (173,000 visits), and the remaining 20% for specialty care (43,000 visits). This reveals that of the total unmet need, the greatest gap is in specialty care services, 95,000 visits, while an additional 35,000 primary care visits are unmet (Exhibit 17).

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17 Based on Lewin Health Benefits Simulation Model and the National Center for Health Statistics (NCHS). The NCHS reports that 55% of ambulatory visits (physician office and clinic, emergency department, and hospital outpatient departments) are for primary care services, and 45% are for specialty care services. Given our understanding of patient care seeking patterns in Tulsa, notably the higher uninsured use of EDs for non-emergent visits, compared to national averages, we estimate that approximately 60% of the expected ambulatory visits are for primary care services, and 40% are for specialty care.
2. Supply of Medical Manpower

**Key Findings:** Compared to the national average, Tulsa has an insufficient number of both primary care physicians and specialists.

Overall the Tulsa MSA has slightly more physicians (adjusted for 100,000 population) than the state, however, it ranks lower than the national average (Exhibit 18). The region has more population-adjusted specialists than the state average, and slightly less primary care providers. Overall, Tulsa ranks 46th among states when comparing the supply of physicians, which is consistent with the number of work force shortage designations throughout the region.18

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Exhibit 18
Population Adjusted Physicians Prevalence
Tulsa MSA, Oklahoma, and US

[Chart showing population adjusted physicians prevalence across Tulsa MSA, Oklahoma, and the United States]

Source: Lewin analysis, American Medical Association.

All seven counties in the Tulsa MSA are Health Resources and Services Administration (HRSA) designated Health Professional Shortage Areas (HPSAs) for primary care, dental, and/or mental health services. In addition, HRSA has designated six of seven counties as partial (PC) or whole county (WH) Medically Underserved Areas (MUAs). Source: HRSA

C. Resources Supporting the Healthcare Safety Net

Key Findings: Insufficient funding from Federal and State payments has imposed a fiscal burden on Tulsa hospitals.

Tulsa medical schools receive significantly less State graduate medical education funding than public universities nationwide.

Source: HRSA
1. Cost versus Payment for Indigent Care

In 2002, Tulsa hospitals absorbed losses in excess of $56.0 million for the provision of care to the safety-net population. Offsetting payments were substantially less than the $187.2 million in indigent care costs experienced regionally (Exhibit 19). Tulsa area hospitals lost nearly twice as much as the state average when adjusted for staffed beds.20

Exhibit 19
Statewide Indigent Care Costs and Payments by Region
2001-2002

Source: Oklahoma Hospital Association and Center for Health Policy Research, OSU-CHS.

In 2005, the Oklahoma Legislature passed HB1088, which allocated $63 million from the state’s General Revenue Fund to the Oklahoma Health Care Authority (OHCA). Because Oklahoma’s FMAP (Federal Medical Assistance Percentage) is roughly 68 percent, and because OHCA used the additional state funding to increase Medicaid payment rates for hospitals and physicians, HB1088 effectively reduces Medicaid losses for Oklahoma providers by approximately $200 to $250 million. Prior to HB1088, Medicaid reimbursement was made at about 68 percent of the cost of hospital care. HB1088 increases reimbursement rates for hospitals and physicians to the level of reimbursement provided by Medicare. However, the legislation requires continued appropriation of the state general fund for it to remain effective on a sustained basis.

2. Federal Funding for Oklahoma Hospitals

Compared to other states, Oklahoma has experienced an imbalance in Federal dollars to support the provision of care to the safety-net population. Oklahoma ranked 42nd of 47 states

20 Hospital Indigent Care: A Statewide Analysis. Oklahoma Hospital Association and Center for Health Policy Research, OSU-CHS; May 2003.
and the District of Columbia in per capita DSH funding. Oklahoma received $6.67 in DSH per capita while the national average was $45.01 in 2004.

In federal fiscal year 2004, the federal Medicaid program allocated nearly $13 billion to disproportionate share hospitals (DSH). Oklahoma receives the national minimum of DSH dollars (1% of Medicaid expense), and virtually none of these dollars flow to hospitals in the Tulsa MSA. For each additional percentage increase in Federal Medicaid monies for the DSH program, Oklahoma would have an additional $22 million to offset the uncompensated cost of caring for the indigent.

The inequitable allocation of DSH funding to Oklahoma leaves the State short of needed funds. And the allocation of those limited resources within the State leaves Tulsa short of needed funds. No Tulsa hospital receives Medicaid DSH payments. The major reasons for this imbalance are that uncompensated care is spread across most of Tulsa’s five major hospitals, and under Oklahoma’s current DSH formulae, no Tulsa hospital meets the volume concentration requirement.

**Current DSH formulae in Oklahoma.** Oklahoma hospitals are eligible to receive DSH payments if they meet one of two requirements. A hospital must either have a Medicaid Inpatient Utilization (MIU) rate\(^{21}\) at least one standard deviation above the mean MIU rate for all hospitals receiving Medicaid payments in the state or a hospital must have a Low-Income Utilization\(^{22}\) Rate (LIUR) exceeding 25%. In addition to meeting one of these two criteria, however, a hospital must have a MIU rate of at least one percent and must meet additional requirements if non-emergency obstetrical care\(^{23}\) is provided at the facility. Hospitals deemed eligible for DSH payments are then classified into one of three categories: (1) public-private acute care teaching hospitals\(^{24}\); (2) other state hospitals; or (3) private hospital and all out-of-state hospitals.

To determine the amount of DSH payments received by each eligible facility, a multi-step formula is used. First, Medicaid revenue and charity care revenue\(^{25}\) are totaled for each facility (\(\text{revenue total} = \text{Medicaid revenue} + \text{charity care revenue}\)). A weight is then calculated for each facility by dividing each facility’s revenue total by the revenue total of the public-private acute care teaching hospital assigned a weight of one\(^{26}\) (weight = \(\text{revenue total}/\Sigma \text{(revenue total)}\)). Revenue totals are then multiplied by the calculated weights to produce weighted facility revenue totals.

---

\(^{21}\) Medicaid Inpatient Utilization=Medicaid Inpatient Days/Total Inpatient Days

\(^{22}\) Low Income Utilization is defined as the sum of a hospital’s low income payment percentage and a hospital’s charity care charge percentage. The calculation is computed as follows:
LIU =((Medicaid Payments + Subsidies from State & Local Government)/Total patient payments) + ((Total Inpatient Charges for Charity Care – Subsidies received from State & Local Government for Inpatient Care)/Total Hospital Gross Inpatient Charges (excluding SNF, NF, NHA, off-site RTC)).

\(^{23}\) The regulations provide further requirements for facilities providing non-emergency obstetrical care. For example, “any hospital offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries.” (4(A)(ii)(I))

\(^{24}\) A public-private acute care teaching hospital has 150 or more full-time equivalent residents enrolled in approved teaching programs (using the most recently completed annual cost report) and is licensed in the state of Oklahoma. Public-private hospital is a former state operated hospital that has entered into a join operating agreement with a private hospital system.

\(^{25}\) Charity Care Revenue is estimated. Charity Care Revenues = (Charity Care Charges/(Medicaid Inpatient Gross Charges/Medicaid Inpatient Days)) * (Medicaid Inpatient Revenue/Medicaid Inpatient Days)

\(^{26}\) OHCA determines which public-private acute care teaching hospital receives a weight of one.
The next step is to allocate available DSH funds to each of the three categories. Funds are allocated to public-private acute care teaching hospitals first. For public-private acute care teaching hospitals, weighted revenue totals are summed and divided by the sum of all weighted revenue totals. If the resulting percentage is less than 82.82 percent, available DSH funds are multiplied by this percentage to determine the amount of DSH funds available to all public-private acute care teaching hospitals. Otherwise, public-private acute care teaching hospitals receive 82.82 percent of available DSH monies. For instance, if the weighted revenues of public-private acute care hospitals accounted for 91 percent of the all weighted revenues, public-private acute care hospitals would receive 82.82 percent of Oklahoma’s DSH allotment. If the weighted revenues of public-private acute care teaching hospitals totaled 75 percent, however, they would receive 75 percent of available DSH payments. The amount received by public-private acute care teaching hospitals is subtracted from total available DSH funds before determining payments available to hospitals in the two remaining categories.

To determine the distribution of funds between the remaining two categories – (1) other state hospitals and (2) private hospitals and all out-of-state hospitals – the weighted revenues are totaled for each category. The total for each category is then divided by the sum of both totals. For example, if the weighted revenue total for other state hospitals’ is $3 million and the weighted revenue total for private hospitals’/all out-of-state hospitals’ is $1 million, the other state hospitals’ percentage is 75 percent and the private hospitals’/out-of-state hospitals’ percentage is 25 percent. Regulations, however, mandate that other state hospitals receive at least 75.3 percent of the remaining DSH funds. As a result, in the example given, other state hospitals’ would receive 75.3 percent of remaining DSH funds not 75 percent. Private hospitals and all out-of-state hospitals would receive remaining funds.

The final step is to distribute funds within each category. Funds are distributed within each group based on the relationship of each facility’s weighted revenue total to the sum of weighted revenue totals of the category.

**DSH Caps.** Medicaid DSH funds are capped by federal policy both at the state level and at the hospital-specific level. The hospital-specific caps require that no hospital (except public hospitals in a few states) can receive reimbursement from the Medicaid program that exceeds what Medicare would pay for Medicaid plus charity care. The state-level caps were based on DSH allocations from the early 1990s, and were established to contain the federal government’s financial exposure to rapidly growing expenditures.

The total Medicaid DSH funding (Federal and State allocations) to Oklahoma health care providers was $31.3 million in FFY 2005 (Exhibit 20). The state allocated $25.5 million (82% of total DSH funds) to OU Medical Center in Oklahoma City. The remainder, $2.3 million and $3.2 million were allocated to other acute hospital providers, and IMDs (facilities that primarily provide psychiatric care), respectively.
The Medicare Modernization Act sought to correct some of the inequities that exist across states in the amount of Medicaid DSH funding available to finance indigent and Medicaid care. The Act specified that “low-DSH” states (defined as those with 0 to 3 percent of total Medicaid expenditures comprised of Medicaid DSH) would receive substantial (16 percent annual) increases in their Medicaid DSH caps between 2004 and 2009. The Oklahoma cap thus increased in Federal Fiscal Year 2004 from $16.61 million to about $19 million – and the 16 percent increases will continue unless DSH funds grow to 12 percent of total expenditures.

In response to the potential to tap a greater amount of federal DSH funding, OHCA staff are considering alternative DSH qualification and reimbursement mechanisms approaches.

3. State Funding for Medical Schools

Oklahoma support is about 64% of the national average for other publicly supported medical schools. In 2004, Oklahoma appropriated an average of $29.9 million to its medical schools compared to $46.8 million nationally.27 In 2004, $60.7 million, or 38% of state dollars directed toward medical education flowed to Tulsa hospitals (Exhibit 21).

Exhibit 20
Federal and State Medicaid DSH Funding, FFY 2005

<table>
<thead>
<tr>
<th>Type</th>
<th>Facility</th>
<th>Total Allocation (millions $)</th>
<th>Percent of DSH Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>OU Medical Center</td>
<td>$25.5</td>
<td>82%</td>
</tr>
<tr>
<td>Acute</td>
<td>All Other Acute Care Facilities</td>
<td>$2.3</td>
<td>7%</td>
</tr>
<tr>
<td>IMD</td>
<td>All IMDs</td>
<td>$3.3</td>
<td>11%</td>
</tr>
<tr>
<td>Totals</td>
<td></td>
<td>$31.1</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Lewin analysis, Oklahoma Health Care Authority.

Exhibit 21
Medicaid Medical Education Funding, 2004

<table>
<thead>
<tr>
<th>($) in Millions</th>
<th>GME</th>
<th>IME</th>
<th>DSH</th>
<th>DME</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tulsa</td>
<td>$33.2</td>
<td>$11.4</td>
<td>$0.0</td>
<td>$16.1</td>
<td>$60.7</td>
</tr>
<tr>
<td>Other</td>
<td>24.6</td>
<td>11.4</td>
<td>26.8</td>
<td>35.3</td>
<td>98.1</td>
</tr>
<tr>
<td>Total</td>
<td>$57.8</td>
<td>$22.8</td>
<td>$26.8</td>
<td>$51.4</td>
<td>$158.8</td>
</tr>
</tbody>
</table>

% to Tulsa 57% 50% 0% 31% 38%

Source: University Hospitals Authority, Association of American Medical Colleges and Liaison Committee on Medical Education.
4. **Other Current Source of Funding to Support the Safety Net**

Tulsa has numerous philanthropic organizations that actively support and meet the needs of its less fortunate citizens. Tulsa’s charitable organizations provide seed money and help sustain important community-oriented initiatives. By doing so, they provide much-needed support to organizations that lack sufficient resources to meet their not-for-profit missions. From 2002-2004, Tulsa foundations donated approximately $65.7 million, of which $14.9 million (23%) was earmarked for health care and medical research.28 These organizations include:

- George Kaiser Family Foundation
- Grace and Franklin Bernsen Foundation
- JA and Leta M Chapman Foundation
- HA and Mark K Chapman Charitable Trust
- Lyle M Gelvin Foundation
- Mervin Boviard Foundation
- Tulsa Community Foundation
- The Williams Company Foundation

While many of these foundations may not provide money for direct medical care, nor subsidize coverage for safety-net patients, they contribute towards programmatic and outreach functions of Tulsa organizations. For example, Foundation resources provide financial assistance to safety-net sites for health outreach and coordination projects, thus enabling community health centers to perform their essential role in providing access to health care.

