HOSPITAL AND MEDICAL STAFF REIMBURSEMENT

The Regents’ Rules governing the University Hospital in 1917, stated: “The hospital of the University of Nebraska in Omaha is not founded with the idea of receiving patients who are able to pay for special medical and surgical care” (160). The hospital was funded virtually entirely by appropriation from the legislature through the University. These funds were not specifically designated for the hospital. The legislature appropriated money to the University of Nebraska upon request of the Board of Regents. A portion of that money was allocated to the College of Medicine and the hospital was a part of the college’s budget.

The number of patients to be admitted was allocated by county, “...allotment of hospital days is based on the census of Nebraska of 1910 and is prorated among the counties according to population; considerable advantage being given to less populous counties situated some distance from hospital facilities” (160). An exact proportional allotment was not used, “...so that the greatest good to all would be received...” (160). If a county did not use its assigned days, they could be used by other counties.

A patient’s contribution toward financing his or her care was taken into consideration. Article VII of Regents Rules governing University Hospital stated: “Patients must come provided with sufficient funds to enable them to reach the hospital and to provide for their return home” (160). Supposedly, this money could come from the county Welfare Department. Patients who were not “established county charges” were expected to pay at least the cost of board and nursing which was established at $2.50 per day in 1917 and had risen to $3.00 per day in 1925.

An article by Marguerite Godsey in the “Nebraska Alumnus” in 1931 (56) reported that a thorough assessment of a patient’s ability to pay was carried out at the time of admission, but no patient was refused admission because of inability to pay. However, Regents’ Rules by this time specified that patients having earning capacity or responsible relatives would be admitted only upon payment of a fee to cover in part the cost of board and nursing. The rate charged should be such as the hospital authorities deemed reasonable for the patient to pay. The rate at that time was $1.00 per day for children up to age 4, $1.50 from 4 through 10 years of age, and $2.00 per day for adults with the exception that obstetrical patients were charged $2.50 per day. Income levels listed in the article were those, “...accepted by creditable social agencies in the Midwest...” A patient or family with an income exceeding these levels, “...should be able to provide medical services” (56). There were a number of exceptions discussed which could modify decisions based on the designated income levels.

At that time, the hospital was facing a deficit as pointed out by Dean C.W.M. Poynter during an address to the Lions Club. The hospital was filled to capacity and, according to the Dean, was serving, “a greatly increased number of applicants for free drugs and treatment” (31). According to information provided by Dr. Edward Holyoke, Dean Poynter
reduced the open beds in the hospital when the hospital budget was cut. As late as 1963, the actual number of open beds was 144 (165).

Little change occurred in state funding or income from patients during the 40's and early 50's. In the 1954-55 fiscal year, state general moneys provided 97% of the hospital budget and 3% came from self-support (167). In late 1956, Dean J.P. Tollman announced the temporary closing of wards A and B. "Rising costs of operation, and more active hospital services have increased our spending rate. Since we have a fixed budget, it will be necessary to reduce hospital operations" (84). Apparently, a little money was derived from counties, especially Douglas County which was paying for the care of some of its patients. The amount of money collected from direct charges to patients was probably insignificant. However, as time went on, somewhat more money was coming from sources other than state appropriations since by fiscal year 1960-61, 13.4% of the hospital budget came from self-support (167).

By 1963, the hospital was beginning to collect more patient revenue (172), and on November 1, 1964 the hospital adopted an "Ability to Pay Schedule" (119). It was based on an individual patient's gross income and number in the family and applied to Nebraska residents only. Individuals living outside the state were expected to pay full hospital rates. An example from the schedule noted that a family with a monthly income of $240 and four children was expected to pay 20% of the standard inpatient hospital rate. Outpatient charges were dismissed, but the patient was expected to pay for drugs (119). Further changes occurred in November, 1965, when the Board of Regents changed its rules relating to the hospital and removed the previous $4.00 a day limit on charges to county welfare departments for the care of patients referred to the hospital (49,129). Other changes were made which allowed the hospital to officially accept paying patients, thus, removing obstacles to the hospital's participation in Medicare. In April, 1967, the hospital discontinued its all-inclusive single daily rate and introduced itemized billing. This was necessary in order to accumulate appropriate statistics required for participation in Medicare. The total charges were not altered and the Ability to Pay Schedule remained in effect (127).