Recent data demonstrate that local organizations in and around Tulsa have received a sizable amount of philanthropic dollars. For example, Tulsa organizations received 28 of the top 50 grants awarded in Oklahoma. $32.3 million were granted to organizations in and around the Tulsa metropolitan area.29 Some organizations, in particular, that have successfully applied for and received large grants include:

- William K. Warren Medical Research Center Tulsa
- Laureate Mental Health Corporation
- Saint John Medical Center

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28 Lewin analysis of Form 990 filed with the IRS for the periods from 2002-2004 by Tulsa area foundations listed on Guidestar.org.
29 Lewin analysis, The Foundation Center.
5. **Initiatives Underway to Support the Safety Net**

There are multiple initiatives underway at the local as well as State level to enhance safety-net delivery and/or financing. These include:

**State of Oklahoma**

- Statewide implementation of Insure Oklahoma, a premium assistance program designed to assist small business owners, the self-employed and certain unemployed individuals and their employees’ families afford and obtain health care. The state appropriation of $63 million, with an expected $126 million match to increase provider Medicaid rates to 100% of Medicare.
- Establishment of a Joint Legislative Commission to review and assess the need for state support to preserve graduate medical education programs at TRMC and thus assist OSU.

**Tulsa**

Another finding of the situation assessment is that several organizations are proceeding with plans and projects designed to enhance service provision to the uninsured an/or underinsured populations. However, all initiatives are occurring independently and lack cohesion and planned coordination of efforts. Efforts include, but are not limited to:

- Saint John’s is developing a new diagnostic imaging center that will serve uninsured residents that have been referred from the Bedlam Clinic and other designated free clinics for treatment. The new center will be located in North Tulsa in an area that has poor health status and high numbers of uninsured residents.
- Through support of the Pricare Board, the Morton FQHC and OU are collaborating to expand services in western Tulsa.
- The Morton Clinic has received expansion funding from HRSA as well as funding from the Tulsa Vision 2025 project to rebuild and expand the array of services offered.
- A new FQHC was awarded to Community Health Connections.
- OSU, utilizing funding received from Tobacco Settlement dollars, is developing a large multi-specialty clinic complex that will serve as the medical home for patients treated by OSU physicians.
- OU and OSU have begun to provide telemedicine services from Tulsa to other communities.
- The Community Healthnet, ShareLink, Health Link and Nurse Link integrative information technology supports referral linkages and tracking among human service agency and free clinic providers.
D. Situation Assessment Conclusion

The challenges faced by Tulsa’s safety-net health delivery and financing system are symptomatic of a community in critical need of coordinated, focused planning and effort. The existing deficiencies in health status, continuing high numbers of uninsured and lack of both capacity and funding to strengthen access to care for safety-net populations clearly requires a coordinated and unified approach.

It is also clear that there is no “quick fix.” Communities with safety-net strategies in place have created their systems of care over twenty or more years. Thus, Tulsa requires a strategic road map that can be put in place and achieved over the “long haul.”

Subsequent sections of this document establish strategic planning goals for Tulsa and provide strategic options and a “road-map” by which to implement the desired strategies, beginning immediately and continuing over the next fifteen to twenty years.
V. STRATEGIC PLAN GOALS

The situation assessment findings support a need for the following goals designed to strengthen health care delivery and financing for Tulsa residents.

<table>
<thead>
<tr>
<th>Strategic Plan Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase availability of services needed by indigent patients</td>
</tr>
<tr>
<td>Enhance access to care for indigent patients</td>
</tr>
<tr>
<td>- Geographic</td>
</tr>
<tr>
<td>- Financial</td>
</tr>
<tr>
<td>Reduce inappropriate utilization</td>
</tr>
<tr>
<td>Improve health status and outcomes</td>
</tr>
<tr>
<td>Stabilize and enhance financial performance of indigent care providers</td>
</tr>
<tr>
<td>Maximize resources for indigent (and Medicaid) care</td>
</tr>
</tbody>
</table>

Achieving these goals requires implementing the following recommended strategies.
VI. RECOMMENDED STRATEGIES

A. Develop a Strong, Well-Coordinated Ambulatory Care Safety-Net System for the Indigent

1. Rationale

Efficient and effective health care requires a balanced and integrated system of services designed to move patients rapidly to the most appropriate treatment setting. Many of the health care issues in Tulsa and many other communities around the nation stem from an uneven ability of many medically marginalized patients to access the full continuum of care due to financial constraints and less than optimal geographic distribution of existing services.

The cornerstone of an effective system for meeting the needs of Tulsa area residents is a strong, well-coordinated ambulatory care network. It, together with a strong medical infrastructure and coordination between care sites can serve as a focal point for reducing inappropriate ED use and hospitalizations, and contribute to improved health outcomes and population health status.

Analysis has led to important conclusions regarding how emergency rooms currently are utilized in Tulsa. These include:

1. **Inappropriate ED use is currently significant and costly.** Almost three-quarters of all Tulsa area emergency department visits in 2004 could have been seen in a more appropriate and less costly urgent care center (43%) or a physician office or clinic setting (30%).

2. **Absent effective intervention, inappropriate ED use will continue to grow due in part to factors outside the health sector’s control.** These include projected regional population growth and regional employment and health care coverage trends.

3. **Continuing the status quo is risky for all Tulsa area residents.** Future trends are likely to exacerbate stresses on the local health care delivery system and further compromise the ability of many Tulsa area residents to access needed care on a timely basis.

4. **Strategies focused solely on re-directing inappropriate ED use are likely to fail.** They will fail due to a current lack of adequate alternative capacity in the region sufficient to absorb service demand by the medically marginalized.

Therefore, any adopted strategy must seek to better balance the local health care system by building appropriate new ambulatory care capacity and improving coordination across levels of care.

2. Tactics

We considered a number of options to expand ambulatory capacity including FQHC, hospital affiliated urgi-care center, medical school/hospital collaborative HealthPlex development, as well as school health expansion. Each option and our recommendations are as follows:
a. Support Planned FQHC Expansion of Morton and Community Health Connection

Expansion of an FQHC Expansion Strategy for the Tulsa Area. In 2005, the CHA commissioned a study to examine how Tulsa could develop a FQHC network in order to expand much needed primary care capacity. The study explored a number of options including new FQHC development, establishing FQHC look-alikes and/or establishing satellites of an existing FQHC (Morton). Our research supports the study’s finding that despite the President’s New Access Point expansion initiative which boosted Federal funding to health centers by about $2.2 billion, it remains unclear to what extent additional Section 330 Federal funding for new FQHCs will be available in FY 2006. And even if additional funds become available in FY 2006, there is no certainty that Tulsa area applications would succeed in a highly competitive application review process. In 2004, less than ten percent of applications nationwide for new Section 330 funded health center sites were approved.

Strategic Issues Regarding Expansion of Current Tulsa-Area FQHC Capacity. Morton Comprehensive Health Center (Morton) is Tulsa’s only mature FQHC and is the largest community health center in Oklahoma. Several recent developments have combined to create a critical mass that proactively positions Morton to be an important component of any proposed local capacity expanding strategy. Highlights of these developments include:

- In 2003, Tulsa county voters approved a 13-year increase in the county sales tax for regional economic development and capital improvements. The package called “Vision 2025” included $14 million for Morton to construct a new 60,000 square-foot medical center in north Tulsa to replace the current facility. Expected to open in spring 2006, the new clinic is scheduled to provide expanded services and after-hours care that will result in a doubling of capacity, from 36,000 visits in 2002 to 71,000 visits.

- The Morton FQHC includes a network of three affiliated centers. One of these centers, the Nowata Family Health Center, also recently received a $295,000 federal grant to fund construction of a new health center. After completing the new center Nowata estimates it will be able to increase medical services by 50%. The annual capacity of the current center is about 4,000 visits.

- After being without a permanent chief executive officer for a number of months, Morton hired a new chief executive officer in the summer of 2005 who is reportedly committed to the expansion of the health center and finding new funding sources to enable Morton to serve more uninsured Tulsans.

Most recently, in December 2005, Community Health Connection, Tulsa’s second and newest FQHC was scheduled to receive a Federal New Access Point grant of $650,000, pending availability of FY 2006 funds.

Together, these recent developments promise to phase-in significant new ambulatory care capacity over the next few years in areas in and around Tulsa where the medically marginalized reside, offering more appropriate access points to care than local EDs. For all of FQHCs benefits, historically, many FQHCs have had problems, including the need for stable and experienced administrative support and difficulties with coordinating the provision of diagnostic and specialty care associated with the provision of primary care.
Given these known FQHC challenges, it is highly likely that the existing FQHCs will take several years to stabilize their operations and establish services. We therefore believe that in the short term, FQHC expansion beyond activities already underway would be extremely challenging.

Looking beyond the near future (0-3 years), a time frame during which Morton and Community Health Connection will be increasing capacity and building their financial health and operational stability, these entities may wish to consider forming a practice management network. If the parties agree, an independent network could be established to integrate, and provide via contract, appropriate management and administrative functions. Minimizing duplication of these functions across health centers should achieve cost efficiencies. Examples of functions whose integration may lead to cost savings include human resource and finance functions and procurement.

Integrating procurement functions also offers the potential for additional cost savings stemming from taking advantage of bulk purchasing discounts available through participation in group purchasing organizations (GPOs). Health centers may realize cost savings through favorable pricing on equipment and supplies purchased when they avail themselves of GPO contracts with manufacturers. Other benefits of GPO membership include such value-added services as technology assessment and professional education.

**Strategic Issues Regarding a Tulsa Area FQHC Look-Alike Conversion Strategy.** FQHC look-alikes are another HRSA program to strengthen the safety-net for at risk populations. The program has grown from an initial 28 designations in 1991 to 111 designated health centers, with 182 sites providing primary care services to over 1.1 million users. To date, about 40 FQHC look-alikes have also successfully competed for Section 330 funding.

An FQHC look-alike is an organization that meets all of the eligibility requirements of an FQHC, but does not receive a Section 330 grant. FQHC look-alike status is not competitive, yet still provides a number of FQHC benefits, including enhanced Medicaid prospective payment levels and Medicare cost based payments, PHS Drug Pricing Discounts, coverage under the Federal Tort Claims Act, and access to DHHS out-stationed eligibility workers.

Because look-alikes meet FQHC eligibility requirements, HRSA regards them as mature applicants for Section 330 funding. HRSA also expects FQHC look-alikes to break even financially in three-four years through revenue diversification and effective leveraging of public-private resources.

While appearing initially attractive, several program-related and Tulsa-specific issues emerged that combined to render this strategy based on converting existing clinic sites to FQHC Look-Alikes unviable.

HRSA requires that FQHC look-alikes be located in and/or serve a medically underserved area (MUA) or medically underserved population (MUP). As depicted in the map below, currently only about 10 clinics are located in or serve Tulsa-area MUA’s/MUP’s. These include clinics of

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30 As recommended in the report: Structural and Strategic Considerations For Establishing An Expanded FQHC Network in Tulsa.
various sizes and affiliations, ranging from Oklahoma University (OU) and Oklahoma State University (OSU) to very small clinics and clinics serving narrowly defined populations. (Exhibit 22)

### Exhibit 22

**Tulsa Clinics in HRSA Designated Shortage/Underserved Areas**

As pointed out in a recent analysis examining the feasibility of undertaking an FQHC expansion strategy in Tulsa,\(^{31}\) in order to qualify for FQHC look-alike designation these clinics would be required to reorganize their clinic governance, administration, and operating policies to meet HRSA requirements. These include a legislative mandate that FQHC look-alike governing boards be comprised of a consumer majority with decision-making power over budget, selection of an executive director, and the establishment of service provision priorities.

Although opportunities may exist to reorganize the OU and OSU clinics under a co-applicant arrangement between OU/OSU partnered with a single community board, it is not clear that this arrangement would receive timely support from university and hospital administration and governing boards. This governance issue also complicates any participation by other specific purpose clinics, such as Planned Parenthood.

**b. Establish Two New Tulsa Area “HealthPlex” Comprehensive Care Centers**

In addition to supporting planned FQHC expansions, Lewin recommends that consideration be given to the development of two HealthPlex facilities. Nationally, HealthPlex comprehensive care centers have grown since their inception in the 1990s, and many believe this concept provides care more effectively and at lower cost than comparable services provided in hospital settings.

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\(^{31}\) "Structural and Strategic Considerations for Establishing an Expanded Federally Qualified Health Center Network in Tulsa; Feldesman, Tucker, Leifer, Fidell LLP, 2005."
The HealthPlex concept is flexible and offers many potential positive features. These include serving as an entry point into the delivery system and consolidating multiple services at one site. These may include access to urgent care and specialty care services, extended hours of operation, and establishing referral systems and coordination of care with other area providers (e.g., hospitals, FQHCs, and school-based health centers). The model appears to be a viable approach to better coordinate and improve access to care for the medically underserved who are currently forced to maneuver through Tulsa’s fragmented delivery system. The HealthPlex model has also shown itself to be easily adapted to meet local needs and concerns and operate in both non-profit and public settings linked to sponsoring hospitals and health systems who provide substantive tertiary care and other services.

**Case Study: INOVA.** The non-profit INOVA Health System located in Northern Virginia operates one HealthPlex facility and is in the process of building another. Patients seek emergency care in its 24-hour emergency center (licensed as part of a hospital located 9.8 miles away), undergo ambulatory surgery in a trio of sophisticated operating rooms, and schedule imaging scans, laboratory work, wellness classes, and appointments with an array of specialist physicians with offices on-site. The INOVA HealthPlex offers a wide variety of services, yet not a single overnight bed, as emergency patients stabilized at the HealthPlex are transferred into the INOVA Health System for inpatient acute care services if needed.

The INOVA HealthPlex receives ambulances, and is able to handle roughly 85% of the "typical emergency room's" volume. The other 15% represents the highest acuity patients who typically require admission.

**Case Study: St. Louis’s ConnectCare.** The St. Louis community incorporated a variant of the HealthPlex concept as an innovative way to coordinate the delivery of care for the safety-net population, as part of its ConnectCare model. The following describes the features of the ConnectCare model in terms of target population, services provided, and financing:

- ConnectCare services primarily uninsured St. Louis City and St. Louis County residents. St. Louis County residents may be referred to ConnectCare after visiting a County health clinic. ConnectCare sites also serve insured patients, though it is not their target population.

- The Smiley Urgent Care Center is ConnectCare’s flagship site, and provides over 15 specialty clinic services, including Cardiology, ENT, General Surgery, HIV/AIDS, Infectious Disease, Neurology, Women’s Health, and several others, and operates extended evening and weekend hours. The Urgent Care Center also provides diagnostic radiology, pharmacy, laboratory, patient transportation, social worker, education, health and wellness, and support group services. Physician specialists affiliated with more than 10 of St. Louis area hospitals staff the Urgent Care Center and refer patients when inpatient care is necessary.

- The program has a Utilization Management Department which coordinates patient care, the referral process, and the flow of medical information among providers for primary, specialty, emergency, and inpatient care.
We recommend the creation of two new HealthPlex facilities, located in the Northwest and Southeast areas of Tulsa to facilitate access to care for medically underserved populations that reside in those areas and currently account for most local inappropriate ED use. The strategy thus represents a direct intervention and resource designed to enhance access to urgent, emergent, specialty, and related care for these populations, and would include triage and care management resources on site.

The two new HealthPlex facilities envisioned in this recommendation would each be approximately 60,000-80,000 square feet in size, serve 50-75,000 patient visits annually and combine current technology with an array of integrated services that will allow patients to be referred to and seen in the most appropriate treatment setting. In addition to primary and preventive care services, each HealthPlex also would explore offering specialty and urgent care and maintain an outpatient pharmacy, diagnostic imaging and laboratory services, and physician offices. Patients requiring tertiary care would be referred to affiliated hospitals.

Affiliated with area hospitals and medical schools, the HealthPlex facilities would also complement and collaborate with Tulsa’s FQHCs and other community care sites through participation in a county-wide patient referral network and expanded telephone nurse triage system described below.

**Proposed Tulsa HealthPlex Governance/Organizational Model.** It is suggested that each medical school partner with one or more of the Tulsa hospitals (including Saint Francis, Saint John and/or Tulsa Regional Medical Center) under a joint operating agreement to own and manage HealthPlex operations. This arrangement would allow the Tulsa-area health care delivery and medical education communities to collaborate on an equitable basis and potentially gain access to new Federal Medicaid disproportionate share funding streams to offset the cost of providing care to the medically underserved. Services provided at the new sites that are not separately licensed, but fall under the purview of an affiliated hospital, should fall within the HHS regulatory definition of “outpatient hospital services” and be eligible for DSH payments.³²

**Proposed Tulsa HealthPlex Clinical Staffing Model.** We examined the potential benefits and challenges of both attending and resident-based staffing models for the proposed new HealthPlex facilities. Hiring specialists and other full or part-time clinical staff may be costly, and the appropriate number and mix of clinical staff may not always be available locally.

Therefore, we believe that a resident staffing model (under full-time and community part-time faculty supervision) may be a more viable approach to ensure appropriate access by the indigent patients to needed specialty care. Each HealthPlex could establish affiliation agreements with one (or both) medical schools to provide and supervise resident rotations at each site. This approach would help provide access to specialty care at a lower cost than directly employing clinicians, enhance educational opportunities, and showcase an innovative model of care for meeting the needs of the medically underserved with possible potential for more widespread replication.

Proposed Tulsa HealthPlex Financing Options. Lewin estimated a range of capital and operating costs for HealthPlex capacity under four different scenarios. Key variables in the estimates of capital costs include:

- Facility size (60,000 or 100,000 sq. ft.);
- Construction cost per square foot ($200 or $250 per sq. ft.);
- Capital spending on diagnostic and ancillary equipment ($1,000,000-$3,000,000); and
- Other equipment and furnishing (10% of construction cost).

Exhibit 23 displays the estimated capital costs for each HealthPlex facility under the different scenarios, which range from $14.2 million to $30.5 million. The smallest 60,000 square-foot HealthPlex option (Scenario 1) would accommodate fewer patient visits and is assumed to offer less specialized services, indicated by the lower level of spending on diagnostic equipment. Scenario 4 is an estimate of capital costs for a facility that offers the most comprehensive and specialized services, including CT, Ultrasound, MRI, and other diagnostic services.

<table>
<thead>
<tr>
<th>Capital Costs</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
<th>Scenario 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Square Feet</td>
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<td>60,000</td>
<td>100,000</td>
<td>100,000</td>
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<tr>
<td>Cost per Square Foot</td>
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<tr>
<td>Other Furnishings</td>
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<td>$1,500,000</td>
<td>$2,000,000</td>
<td>$2,500,000</td>
</tr>
<tr>
<td>Total</td>
<td>$14,200,000</td>
<td>$18,500,000</td>
<td>$24,000,000</td>
<td>$30,500,000</td>
</tr>
</tbody>
</table>

The estimated operating cost of a HealthPlex will vary with the volume of visits and the intensity of services offered. Conservatively, it was estimated that the 60,000 square foot model could accommodate about 60,000 visits annually, and the larger facilities under Scenarios 3 and 4 could accommodate 100,000 annual visits. Note that although these volumes are consistent with similar sized facilities, volumes could increase or decrease depending on the operating hours, space configuration, and mix of services offered.

Consistent with the above capital estimates, the operating cost per visit is projected to increase with the intensity of specialty services offered at each facility. The cost per visit under Scenario 1 is consistent with a facility offering limited ancillary and specialty services (lab, pharmacy, x-ray), whereas the per visit cost under Scenario 4 represents that of a facility providing more specialized and comprehensive services. Annual operating expenses under these scenarios are projected to range from $9.0 million to $22.5 million.
Multiple funding sources will be necessary to ensure the long-term financial viability of the HealthPlex model. Expected payment sources include third-party reimbursement, foundation and other philanthropic support, and possible Federal Medicaid disproportionate share (DSH) dollars.

For the HealthPlex operations to yield DSH funds, they must (under current federal rules) be licensed as part of a hospital. The legislative agenda recommended later in this plan suggests mechanisms that could allow incremental DSH funding to flow to the hospitals that sponsor the recommended HealthPlex programs.

Although these two facilities may initially operate at a loss until all sources of funding are available, their deficits would be far smaller than care provided in any new Tulsa safety-net hospital. Additionally, they have the strong potential to reduce uncompensated care at area hospitals. We understand that private foundations in Tulsa may be willing to provide grants to ensure bridge funding. This could be a useful funding source to help ensure adequate cash flow and address initial operating deficits as the HealthPlex sites rapidly build capacity and a diversified, sustainable funding stream.

In conclusion, creating an expanded network through new HealthPlex capacity, building on the momentum fostered by the Vision 2025 initiative and other ambulatory care expansions described in this plan are likely, in conjunction with coordination enhancing initiatives, to bring significant benefits to the Tulsa area health care system. Nearer-term benefits are likely to include reduced inappropriate ED use and hospital admissions and improved health outcomes for the uninsured and other safety-net populations.

In the longer term, a better balanced and less fragmented network of care promises to achieve sustainable improvements in a number of important health status and lifestyle indicators. These may include mortality rates for chronic and communicable diseases, improved perinatal health status, disease prevention, and racial disparities in health outcomes.

c. Expansion of School-based Health Centers.

Lewin supports the further expansion of school-based health centers in the Tulsa area, recognizing that over the past thirty years, they have become an increasingly familiar part of the nation’s child health safety-net and mainstream health care. School-based health centers now
total over 1,500 and provide medical, behavioral, and other health care to several million children annually at locations accessible to children and their families.33

They serve a useful role in detecting illness early and help to avoid unnecessary ED and hospital use. In addition, expanding school-based health center capacity is an appropriate response to the fact that today’s cohort of school-aged children approaches the largest ever and, by 2010, will match the record-breaking baby boom level of 1970.

Nationally, as of 1999, an average school-based health center operating budget was about $170,000 annually. To support their operations, centers historically have relied on six major sources of funding. These include state government (29%), local government (20%), local in-kind sources (17%), private grants and donations (14%), patient revenue (12%) and the federal government (8%).34 State grant funding is the largest source of school-based health center funding-through state general funds (38%), the Maternal and Child Health Block Grant (15%) and, more recently, through tobacco tax and tobacco settlement funds (35%).

Case Study: Bedlam Clinic. An excellent example of a school-based health center is the Bedlam Clinic, open since August 2003, is run by OU Medical School students supervised by volunteer physicians from that medical school. As the clinic grew, OU expanded its services to the poorest communities in Tulsa County by establishing three school-based clinics.

Each is open daily for four to eight hours, staffed by non-physician providers, social workers and outreach workers supervised by a family medicine physician. The OU Pediatric Clinic and Family Medicine Clinic provide hospital coverage. Funding is reportedly secure for five years, through a fund of private donations that covers uninsured students, a large number of students who qualify for Medicaid reimbursement, and those covered by their families commercial health insurance.

We believe that certain distinguishing features of the school-based health center model established by the Bedlam Clinic at Union’s Clark Elementary School in 2005 make it worthy of consideration for more widespread replication in other Tulsa-area school districts. These include:

- The clinic provides preventive health care, physical exams, immunizations and same-day treatment for common ailments and typical childhood illnesses. For those who are uninsured, services are free and the enrollment process is streamlined.
- The clinic at Clark Elementary School has achieved sufficient capacity to open its enrollment to include students and their families from six other designated Union district schools. This “hub and spokes” network development strategy has several features favoring its further “spread.” It has expanded the catchment area for community access to primary and preventive care for children, while taking advantage of economies of scale offered by centralizing care at a single site.

34 “School-Based Health Center Revenue,” Data from 1999-2000 School-Based Health Center Finance Survey, National Assembly on School-Based Health Care.
Expanding this model to additional local school districts, coupled with expanding hours of operation at each school health center to a minimum of eight hours daily appears to be a strategy that should meaningfully reduce inappropriate ED use and hospitalizations by children and provide the types of primary and preventive services that have contributed to improved health status in other communities.

Financing continued expansion of school-based health center capacity based on this model will likely depend upon a mosaic of funding sources and shrewd management. In addition to current funding sources, other possible future funding strategies that Tulsa area stakeholders may consider pursuing include the following approaches:

- Ensuring through legislative action that school-based health centers receive a portion of tobacco settlement and tobacco tax dollars, as was enacted in Maine. Currently, interest generated from Oklahoma’s Tobacco Settlement Endowment Trust Fund is authorized to be spent on a variety of tobacco use prevention and other health related programs, including children’s health. Lobbying for an annual set-aside of funding to support school-based health centers state-wide could help subsidize care to uninsured children.

- Explore leveraging the fact that Congress, state legislators and Medicaid directors can mandate that school-based health centers be included in Medicaid managed care provider networks, as is done by the Connecticut Department of Public Health.

- Explore pursuing congressional support for offering school-based health centers an enhanced Medicaid payment rate that reflects their actual costs of care, as is the case for community health centers.

Improving Coordination of Care throughout the Tulsa Area. Many Tulsa area stakeholders believe, and the experiences of other communities confirm, that growth in ambulatory care capacity needs to be accompanied by improved care coordination to effectively reduce inappropriate ED use and fragmentation of care. Improving care coordination will require community-wide involvement and linkages. At the provider level, key features will likely include such mechanisms as:

- Establishing county-wide, contractually-based and protocol-driven patient referral linkages between hospital EDs, FQHCs, HealthPlex sites, other clinics, and urgent care centers to reduce fragmentation of care.

- Use of a Web-based system to coordinate patient referrals from EDs to urgent care centers and community-based clinics, coupled with use of common IT and data reporting systems and integrating patient medical records to follow patients across sites of care.

At the community level, Tulsa residents should consider:

- Integrating the current 211 system operated by the Community Services Council with a 24/7 telephone nurse triage clinical care referral system (that can be housed at HealthPlex sites) to provide both counseling and referral services county-wide.
**Case Study: The Cook County, Illinois Bureau of Health Services Referral Network.**

The following case-study describes a model for improving care coordination for medically disadvantaged residents through development of a referral network between hospital EDs and community based clinics. The case study is followed by a discussion of opportunities and challenges this type of network may present for Tulsa.

*Program Description:* Since 1985, Cook County has maintained a contractually based referral system with both affiliated and non-affiliated community-based clinics. The referral network allows patients presenting with a non-emergent condition at the ED of any of the county’s three hospitals to be referred to either Cook County’s Ambulatory & Community Health Network or non-affiliated community-based clinics for more medically appropriate care.

The referral system further enhances coordination of care by allowing medically underserved patients access to specialty care through referrals to county hospitals from county affiliated and non-affiliated community-based clinics and FQHCs.

*Key Features of the Referral Network:* Clinics in the network and the county hospitals utilize a Web-based referral system that coordinates patient referrals from EDs to community-based clinics located as near the patient’s residence as possible to minimize travel time. Primary Care Physicians must abide by referral rules detailed in the Web-based system. *To date, this system has reportedly increased specialty appointment capacity by 22%.*35

*Implications of the Cook County Referral Network for the Tulsa Area:* In order to develop this network, we believe an entity, such as an expanded and strengthened Tulsa Community Hospitals Authority, will have to support coordinating referrals in a linked network by assuming leadership in brokering relationships with ambulatory care sites and hospital providers, including developing protocols for directing referrals and rights to any reimbursement. It would be appropriate for all parties to agree to share costs, reach consensus on equitable allocation of referrals and other details to manage the cost and operations of the system.

Building on the concept of community partnership by managing the flow and location of services to benefit patients by referring them to needed services as close to home as possible and benefit institutions by directing patients where service is available. Increasing access to appropriate primary and specialty care by supporting the building and expanding of a fully standardized Web-based referral system.

d. **Expanding Tulsa’s 211 System to Include a Telephone Nurse Triage Clinical Care Referral System**

Establishing a Telephone Nurse Triage Clinical Care Referral System to complement Tulsa’s existing and effective 211 Helpline system will provide local residents with an alternative to seeking emergency care for non-emergent conditions. The objective of Tulsa’s Telephone Nurse Triage System (TNT) would be to implement a community-wide TNT system that operates 24 hours/day, seven days a week with at least bilingual capacity. The proposed service would be available to residents of the same catchment area served by the 211 Helpline. These include Tulsa, Creek, Rogers, Okmulgee, Osage and Wagoner counties.

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The system would be organized to offer guidance and direct callers to the appropriate level of care to address their health care issue(s). These levels of care include self care, next day appointments, urgent care and/or emergent care.

The Tulsa area TNT should have the capacity to handle several hundred calls daily by the end of its first full year of operation. Based upon the experiences of the Denver Health Nurse Line, when fully operational the program would be expected to produce about a ten percent reduction in ED visits for care that are determined to be non-emergent. As future additional capacity phases in, we would expect this program to contribute to even greater reductions in inappropriate ED use.

If it agrees, the new Tulsa area TNT could be operated by the Community Service Council of Greater Tulsa and hopefully leverage financial support from both the organizations that currently fund the 211 Helpline and local provider organizations. These include local hospitals, foundations, the Tulsa Area United Way, grants from the city of Tulsa, and state and federal funding through the Oklahoma Department of Health.

CentraMax is a protocol-driven computerized software system for nurse triage used by many similar systems nationwide. Funding of this, or another comparable system, would allow Tulsa to begin developing and testing a pilot for a community-wide system that would enable residents to call one number and talk to a registered nurse. We would anticipate that other early system implementation activities would include:

- Review and approval of clinical protocols.
- Training of RNs and interpreters.
- Development and initiation of a small media marketing campaign.

**B. Implement Community Wide Programs that Improve Health Care Outcomes**

**1. Rationale**

Given Tulsans poor health status coupled with low income and lack of insurance, it is crucial to improve both access to health care as well as the breadth of health care services for this population.

An individual’s or population’s health status results from a number of factors including genetic makeup, environmental conditions, lifestyle behaviors, access to health care, social support systems, and many others. Some factors, such as genetic makeup, cannot be altered, whereas others like lifestyle and access to medical services can be influenced. According to the National Civic League, lifestyle behaviors are the largest determinant of an individual’s health status (Exhibit 25).
Health Status Determinant: Lifestyle

While health care organization may face significant challenges in attempting to create widespread lifestyle change in a specific population, the Institute of Medicine has recognized the importance of making lifestyle and behavioral changes a focus of community health initiatives:

“Approximately half of all causes of mortality in the United States are linked to social and behavioral factors such as smoking, diet, alcohol use, sedentary lifestyle, and accidents. Yet less than 5% of the approximately $1 trillion spent annually on health care in the United States is devoted to reducing risks posed by these preventable conditions. Behavioral and social interventions therefore offer great promise to reduce morbidity and mortality, but as yet their potential to improve the public’s health has been relatively poorly tapped.”

Research from the University of Oklahoma indicates that Oklahomans’ poor health status as compared to the nation is mostly due to cultural health values and beliefs that are “ingrained in the behaviors of Oklahomans.”

2. Tactics

a. Develop disease management programs

We believe you should consider the creation of a pilot Chronic Disease Program, as has been developed successfully in communities across the country. Chronic disease program goals are to improve a patient’s ability to manage chronic disease, improve the level of care clients receive and decreased the costs of care through improved self-management, including reducing

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inappropriate ED visits. Essential program components include advanced information tracking and accounting, decision support and protocols for clinicians and self-management programs. A unique aspect of the program is the use of health coaches who are lay workers (paraprofessionals) from the neighborhood. They function as case managers, tracking patients, making home visits, and educating them on their diseases, medications, etc. Training community residents to perform home visits is less expensive than using health professionals.

Below are examples of two large scale care management programs that could be adapted by one or more Tulsa providers that are aimed at influencing lifestyle and behavior patterns that contribute to major health issues facing residents of Tulsa.

**Case Study: The Grace Hill Neighborhood Health Center.** In 1998, The Grace Hill Neighborhood Health Center launched the C.I.R.C.L.E. of Care Chronic Disease Program focuses on improving health care outcomes. The program goals are to improve the patient’s ability to manage chronic disease, improve the level of care clients receive, and decrease the costs of care through improved self-management.

The essential components of the program are:

- advanced information, tracking and accounting;
- system redesign, as part of the Institute for Healthcare Improvement (IHI);
- decision support and protocols for clinicians; and
- self-management programs

The program utilizes health coaches who are lay workers (paraprofessionals) from the neighborhood. The coaches, who are paid for their time, are trained to take blood pressure and respiration measures. They function as case managers, tracking patients, making home visits, and educating them on their diseases, medications, etc. There are currently six coaches funded by national grants, and approximately 25,000 patients, who are mainly uninsured or Medicaid patients. The coaches work with teams of six or seven people, including physicians, nurses, nutritionists, etc. The program, which is based on Ed Wagner’s Chronic Care Model, covers diabetes, hypertension, asthma, and cancer. There are five sites. Training community residents to perform home visits is less expensive than using health professionals.

Patients also participate in “cluster visits,” which are meetings of patients at the hospital. At the cluster visits, patients see the doctor to have their hemoglobin and glucose checked, and to learn about such things as reading labels, preparing healthy foods for holiday meals, etc.

The organization has an information and management tracking system and clinical guidelines for asthma, diabetes, CVD, smoking, and breast and cervical cancer. The IT system was developed in-house that allows access to patients’ electronic records from multiple sites.
Case Study: The Jackson Health System care management program began in 1996. Initially, the program focused exclusively on managing diabetes. There was one half-time FTE to run the pilot project with 50 patients for one year. The pilot showed a reduction of 50 ER visits per year and a savings of $4 for every $1 spent on the FTE. There are now 180 – 190 employees (out of 10,000 employees in the system) in the care management program, two coordinators, and thirty care managers. Diseases include asthma, diabetes, pediatric diabetes, high-risk obstetrics, hypertension, renal-care management, obesity, HIV, and cancer, depending on the funding source. Patients are either referred, they self-refer, or they are identified from hospital claims data.

The diabetes and renal-care management programs have been in place since 1995 and 1997, respectively. Jackson has observed a decrease in total hospitals admissions and lengths of stay and a reduction of costs associated with these factors. The hypertension program has resulted in decreased A1c levels, decreased lipid levels, and decreased ED room visits for its diabetic patients.

Jackson has invested in a “home-grown” software and computer tracking system to collect and analyze data on its chronic disease patients and to evaluate program effectiveness. New clients are assessed to determine risk. The “risk stratification” determines the frequency of contacts. Patients interact either in person or by phone with registered nurses, dieticians, respiratory therapists, etc. There are also group classes held in 3 languages—English, Spanish and Creole. The care management is provided within the primary care setting so there is interaction with the provider and patient at the same time. Patient education materials are supplied primarily by pharmaceutical companies, and are also translated into multiple languages.

Most of the clients are minorities; many are African American or immigrants from Central or South America or the Caribbean. The program is therefore designed to improve healthcare outcomes and reduce health disparities in these populations.

b. Develop standardized policies for improving access

The medically indigent often experience financial barriers that significantly limit their ability to appropriately access the safety-net health care system for their outpatient needs. We recommend the development of a standardized uncompensated care policy across outpatient primary and specialty care safety-net providers and conduct a standardized review of eligibility for reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency. We also recommend that consideration be given to the development of a regional ombudsmen to help safety-net consumers access/navigate the system and to assist with key financial counseling issues.
Case Study: The St. Louis Regional Health Commission (RHC). The RHC is a collaborative effort of St. Louis City, St. Louis County, the State of Missouri, health providers, and community members to improve the health of uninsured and underinsured citizens in St. Louis City and County. In 2003, the RHC completed *Building a Healthier St. Louis*, an assessment of the region’s health status and the region’s health care safety-net primary care and specialty care delivery system. In 2004, the RHC released recommendations for improving the region’s health care safety net. Specific recommendations are detailed below.

To reduce medical debt, the RHC has recommended four responses:

- Develop a standardized uncompensated care policy across outpatient primary and specialty care safety-net providers;
- Identify administrative barriers to Medicaid coverage determinations and conduct staff training sessions on Medicaid eligibility and policies;
- Develop a regional ombudsmen program to help safety-net consumers access/navigate the system and to assist with key financial counseling issues; and
- Safety-net providers conduct a standardized review of eligibility for reduced fees and financial counseling prior to reporting uninsured patients with overdue payments to a collection agency.

To reduce the cost of catastrophic hospital care for patients, the RHC has recommended:

- Convene area hospital leadership with community representatives to develop effective solutions to medical debt, uncompensated care and billing, and to generate other ideas for reducing financial barriers to care within the boundaries of the law.

To reduce the lack of insurance and barriers to care, the RHC has recommended:

- Develop a uniform “no turn-away due to inability to pay” policy across outpatient safety-net providers;
- Advocate for maintenance and expansion of Medicaid coverage; and
- Coordinate with the State of Missouri and existing entities to examine the development of a statewide or local insurance program for low-income uninsured residents.

To break down these cultural and informational barriers, the RHC has recommended the following efforts:

- Regularly assess, report and set goals for reducing cultural and racial barriers to safety-net care;
- Institute service quality training programs and cultural sensitivity training programs;
- Integrate cross-cultural education into CME sessions for health care professionals;
- Develop a comprehensive coordinated marketing campaign to raise awareness about the safety-net system and how to access care;
- Develop a coordinated health literacy program and campaign; and
- Develop a minority health professional recruitment and retention program for the primary and specialty care safety-net.

37 “Recommendations for Improving Safety Net Primary and Specialty Care Services in St. Louis City and County”, St. Louis Regional Health Commission, October 2003.
C. Consider Creation of a “Virtual” Safety-net to Achieve Safety-Net Hospital Benefits

1. Rationale

In recent months, much discussion in Tulsa has focused on the fact that Tulsa does not have a public or private safety-net hospital. Discussions with stakeholders indicate that there is a lack of clarity regarding what constitutes a safety-net hospital and what are the attributes required of a safety-net provider hospital. For purposes of clarification and discussion, in this document, we:

- Provide a generally accepted definition of a safety-net hospital;
- Describe the characteristics of a safety-net hospital;
- Assess Tulsa hospitals capabilities, readiness and/or interest in meeting safety-net hospital criteria; and
- Discuss creating a “virtual” safety-net in lieu of converting an existing hospital or building a new hospital.

According to the National Association of Public Hospitals and Health Systems (NAPH), a safety-net hospital is “a hospital or health system that provides a significant level of care to low-income, uninsured, and vulnerable populations.” A hospital’s type of ownership is not considered in this broad definition, and as such, safety-net hospitals throughout the country range from government to publicly to privately owned and may be non-profit or for-profit institutions. As the definition suggests, safety-net hospitals are committed to providing access to care for individuals whose financial or insurance status or health condition limits their access to health care. Consequently, there are two main distinguishing characteristics:

- A stated mission and “open door” policy through which the hospitals offer access to services regardless of ability to pay; and
- The uninsured, Medicaid recipients, and other vulnerable populations make up a substantial share of the patient mix.

To fulfill the stated mission to serve the medically indigent, safety-net hospitals typically:

- Are geographically located in reasonable proximity to the targeted populations.
- Have dedicated physicians to staff the hospital and either are a teaching hospital or are affiliated with an academic medical center or medical school. According to the NAPH, 84% of NAPH members are teaching hospitals according to ACGME standards. In 2003, public hospitals trained 30% of medical and dental residents, and 47 percent of allied health professionals in their market. Thus safety-net hospitals serve as training sites for primary care as well as specialty physicians.
- Provide a broad array of services to meet the needs of indigent populations, and tend to offer a high level of care, including such services as trauma and behavioral health. The comprehensive service array, including tertiary care is provided in part to meet the
needs of the medically indigent, but also to support training of physicians, which requires providing complex as well as routine patient care.

- Operation of primary care and specialty outpatient clinics, staffed primarily by residents, to help channel non-emergency cases to more appropriate settings of care. In 2002, the average publicly sponsored health system provided 368,318 outpatient visits.

- Are culturally sensitive to the needs of diverse populations, providing supportive services including offering financial counseling, transportation assistance, etc.

- Experience a payer mix skewed towards those revenue sources relied upon to cover the expense of indigent health care: Medicaid, State/Local Subsidies including DSH, Self-Pay/Other. Notably, NAPH members received 15% of revenue directed at uncompensated care from some sort of State or local subsidy.

Five hospitals compose the main source of hospital-based health care in Tulsa. Based on our considerable work with and for safety-net hospitals across the country, we have determined that no one Tulsa hospital meets all of the requisite attributes of a safety-net hospital.

While meeting the needs of safety-net populations has been of concern, of equal concern is the fact that funding for indigent care differs significantly in Tulsa. None of the five Tulsa hospitals receive state or local subsidies. In addition, given the lack of a safety-net designated hospital, no one hospital has the critical mass of medically indigent care to qualify for Medicaid DSH payments. Consequently the hospitals suffer an overall shortfall in funding as they are forced to rely on only GME funding and Medicare DSH for supplemental support. In 2002, while providing $187 million in care to the medically indigent, Tulsa’s hospitals received $131 million in payments and other offsets and lost $56 million in un-reimbursed expenses (Exhibit 26).
Four Tulsa hospitals (excluding Southcrest) will report $63 million in charity care expenses in 2005, not including bad debt. This represents approximately 40% of all the charity care in the state of Oklahoma.\textsuperscript{38}

Thus, given the lack of a hospital focused specifically on meeting the needs of the medically indigent and as a key funding source is not available to the Tulsa provider community to support indigent care delivery, creating a safety-net hospital has been worthy of consideration.

\textbf{2. Tactics}

While an analysis assessing the feasibility of a safety-net hospital was beyond the scope of this engagement, we have determined that the size of the uninsured/underinsured population (approximately 300,000) would require a hospital with anywhere from 150-200 med/surg beds. In addition, a safety-net hospital would need to meet all of its associated attributes: geographic proximity to the medically indigent, providing comprehensive primary and specialty clinics, full affiliation with a comprehensive medical school, discounted charity care policies and cultural competency. At the current time no Tulsa hospital meets all of these requirements, and it would be extremely costly to pursue this strategy.

\textsuperscript{38} Provided by Mike LaPolla
While the issues are not insurmountable, we believe that in the short term resources should be devoted to creating a “virtual” safety-net by defining the essential roles that current stakeholders should play to meet the desired vision of measurably strengthening the Tulsa safety-net delivery system.

Our view is that while important, getting access to DSH dollars should not be the driving force beyond the need for a safety-net hospital, and we provide several suggestions regarding DSH opportunities in the funding section of this document.

That being said, in the long-term, if there is consensus among stakeholders that a safety-net hospital strategy should be pursued, a detailed programmatic, bed and ambulatory care assessment and financial feasibility study needs to occur.

D. Support the Strengthening and Coordination of Graduate Medical Education Training

1. Rationale

In recent years, the relationship between medical education and delivery of health care to the indigent has grown in importance due to the rising number of uninsured and the escalating costs of providing health care.

Tulsa’s two medical schools are the University of Oklahoma College of Medicine and the Oklahoma State University Center for Health Sciences College of Osteopathic Medicine. The Tulsa medical schools are an important resource for Tulsa residents, each having a long and unique tradition of service to the Tulsa community.

The University of Oklahoma (OU) College of Medicine’s main campus is in Oklahoma City, but Tulsa is home to a community-based medical school campus. In comparison to the Oklahoma City campus of the College of Medicine, the program on the Tulsa campus is smaller, with fewer students, faculty members, and clinical science departments.

The OU College of Medicine-Tulsa has 12 residency and fellowship programs, including family medicine, sports medicine, general surgery, internal medicine, ob/gyn, psychiatry, pediatrics, emergency care, and rural medicine.

While the school is a college of allopathic medicine, the residencies are marketed to graduates of both allopathic and osteopathic medical programs. OU College of Medicine’s oversight of residency programs on both campuses is conducted through the Graduate Medical Education Committee and the Associate Dean for Graduate Medical Education. OU provides clinical services and educational programs in a community based settings. This includes working in partnership with the Tulsa Medical Education Foundation (TMEF) “to foster excellence in medical education and research and to deliver health care services to the people of northeastern Oklahoma.” The TMEF is a consortium of the three teaching hospitals affiliated with the medical school: Hillcrest Medical Center, Saint Francis Hospital, and Saint John Medical Center. In Tulsa, OU College of Medicine has access to more than 2,000 teaching beds, has 19 clinics. Five sites provide most of the indigent care in Tulsa with 140,000 visits across the region and affiliations with over 30 safety-net clinics and community health agencies.
The Oklahoma State University (OSU) Center for Health Sciences in Tulsa is home to the OSU College of Osteopathic Medicine. The OSU medical school also has 15 specialty and subspecialty areas, including anesthesiology, diagnostic radiology, emergency medicine, family medicine, general surgery, internal medicine, pediatrics, ob/gyn, orthopedics, ophthalmology, otolaryngology, cardiology, interventional radiology, nephrology, and sports medicine. Tulsa Regional Medical Center (TRMC), founded in 1944, was Oklahoma’s first osteopathic hospital, pre-dating the University program, at which time TRMC became the teaching hospital for the college. OSU has 2,065 medical graduates who are practicing in nearly all of Oklahoma’s 77 counties. OSU physician faculty administer more than 100,000 patient visits each year, and 70% of patients at TRMC are managed by OSU faculty. OSU’s largest teaching clinic at Houston Parke is located adjacent to TRMC.

**Tulsa Medical Schools Challenges.** OU and OSU are an important resource and provider of care for safety-net populations. However, graduate medical education in Tulsa faces three major challenges that limit their effectiveness and support of indigent care delivery.

1. Neither school is comprehensive in scope and both lack the array of subspecialty training fellowships and residencies provided at more comprehensive medical schools. As a result, neither school is substantially able to provide needed specialty care to community residents in both inpatient and outpatient settings. Many of the residencies that are not offered in Tulsa, or are offered on a limited basis are services that are in great need among safety-net populations, including gastroenterology, urology and child and adolescent psychiatry (Exhibit 27).

<table>
<thead>
<tr>
<th>Residency Program</th>
<th>Dayton, OH</th>
<th>Birmingham, AL</th>
<th>Tulsa, OK</th>
<th>Omaha, NB</th>
<th>Knoxville, TN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>X</td>
<td>X</td>
<td>Both</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>X</td>
<td>X</td>
<td>Both</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obstetrics and Gynecology</td>
<td>X</td>
<td>X</td>
<td>Both</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Surgery-General</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>X</td>
<td></td>
<td>OSU</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Cardiovascular Disease (IM)</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Child and Adolescent Psychiatry (P)</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>X</td>
<td></td>
<td>OSU</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Gastroenterology (IM)</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Geriatric Medicine (IM)</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hematology &amp; Oncology (IM)</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Infectious Disease (IM)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Internal Medicine/Pediatrics</td>
<td>X</td>
<td></td>
<td>Both</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>X</td>
<td></td>
<td>Both</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Pathology-Anatomic &amp; Clinical</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>X</td>
<td></td>
<td>Both</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>X</td>
<td></td>
<td></td>
<td>OU</td>
<td>X</td>
</tr>
<tr>
<td>Radiology-Diagnostic</td>
<td>X</td>
<td></td>
<td>OSU</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sports Medicine (FP)</td>
<td>X</td>
<td></td>
<td>Both</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Urology</td>
<td>X</td>
<td></td>
<td>Both</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
2. Both OU-Tulsa and OSU face unique funding challenges. OU-OKC receives significantly more funding to manage its Medicaid patients than OSU or OU-Tulsa. As OU funding flows through Oklahoma City, OU-Tulsa has had less direct access to funds. At the same time, there is currently considerable unrest regarding the future of OSU’s teaching program at TRMC.

Oklahoma support is about 64% of the national average for other publicly supported medical schools. In 2004, Oklahoma appropriated an average of $29.9 million for its medical schools compared to $46.8 million nationally. In 2004, $60.7 million, or 38% of state dollars directed toward medical education flowed to Tulsa hospitals (Exhibit 28).

<table>
<thead>
<tr>
<th>($) in Millions</th>
<th>GME</th>
<th>IME</th>
<th>DSH</th>
<th>DME</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tulsa</td>
<td>$33.2</td>
<td>$11.4</td>
<td>$0.0</td>
<td>$16.1</td>
<td>$60.7</td>
</tr>
<tr>
<td>Other</td>
<td>24.6</td>
<td>11.4</td>
<td>26.8</td>
<td>35.3</td>
<td>98.1</td>
</tr>
<tr>
<td>Total</td>
<td>$57.8</td>
<td>$22.8</td>
<td>$26.8</td>
<td>$51.4</td>
<td>$158.8</td>
</tr>
<tr>
<td>% to Tulsa</td>
<td>57%</td>
<td>50%</td>
<td>0%</td>
<td>31%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Source: Lewin analysis, Oklahoma Health Care Authority

3. Greater planning and collaboration between the two schools could substantially improve the delivery of care to the indigent. Each medical school currently has plans to enhance its provision of care to the medically indigent. OU plans to substantially expand its primary care services throughout the Tulsa MSA, and OSU is constructing a primary and multi-specialty clinic. However, there are still significant gaps in service delivery as it relates to the provision of care.

### 2. Tactics

a. Develop comprehensive strategic plan for medical education that supports the provision of community-based clinical care

The Tulsa community could benefit from the development of a comprehensive strategic plan for medical education that supports the provision of community-based clinical care. The plan should focus on:

- Identifying short and long-term residency training needs both in primary and specialty care and creative slots to increase match rates;
- Developing strategies to incentivize joint planning by the two medical schools to design and deliver a more appropriate system of care, including increasing the focus on culturally appropriate outreach, case management and diagnostic care; and

39 Source: University Hospitals Authority, Association of American Medical Colleges and Liaison Committee on Medical Education.
Developing strategies to incentivize the medical schools to jointly develop new residency training programs to facilitate service provision and increase the supply of physicians to the region.

E. Implement Discounted Prescription Drug Program

1. Rationale

A significant factor in improving health outcomes is to improve patient participation when caring for their chronic diseases. Among the uninsured, three significant issues have been found with respect to medications:

- Obtaining appropriate medications,
- Acquiring adequate supplies of required medications, and
- Using medications appropriately.\(^{40}\)

To this end, medication assistance programs have been implemented around the country with the goal of giving the uninsured increased access to health care so that they can better manage their illnesses and reduce morbidity. Central to this strategy is the ability for patients to visit physicians regularly to help them understand and manage their conditions. Access to low-cost or free prescription drugs has also been shown to improve medication compliance, reduce hospitalization rates, and decrease the number of emergency room visits. The combination of access to care and prescription drugs, therefore, can be significant in improving the overall health status of uninsured populations.\(^{41}\)

Case Study: The Rapides Foundation Prescription Assistance Program. The following is a discussion of a medication assistance program that has been run successfully by the Rapides Foundation in Alexandria, Louisiana since 2001. Its discussion serves as an example of a clinic-based prescription assistance program that could be implemented in the Tulsa area.

The Rapides Foundation operates a prescription assistance program, CMAP, for low-income adults in a nine county parish area in central Louisiana. CMAP serves low-income adults by purchasing generic and brand drugs and by assisting patients in accessing the manufacturer prescription assistance programs. Prescription assistance across all three programs is limited to chronic medications – the programs do not purchase or distribute medications like antibiotics.

Eligible participants must meet the following requirements:

- Be age 18 or older,
- Not qualify for full Medicaid benefits (including prescription benefits),
- Have a chronic disease (diabetes, hypertension, asthma etc.),
- Meet income requirements.


The Rapides CMAP program is composed of three fairly distinct programs, but we discuss here the implementation of the clinic-based program, the most efficient of the three programs.

To be eligible for the clinic-based program, enrollees must be patients of the clinic and have incomes below 200% of FPL. The clinic-based program provides prescriptions by purchasing generic medications at 340B prices, by completing and dispensing individual manufacturer assistance program applications, and by administering bulk donation programs. Patients are required to pay $3 per prescription but no more than $24 total each time they visit the clinic pharmacy.

The program budget in 2004 was $1,462,000, including $885,000 for generic drug purchases and $577,000 in administrative expenses. The co-payments collected from patients are put toward the purchase of diabetic supplies, which the Rapides Foundation does not cover. The administrative expenses include salaries of staff, including pharmacists and pharmacy techs.

The clinic-based program makes use of bulk donation arrangements with a number of drug manufacturers. In these arrangements, the manufacturer ships medicine directly to the pharmacy for dispensing on-site, and the pharmacy is responsible for verifying that the patient meets the manufacturers' income and other eligibility guidelines. Such arrangements dramatically increase efficiency, reduce the need for patients to wait for their drugs, and avoid the need to burden physician office staff with paperwork. For this reason, the largest pharmacy assistance programs use this approach whenever they can.

Patients of the clinic are typically uninsured and are charged on a sliding scale. The program screens eligible patients through the already-established income eligibility process. After visiting a clinic physician, they are sent to a social services office which completes the additional paperwork and verification process for enrollment. At that time, the social workers have patients sign multiple manufacturer assistance program applications so that prescriptions can be filled prospectively. Additionally, enrollees are asked to sign a statement donating unused prescriptions to the program so that the program can keep and dispense the stock. In general, manufacturer assistance programs require that prescriptions are only dispensed to the applicant.

Because the application process is incorporated into the patient flow through the hospital, the clinic-based program has reached greater efficiency and retention. Patients are required to come into the clinic to renew eligibility and pick up prescriptions, too. The clinic-based program cannot not increase program enrollment substantially, however, because it is limited to its capacity of active patients.

There are a number of aspects to the clinic-based program that make it favorable:

- The program is incorporated into the patient flow within the clinic: patients go from check-in, to the physician, to the social services office of the program, down to the pharmacy. It is also very efficient because a lot of the application processes for manufacturer-donated drugs are automated – the social workers will renew the application at timed intervals and scripts obtained through a bulk
donation arrangement require no re-application every 3 months;

- High retention of patients is possible because the program relieves patients of the cumbersome tasks associated with enrolling in manufacturer donation programs (e.g., frequent applications and doctors signatures). Because patients sign over unused medications to the program, the program has stock to refill prescriptions if an individual application is delayed – the administrative hassles do not affect the patients;
- Most likely to improve health outcomes because program enrollees are required to see physicians in the clinic, and are required to see them regularly to continue receiving medications from the program; and
- If the sponsoring clinic is a “covered entity”\textsuperscript{42}, then it can draw down 340B drug prices for the medications purchased by the program. 340B prices are typically 49% of AWP.

There are also a number of aspects to the clinic-based program that can make it a difficult proposition:

- The program requires a large amount of organization to set up;
- There is a significant ramp-up period, especially to implement a bulk donation program arm. A new program would have to begin by purchasing generic drugs and inexpensive brands and filling individual applications on behalf of enrollees for brand drugs through manufacturer assistance programs. Bulk donation arrangements are very difficult to set up without significant experience – manufacturers will not agree to them if the program has not demonstrated need and the ability to operate a bulk donation program;
- There is a need for dedicated physical space for the staff to operate the pharmacy (pharmacists and techs) and social services office; and
- The program is administratively complex to operate. Manufacturers maintain strict rules about how stock (especially bulk donation stock) must be stored and accounted for. Bulk donation stock may not be mixed with the stock purchased by the program and donated through individual application. Manufacturers that agree to bulk donation arrangements perform regular audits of program records to ensure that only eligible patients are receiving the drugs and that all stock is accounted for.

2. Tactics

a. Implementing a Discounted Prescription Drug Program in Tulsa

As discussed above, the requirements of a clinic-based pharmacy program are that participants be active patients at the clinic, and that they pick up their prescriptions at the clinic-based pharmacy. Locating such a program in Tulsa while maximizing participation, requires that the clinic be in proximity to uninsured populations. The figure below marks the location of hospitals and clinics in the Tulsa area. The Morton Clinic appears to be central to the zip codes with large populations of uninsured (\textit{Exhibit 29}).
Another factor to consider in locating the pharmacy is whether the hosting clinic is a “covered entity” eligible for 340B pricing. As an FQHC, Morton would be eligible to serve as a covered-clinic site for such a program. If Morton were to partner with the Bedlam clinic, additional uninsured residents could be served.

The Rapides Foundation program costs are outlined in the following figure and provide a foundation for estimating a Tulsa program. Total costs per member per year totaled $360. Drug costs accounted for 61 percent of the total cost (Exhibit 30).

### Exhibit 30
Estimated Cost of the Rapides Foundation Clinic-based Pharmacy

<table>
<thead>
<tr>
<th></th>
<th>Drug</th>
<th>Administrative</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMPY</td>
<td>$218</td>
<td>$142</td>
<td>$360</td>
</tr>
</tbody>
</table>

There are two perspectives to consider when estimating the total cost of implementing clinic-based pharmacy programs in the Tulsa area: the cost of one clinic-based program, and the cost of covering all uninsured in the area. While the latter scenario is unlikely to transpire (not every uninsured will participate, and not every willing candidate will qualify), it is worth considering. As described below, a program covering 5,000 patients is estimated to cost $1.8 million (the
Rapides Foundation program covered approximately 4,000 individuals at a cost of $1.46 million (Exhibit 31).

### Exhibit 31
Estimated Cost of One Clinic-based Pharmacy in Tulsa

<table>
<thead>
<tr>
<th>Persons Covered</th>
<th>Drug</th>
<th>Administrative</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,000</td>
<td>$2,180,000</td>
<td>$1,420,000</td>
<td>$3,600,000</td>
</tr>
<tr>
<td>7,500</td>
<td>$1,635,000</td>
<td>$1,065,000</td>
<td>$2,700,000</td>
</tr>
<tr>
<td>5,000</td>
<td>$1,090,000</td>
<td>$710,000</td>
<td>$1,800,000</td>
</tr>
<tr>
<td>2,500</td>
<td>$545,000</td>
<td>$355,000</td>
<td>$900,000</td>
</tr>
<tr>
<td>1,500</td>
<td>$327,000</td>
<td>$213,000</td>
<td>$540,000</td>
</tr>
<tr>
<td>1,000</td>
<td>$218,000</td>
<td>$142,000</td>
<td>$360,000</td>
</tr>
</tbody>
</table>

If several prescription assistance programs were implemented throughout the Tulsa region, it is conceivable that a significant portion of the uninsured population in the seven county area could participate. Assuming an additive nature, the cost of several programs would vary depending on the proportion of the uninsured population covered (Exhibit 32).

### Exhibit 32
Estimated Cost of Covering Uninsured in the Tulsa Area Through Multiple Clinic-based Pharmacies

<table>
<thead>
<tr>
<th>Persons Covered</th>
<th>Percent Uninsured</th>
<th>Drug</th>
<th>Administrative</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Seven County Area</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>166,306</td>
<td>100%</td>
<td>$36,254,708</td>
<td>$23,615,452</td>
<td>$59,870,160</td>
</tr>
<tr>
<td>133,045</td>
<td>80%</td>
<td>$29,003,766</td>
<td>$18,892,362</td>
<td>$47,896,128</td>
</tr>
<tr>
<td>99,784</td>
<td>60%</td>
<td>$21,752,825</td>
<td>$14,169,271</td>
<td>$35,922,096</td>
</tr>
<tr>
<td>66,522</td>
<td>40%</td>
<td>$14,501,883</td>
<td>$9,446,181</td>
<td>$23,948,064</td>
</tr>
<tr>
<td>33,261</td>
<td>20%</td>
<td>$7,250,942</td>
<td>$4,723,090</td>
<td>$11,974,032</td>
</tr>
<tr>
<td>16,631</td>
<td>10%</td>
<td>$3,625,471</td>
<td>$2,361,545</td>
<td>$5,987,016</td>
</tr>
<tr>
<td><strong>Tulsa County</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>109,374</td>
<td>100%</td>
<td>$23,843,532</td>
<td>$15,531,108</td>
<td>$39,374,640</td>
</tr>
<tr>
<td>87,499</td>
<td>80%</td>
<td>$19,074,826</td>
<td>$12,424,886</td>
<td>$31,499,712</td>
</tr>
<tr>
<td>65,624</td>
<td>60%</td>
<td>$14,306,119</td>
<td>$9,318,665</td>
<td>$23,624,784</td>
</tr>
<tr>
<td>43,750</td>
<td>40%</td>
<td>$9,537,413</td>
<td>$6,212,443</td>
<td>$15,749,856</td>
</tr>
<tr>
<td>21,875</td>
<td>20%</td>
<td>$4,768,706</td>
<td>$3,106,222</td>
<td>$7,874,928</td>
</tr>
<tr>
<td>10,937</td>
<td>10%</td>
<td>$2,384,353</td>
<td>$1,553,111</td>
<td>$3,937,464</td>
</tr>
</tbody>
</table>
F. Support Insure Oklahoma Initiative

1. Rationale

Insure Oklahoma (O-EPIC) represents a major initiative for the State that, if successful, will expand coverage and attract substantial federal funding. Patients and providers would benefit from initiatives that help encourage adoption and implementation of the program, and this strategic plan therefore suggests:

- Development of a regional campaign to build awareness about the program;
- Implementing specific policies and procedures at all patient care delivery sites to encourage employers and individuals to participate in the program; including
- The offering of financial incentives to encourage adoption.

Insure Oklahoma was designed to assist uninsured Oklahomans with the purchase of health benefits. The program is the result of the joint effort between Governor Henry, state policymakers, the Oklahoma Health Care Authority (OHCA), and other organizations. In April 2004, Senate Bill 1546 authorized the Oklahoma Health Care Authority to develop a program to assist eligible adults, defined as those who are 19 to 64 years of age, and are at or below 185%.

Subsequent to an OHCA administered study of strategies to cover the uninsured, Oklahomans passed the Oklahoma Health Care Initiative (State Question 713) in November 2004, which provided designated funds to support Insure Oklahoma, and the creation of the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program. O-EPIC administers Insure Oklahoma, and provides two ways which eligible Oklahoma residents to participate:

1. The Premium Assistance Partnership Program, designed to assist small business owners in providing their employees and their employees’ families with health insurance; and

2. The Premium Assistance Public Program, designed to assist sole proprietors (self-employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage. 43

The following highlights employer and employee eligibility criteria to participate in the program. For small employers, the business must meet the following eligibility criteria:

- The business must be located within Oklahoma;
- The business must have 25 or fewer full-time and part-time employees;
- The small employer must contribute at minimum 25% of eligible employees' premium costs; and

43 Source: http://www.oepic.ok.gov.
• The insurance plan must be qualified by OHCA and must cover a minimum of hospital, physician, and pharmacy services. 44

Eligible employers who choose to participate in the O-EPIC program should assure that:

• Eligible employees are Oklahoma residents;
• The employer will contribute at least 25% of the premium for both full-time and part-time employees;
• The employee will contribute no more than 15% of their family’s premium; and
• Employees are made aware they must complete their own eligibility application verifying their household income is no greater than 185% of the FPL. 45

Any employee, regardless of time status (full-time, part-time, etc), who is eligible for their employer-sponsored insurance can apply. There are currently nine participating O-EPIC health plans that are qualified to offer health benefits through the Insure Oklahoma program.

Additional information, including a description of health benefits, O-EPIC qualified health plans, payment arrangement mechanics, employer, employee, and non-qualified health plan enrollment forms, and other detail about the program may be found at O-EPIC’s website: http://www.oepic.ok.gov.

The rationale for regional support of Insure Oklahoma to expand health coverage is compelling. It is an operational program that has potential to touch those who currently lack health insurance. For example, over 71% of the uninsured Oklahomans reside in a household where there is a full-time worker. In addition:

• Insure Oklahoma is a Center for Medicare and Medicaid Services (CMS) approved mechanism to expand insurance coverage. The review and approval process for federally approved programs that provide benefits such as state funding assistance typically are lengthy, and take time to implement;
• The program is funded, in part, by new dollars that flow into the State to support health insurance expansion. The federal government will match State dollars at the current OCHA program match (67.9% in FFY2006). This means that for every dollar the State contributes to subsidize the program, the Federal Government will contribute an additional $2.12;
• The program is a cost effective means for an employee to obtain health insurance for oneself (or family members). An employee’s contribution is limited to the lesser of either 15% of their premium or 3% of their gross income. In another state, in which employees pay the full premium up-front under a similar program, eligible employees who do not participate cite cost as the primary reason for not enrolling in the program.

44 Ibid.
45 Ibid.
• Additional funding to support a dental benefit in the Tulsa area would make the program more attractive to potential enrollees. The benefits package currently includes inpatient, outpatient, physician, laboratory, and pharmacy. OCHA staff believe a regional dental benefit is feasible, and could be supported by leveraging additional federal matching funds.

• The success of the Insure Oklahoma will depend on qualifying employee’s awareness of the program. Currently, insurers are the primary audience for program marketing, and are a limited source of program outreach. All stakeholders in the region, especially those at the point of care (e.g., providers, financial counselors, social workers) and those with relationships with small business (e.g., Chamber of Commerce) will ensure heightened awareness. In addition, a statewide- or regionally-supported campaign is necessary. Another state contributed marketing dollars to promote a similar program in television, radio, print, and web-based media, leading to increased enrollment; and

• Providers, foundations, and other committed organizations can facilitate uptake of Insure Oklahoma by providing incentives above the current financial structure of the program. These may be in the form of special co-pay or deductible discounts of O-EPIC enrollees, cash rebates for employees who enroll, free health screenings, free prevention visits, and related initiatives.

2. **Tactic**

   a. **Develop Infrastructure to Support Insure Oklahoma Initiative**

      i) Name a champion like “Tulsa Chamber of Commerce” to promote Insure Oklahoma;

      ii) Support development of a regional campaign to build awareness of the program

      iii) Implement specific policies and procedures at all patient care delivery sites to encourage employers and individuals to participate in the program; and

      iv) Consider offering of incentives to encourage adoption.
VII. ESTIMATED MAJOR STRATEGIC INITIATIVE COSTS

The table below summarizes the estimated costs of each initiative based on the assumptions highlighted below the table. Note that due to lack of the specifics regarding the operational configuration of a freestanding or virtual safety-net hospital an estimate for this was not provided (Exhibit 33).

Exhibit 33
Estimated Capital and Operating Costs of Strategic Initiatives

<table>
<thead>
<tr>
<th>Strategic Initiative</th>
<th>Fixed Capital Costs</th>
<th>Ongoing Annual Operating Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction of Two HealthPlexes</td>
<td>$44,700,000</td>
<td>$6,300,000</td>
</tr>
<tr>
<td>Expansion of School-based Health Centers</td>
<td>0</td>
<td>250,000</td>
</tr>
<tr>
<td>Implement Community Referral Network</td>
<td>300,000</td>
<td>360,000</td>
</tr>
<tr>
<td>Implement Disease Management Program</td>
<td>300,000</td>
<td>600,000</td>
</tr>
<tr>
<td>Support the Strengthening and Coordination of GME Training</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Discounted Prescription Drug Program</td>
<td>300,000</td>
<td>10,800,000</td>
</tr>
<tr>
<td>Support Insure Oklahoma</td>
<td>250,000</td>
<td>2,250,000</td>
</tr>
<tr>
<td>Strengthen Governance and Organizational Accountability</td>
<td>300,000</td>
<td>500,000</td>
</tr>
<tr>
<td>Total</td>
<td>$46,150,000</td>
<td>$21,060,000</td>
</tr>
</tbody>
</table>

The key assumptions for each initiative include:

- **Construction of Two HealthPlexes** - The capital and operating costs of two new HealthPlexes assumes one HealthPlex will be a smaller, less comprehensive 60,000 square foot facility (Scenario 1) and one will be a larger 100,000 square foot facility offering a more comprehensive range of services (Scenario 4). Estimated annual operating costs are reported net of revenue and assume 20% unreimbursed cost of uncompensated care.

- **Expansion of School-based Health Centers (SBHCs)** - Assumes expansion to five SBHCs. Each expansion site assumes a $250 thousand annual operating budget and 20% unreimbursed cost of uncompensated care.

- **Implement Community 24/7 Nurse Telephone Triage Referral Network** - Assumes $300,000 in capital-related implementation costs, and a fully operational annual operating budget of $360,000.

- **Implement Disease Management Program** - Assumes $300,000 in implementation costs, and an annual operating budget of $600,000.

- **Support the Strengthening and Coordination of GME Training** - Assumes existing providers revenues match costs for this initiative.

- **Discounted Prescription Drug Program** - Assumes $300,000 in implementation costs, and cost of 30,000 covered lives at $360 per member per year.
• **Support Insure Oklahoma Initiative** - Assumes $250,000 in awareness building campaign. Assumes private sources of funds provide premium assistance for half of employer share (25% of $200 monthly premium) for 7,500 covered lives. Ongoing operating cost will vary based on the number of enrollees, the monthly premium, and the level of assistance, e.g., the annual cost for 10,000 enrollees in a plan with a $250 average monthly premium for which assistance is provide for half of employer and employee share (40%) would be $6 million.

• **Strengthen Governance and Organization Accountability** - Assumes $300,000 in implementation costs, and an annual operating budget of $500,000.
VIII. RECOMMENDED GOVERNANCE AND ORGANIZATIONAL STRUCTURE

In 2002, legislation was enacted that created the Community Hospitals Authority (CHA). CHA’s purpose has been to “provide maximum utilization and efficient administration in order to deliver health care services to medically indigent persons and to promote the teaching and training of physicians.” A clear legislative intent also was to support the needs and mission of the Oklahoma State University College of Osteopathic Medicine and the University of Oklahoma College of Medicine (Tulsa).

There is a critical need to empower an entity to serve as the locus for joint planning, implementation and coordination of services in the Tulsa region. Such empowerment would effect real change and improve the delivery and financing of health care for the indigent in the area.

Legislation that created CHA states clearly that the Authority cannot issue bonds, employ personnel, or acquire any real property – and that CHA cannot receive state appropriations (except those it is entitled to through the Medicaid program as administered by OHCA). The legislation also states that “in the event a program is enacted whereby hospitals are reimbursement for the cost, or a portion thereof, of providing indigent health care, the Legislature shall insure that reimbursement shall be made to all hospitals statewide with the exception of the University of Oklahoma Medical Center based on each hospital’s indigent care caseload as it relates to the total amount of indigent care provided by all hospitals other than the University of Oklahoma Medical Center.”

CHA does not have the same level of authority, breadth of representation, or independence as other entities that have a comparable mission across the United States. To achieve the stated goals of the strategic plan, we recommend that the authority include at minimum the following elements as part of its management agenda:

- Monitor implementation of the long-range strategic plan to strengthen Tulsa’s safety net. An organized body with a clear mission that is empowered to make decisions affecting the safety-net will advance strategic change, and facilitate consensus among multiple stakeholders;
- Consider establishing community-wide charity care policies and procedures (voluntary guidelines, or mandatory before allowing providers to participate in any new funding targeted toward the safety net). This initiative would facilitate more providers qualifying for DSH, prevent patients truly unable to pay their bills from being billed, and potentially avert a state mandate that would require providers to provide a minimum level of charity care;
- Monitor the OHCA Emergency Department utilization program to assess whether it is applicable to the uninsured in Tulsa. ED over utilization has been a pressing issue for providers, and poses risks to ED visitors who require emergency care. Application of

46 Enrolled Senate Bill No.686, Section 3240.2 Community Hospitals Authority Act
successful intervention strategies would alleviate overcrowded EDs, direct care to more appropriate settings, and improve the safety of truly emergent cases;

- Discuss information technology solutions, data standards, and ensure how the current IT initiative in Tulsa (RHIO) will broaden to incorporate the safety net. Most successful strategies include an IT component to support care management techniques, decision making support, and promote cost effective care delivery;

- Request and analyze data to monitor the effectiveness of the plan. This will help the authority assess the success of various programs and policies, ensure that progress is being made, and will allow for uniform standards to assess and inform stakeholders; and

- Develop standards and protocols for indigent care, including: access phone lines, triage protocols, referral arrangements, development of a specialist provider network, etc. This will help bridge the fragmented system, provide the community with a common procedure to deliver care, and ensure that no single provider bears an undue burden.

The remainder describes the roles and responsibilities of two authorities and serves as background information to help provide context within our specific recommendations for the roles and responsibilities of the proposed authority. Similar to the CHA, both organizations were created to serve a particular vulnerable population, within a specific geographic region that is not state-wide.

Established in 1987 by the City and County of Tulsa, the Long Term Care Authority of Tulsa (LTCA) was created to provide planning, research, and development to establish and refine a coordinated system of care for long term care populations. Major responsibilities include administrating the Advantage program, (a home and community-based Medicaid long term care waiver program); and collecting and maintaining information on trends affecting long term care populations; and working with advocacy groups, service providers, and governmental agencies to increase options for long term care services.

After an in-depth planning process, and with support from the Governor’s Office, St. Louis Mayor’s Office and the St. Louis County Executive’s Office, the St. Louis Regional Health Commission (RHC) was created. The RHC’s mission is to “improve the health of uninsured and underinsured citizens in St. Louis City and County, with major efforts focused on increasing access to health care for people who are medically uninsured and underinsured, reducing health disparities among populations in the St. Louis City and County region and improving health outcomes, especially among those most at risk”47. The RHC successfully applied for a Medicaid 1115 waiver, allowing it to retain DSH funds that had historically been collected by a public hospital that was on the verge of closure. Twenty million DSH dollars thus was made available and was used to expand primary and specialty care capacity.

Both the LTCA and the RHC have met with substantial success. Below is a chart that compares authorities and responsibilities possessed by the LTCA, the RHC, and CHA. We have

47 St. Louis Regional Health Commission website: About the RHC
concluded that unless CHA is granted certain authorities, its effectiveness in achieving its mission cannot be assured.

<table>
<thead>
<tr>
<th>Authorities and Responsibilities</th>
<th>CHA</th>
<th>LTCA</th>
<th>RHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizes or designates advisory committees/workgroups including broad array of stakeholders to provide input and participate in planning and implementation activities</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Files annual report with governing bodies that, in addition to accounting information, summarizes activities and makes recommendations to improve status of populations served</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Solicits and can receive funds from government and private sources that can be used to purchase services</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Fiscal intermediary for governmental and non-governmental programs</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
<tr>
<td>Can hold, maintain, and administer real property</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Employs independent counsel, agents, and or employees as deemed necessary</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

The problems identified in the Situation Assessment require the intervention of “an Authority with Authority” in Tulsa – one that is empowered to act in an independent and meaningful fashion.

Thus, we recommend the creation of the Tulsa Healthcare Authority that would be established through Legislative authority. In addition to the significant benefits to be realized from greater collaboration among organizations that currently play important but incomplete roles in the provision of services for the indigent, such an authority could pursue the following benefits achieved in other communities:

- The authority would broaden community-based participation and collaboration beyond the local hospital community
- The Authority would provide a forum to enhance collaboration between the Medical Schools and Tulsa’s growing FQHCs that offer significant medical and supportive social and human services to the communities they serve
- Structure would provide needed support to existing and newly funded FQHCs
- Provides a possible vehicle for generating local tax support
- Provides a vehicle for sharing and coordinating important programs/infrastructure (e.g. case management) and for setting policy (e.g., EMR participation and standards)

The chart below summarizes proposed changes/additions in role/responsibilities and or powers, as compared to the current CHA.
<table>
<thead>
<tr>
<th>Recommendation And Rationale</th>
<th>Existing</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Change Name:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rationale:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change name to reflect a broader focus beyond hospitals as it relates to improving health care delivery for indigent populations</td>
<td>Community Hospitals Authority (CHA)</td>
<td>Tulsa Health Care Authority (THCA)</td>
</tr>
</tbody>
</table>

| **Refocus And Expand Mission:** |          |          |
| **Rationale:**                   |          |          |
| Refocus mission to clearly focus on planning and coordinating services for delivery of indigent care. Supporting GME and securing funding should clearly and solely be related to achieving this primary mission. | Support the missions of the Oklahoma State University College of Osteopathic Medicine and the University of Oklahoma College of Medicine (Tulsa) with regard to:  
- Teaching and training for medical students,  
- Conducting medical and biomedical research, and  
- Medical care for indigent and non indigent populations.  
Act as a vehicle for securing funding that is in addition to existing state Medicaid program appropriated funding for education, and indigent care, and graduate medical education, and  
Coordinate the delivery and efficiency of medical service across Northeast Oklahoma including, but not limited to, all counties located totally or partly in the Tulsa Metropolitan Area.  
The Authority may contract for indigent care with participating health care systems. | Plan and coordinate programs and services for delivery of health care to the indigent population.  
- Increase access to health care for people who are medically uninsured and underinsured.  
- Reduce health disparities among populations in the Tulsa region  
- Improve health outcomes among populations in the Tulsa region, especially those most at risk  
Support the service, research and educational missions of Oklahoma State University College of Osteopathic Medicine and the University of Oklahoma College of Medicine, Tulsa.  
Act as a vehicle for securing and administering funding that is in addition to or leverages available sources of funding, including but not limited to grants and or federal funding, e.g. DSH appropriations  
The Authority may contract for indigent care with a wide array of providers, hospitals, health systems, medical schools and clinics, that support the THCA mission |
<table>
<thead>
<tr>
<th>Recommendation And Rationale</th>
<th>Existing</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expand Board Composition</strong></td>
<td><strong>Current Board:</strong></td>
<td><strong>Consider Adding:</strong></td>
</tr>
<tr>
<td>Rationale:</td>
<td>The presidents of Oklahoma State University and the University of Oklahoma or their designees;</td>
<td>➢ One member from the Tulsa Philanthropic community</td>
</tr>
<tr>
<td>Modify the Board membership to include a larger Board (13 -15 members) that is more inclusive of greater community perspectives. It is suggested that four to six additional members be added to reflect community views. Members must be results-oriented, energetic, and in positions of leadership that will allow for the promotion of solutions.</td>
<td>One member appointed by the Governor who shall be a citizen and resident of the Tulsa MSA who has no direct affiliation with a participating health care system or a university as described;</td>
<td>➢ One member from the City/County Health Department</td>
</tr>
<tr>
<td></td>
<td>One member appointed by the Speaker of the House of Representatives;</td>
<td>➢ One member from the Tulsa business community</td>
</tr>
<tr>
<td></td>
<td>One member appointed by the President Pro Tempore of the State Senate;</td>
<td>➢ One non-hospital provider member, representing the clinic provider and or human service community</td>
</tr>
<tr>
<td></td>
<td>The Director of the Oklahoma Health Care Authority; and</td>
<td>➢ One local community physician, e.g. a Tulsa Medical Society Board member</td>
</tr>
<tr>
<td></td>
<td>One representative from each of the three participating health care systems, defined as a system that provides $5 million or more annually in indigent care, serving a multi-county region, with a population of 375,000 or more that does not have a statutorily provided safety-net hospital.</td>
<td>➢ One community at large member, who is not a part of the provider community</td>
</tr>
</tbody>
</table>

<p>| <strong>Expand Authority Role</strong> | | <strong>Consider Adding:</strong> |
| Rationale: | Support the missions of the Oklahoma State University College of Osteopathic Medicine and the University of Oklahoma College of Medicine (Tulsa) with regard to teaching and training for medical students, conducting medical and biomedical research, and medical care for indigent and non-indigent populations | ➢ Establish direction and priorities for Authority and workgroups (see below) |
| Authority requires broader powers and greater coordination role to truly effect positive change | Act as a vehicle for securing additional funds outside existing state | ➢ Hire and supervise Authority staff |
| | | ➢ Make annual recommendations to governmental authorities (City/County/State) for needed changes in safety-net delivery and/or financing |
| | | ➢ Implement programs to finance and serve indigent populations |
| | | ➢ Accept and utilize governmental appropriations in furtherance of the CHA mission |
| | | ➢ Establish standards, policies and procedures that health systems |</p>
<table>
<thead>
<tr>
<th>Recommendation And Rationale</th>
<th>Existing</th>
<th>Proposed</th>
</tr>
</thead>
</table>
|                              | appropriations for education and indigent care and graduate medical education.  
- Coordinate the delivery and efficiency of medical service across Northeast Oklahoma  
- May contract for indigent care services with participating health care systems. | shall accept through contracts with the Authority |

**Require Creation Of Formal Workgroups**

**Rationale:**  
All levels of stakeholders should have a role and be vested in the outcome of planning and implementation activities

|                              | None                                                   | Create formal workgroups/ advisory boards representing:  
Provider Services will implement a process assuring participation from all segments of the provider community in the planning and implementation of the strategic plan as it relates to the provider community.  
Community Health Services will focus on supporting and strengthening collaborative community health efforts within the Tulsa MSA.  
Access and Care Coordination will focus on care coordination of primary and specialist services within the Tulsa region to enhance access to care, and improve health care outcomes.  
Monitoring and Measurement will include developing a measuring system to track progress in access to care and progress made toward better health care outcomes. This will advance the tracking and regular reporting to the public of specific metrics, documenting both community benefits and progress made toward achieving health care improvements.  
Other advisory groups may be formed to suit local needs. Each workgroups/advisory board would be approximately a dozen representatives.  
Each workgroup/advisory board will be chaired by a Commission Board Member; each Board member must serve on at least one workgroup/advisory board. |
<table>
<thead>
<tr>
<th>Recommendation And Rationale</th>
<th>Existing</th>
<th>Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish Staffing/Budget And Independent Space</td>
<td></td>
<td>Create a small, paid, support staff to support ongoing administration, marketing and research. Suggested initial size would be three: Executive Director, Administrative Assistant and Research Associate. House the staff in a geographically neutral environment – perhaps co-located with a local foundation.</td>
</tr>
<tr>
<td><strong>Rationale:</strong></td>
<td>The independence of the Authority, in its administration and mandates is imperative</td>
<td></td>
</tr>
</tbody>
</table>
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IX. IMPLEMENTATION REQUIREMENTS

Below we discuss three requirements for implementation under three key areas: 1) Funding; 2) Legislation; and 3) Role and Responsibilities of Key Stakeholders.

A. Funding

The strategies in this plan require new resources for successful implementation. Throughout the planning process, The Lewin Group considered several possible strategies for generating new funds to support indigent care in the Tulsa Region. These include:

- New taxes, such as a parcel tax, sales tax, or a regional supplement to the recently enacted, statewide tobacco tax (which would have the potential both to generate new money and to deter smoking – one of the probable causes of health status problems). Discussions with stake-holders indicated that the probability of enacting new taxes at this time is remote.
- Medicaid Disproportionate Share funding
- Foundation resources
- Additional state, federal, and employer/individual resources that will flow into the Tulsa region through enhanced Medicaid rates and the Insure Oklahoma program.
- Federal resources from 330 grants (available to qualifying clinics) and other grant sources.
- Additional federal resources that would result from a new “provider fee” such as the one proposed (but not enacted) in 2005.

Of these potential sources, Foundation funds, enhanced Medicaid rates, Insure Oklahoma are currently are available to support the strategic plan – without additional legislative action. This is one reason why this plan suggests aggressively supporting the Insure Oklahoma programs, among other initiatives. New funding from Medicaid DSH and from a “provider fee” system would require legislation.

The increases that will occur to the state-wide Medicaid DSH caps for Oklahoma provide a real opportunity to provide new resources for the Tulsa region. As suggested below, legislation that qualifies additional hospitals and that clearly recognizes uncompensated outpatient hospital care as for DSH funding would be highly constructive. A provider fee-based system also could yield substantive resources for uncompensated care, if it is designed like the programs in other states (e.g., the Massachusetts Uncompensated Care Pool).

B. Legislation

This strategic plan also contemplates the following legislative agenda:

- Legislation that assures HealthPlexs can be licensed as part of hospital(s) without barriers.
• Resolution (and legislative support) to prevent any further deterioration in Oklahoma's FMAP. Scheduled declines in the Federal Medical Assistance Percentage – from over 70 percent to 68 percent – significantly affect the federal funds that flow to Oklahoma through the Medicaid program and reduce the “yield” associated with matching funds from state or other regionally-generated sources.

• Implementation of an updated DSH formula that expands the number of hospitals eligible for funding: based either on (a) the total quantity of charity and Medicaid services they provide, or (b) a mechanism that explicitly recognizes outpatient charity and outpatient Medicaid care.

• Legislation that creates an outpatient Medicaid DSH pool – so that funding provided to qualifying hospitals rewards hospitals that provide access to outpatient care and is less dependent or driven by inpatient utilizations.

• Legislation that makes the rate increases that Oklahoma providers recently received for Medicaid as permanent as possible.

• Legislation that enables the Community Hospitals Authority to assume the responsibilities recommended in this plan – including the ability to receive and expend appropriations from the State, from the University Hospitals Authority, or both.

C. Roles and Responsibilities

In recent years, Tulsa stakeholders have contributed much to improve the health care environment for the medically indigent. The major change that is recommended is that stakeholder planning and implementation occur in coordination with other efforts, rather than in isolation. In this manner, efforts can be leveraged to achieve greater results.

Hospitals should continue to coordinate high level inpatient services, and collaboration via joint operating agreements with other providers (community physicians and/or Tulsa medical schools) to strengthen the provision of ambulatory care.

Medical Schools will continue to be looked upon to contribute valuable clinical and research resources, and to consider collaborating with each other to bring additional GME resources into Tulsa.

Foundations will be looked to in support of the Tulsa Strategic Plan, specifically as it relates to providing seed money for innovative programs such as the Medication Assistance Program, and the Chronic Disease Management Program, as well as providing needed one-time capital funding to meet new capacity requirements, such as development of the HealthPlex clinics.

The business community (via an organization such as the Tulsa Chamber of Commerce) should support the Insure Oklahoma Initiative in support of decreasing the number of uninsured in Tulsa.

Legislators will be asked to support the Tulsa Strategic Plan, particularly as it relates to bringing additional Federal and State funding to the Tulsa region.
X. IMPLEMENTATION PLAN

The implementation plan presented below delineates the desired timeframe for completion of each recommended strategy and tactic across three components: delivery system strategies that enhance availability and access to care, governance and organizational strategies that improve the safety net system infrastructure and accountability and financing strategies to increases both the sources of funding and total dollars available to support the strengthening of Tulsa’s safety net delivery system.

<table>
<thead>
<tr>
<th></th>
<th>Immediate (within 1 to 3 years)</th>
<th>Short-Term (within 3- 5 years)</th>
<th>Long-Term (5- 10 years +)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery System</td>
<td>Establish JOA between one or more hospitals and OU and/or OSU to plan and build two HealthPlex facilities.</td>
<td>Implement infrastructure changes including electronic referral tracking and appointment system</td>
<td>OSU/OU develop joint residency/fellowships in selected subspecialties, thereby creating additional capacity.</td>
</tr>
<tr>
<td></td>
<td>Support FQHC initiatives already underway.</td>
<td>Medical schools reach consensus on graduate medical education training needs.</td>
<td>Expand 211 to include 24/7 nurse triage.</td>
</tr>
<tr>
<td></td>
<td>Pursue school health clinic expansions.</td>
<td>Foundation funds and establishes discount pharmacy program that would be administered via the THA, and established at the Bedlam Clinic and or the new HealthPlex facilities.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>One or more providers develop community-wide chronic disease case management program.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Structure</td>
<td>Through legislative authority, establish Tulsa Healthcare Authority- CHA would be restructured to create the THA) that would plan and coordinate indigent care delivery as well become the conduit for new sources of funding.</td>
<td>THA, and workgroups issues first Tulsa Indigent Care Progress and Community Benefit Report.</td>
<td>Further develop THA capacity to attract financing and monitor utilization.</td>
</tr>
<tr>
<td></td>
<td>Establish Work Groups</td>
<td></td>
<td>Consider integrating / coordinate city and county public health functions under THA.</td>
</tr>
<tr>
<td>Financing</td>
<td>Immediate (within 1 to 3 years)</td>
<td>Short-Term (within 3-5 years)</td>
<td>Long-Term (5-10 years +)</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------</td>
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<td>-------------------------</td>
</tr>
<tr>
<td>Chamber of Commerce and providers actively support “Insure Oklahoma”. THA seeks legislative support to modify DSH formula,</td>
<td>Foundations collectively establish Indigent Health Care Fund, the distribution of which would be managed by the THA. The continuance and use of these funds would be contingent upon receiving matching funds from other sources including local, state and federal dollars; with a preferred match rate of 2 to 1. Begin building political support for a regional revenue source for indigent care/public health.</td>
<td>Consider further coverage enhancements via increasing Medicaid coverage and/or further expansions of employer coverage to low income employees.</td>
<td></td>
</tr>
</tbody>
</table>