Around the same time, the Medical Center was aggressively recruiting a full-time clinical faculty under Dr. Cecil Wittson, as College of Medicine Dean and, subsequently, as UNMC Chancellor. This created the need for a more diversified patient population within the hospital adding impetus to change the concept of the University Hospital as a strictly indigent care facility. Changes in the methods of reimbursement for both the hospital and the staff were occurring. Although, in many respects, these were interdependent, they had to proceed largely independently and will be discussed separately in this section of the hospital's history.

Following the changes in 1965, which permitted the hospital's participation in Medicare, participation in the Blue Cross Plan occurred in 1966, and in 1967 the hospital staff gained approval for participation in the Blue Shield Plan (198). Other insurers
followed in a relatively short time period. With the opening of Unit 4 in 1969, private and semiprivate rooms replaced the wards. This, plus an increasingly diverse full-time clinical faculty, led to the admission of more and more private patients. Hospital room rates began to change. In January, 1967, the Board of Regent's approved new rates: private rooms $30.00 per day, semiprivate $26.00 per day, ward $24.00 per day (essentially Pediatrics) and intensive care $45.00 per day (136). By September, 1969, the rates had increased to $47.00 per day for private rooms, $42.00 for semiprivate, $37.00 for ward and $85.00 per day for intensive care. Clinical visits were raised to $5.00 (134). Although these rates may seem a far cry from today's, they were even further from the rates of 1917. Many economic and social changes not under control of the hospital influenced these differences, and further discussion of room rate charges does not appear pertinent to this history.

In 1975, the Nebraska State Legislature directed that the hospital become increasingly self-sufficient and fund clinical equipment requirements from patient-generated revenue. The state was to cover only those expenses associated with indigent care and also provide support for expenses associated with health science education (172). From 1975 to 1981, the level of state support decreased by two million dollars and the cost of indigent care rose by two million dollars. At that time, 13% of the care provided by the University Hospital went to those unable to pay (172). Accordingly, in April, 1981, the Board of Regents placed restrictions on indigent care. Indigent patients who were not residents of Nebraska would not be admitted except for emergency conditions. As of October, 1981, all non-emergent indigent Nebraska residents had to obtain written authorization from their counties prior to admission. Patients without such authorization had to meet hospital admission policies which included a down-payment (172).

Throughout the period from 1981 to 1992, the percent of general funds in relation to total hospital budget continued to decrease. In 1981-82, general fund support amounted 4% of the total hospital budget, whereas, in 1991-92 it amounted to only 1.4%. In the 75 years from 1917 to 1992, the University of Nebraska hospital went from an institution totally supported by the State to an institution which was 98.6% self-supporting (167).

As noted previously, the recruitment of full-time clinical faculty and the advent of private patients at the University Hospital also raised issues pertaining to professional fee reimbursement. Historically, when the hospital opened in 1917, the Regents' Rules of Governance (160) referring to the staff stated, "These men receive no compensation from the state, and are not permitted by Regents' rules to receive remuneration from the patients in the University Hospital". Some changes in Regents' Rules occurred subsequently since an article by Dr. J.J. Keegan in the Nebraska State Medical Journal (38) in 1927 cited the following in the final paragraph of Article II of the Regents' Rules, "Emergency cases requiring immediate attention will be admitted regardless of financial status or application and charged private patient rates if they want to pay for professional services." Also, in Article IV, the following statement appeared, "No member of
the hospital staff shall receive compensation for professional services from any hospital patient, unless especially authorized by the superintendent” (1).

Since, at that time, the entire hospital staff consisted of voluntary faculty engaged in private practice outside the University Hospital, it is unlikely that much use was made of these provisions. With the advent of the first full-time clinical faculty in 1953, the following statement was considered and passed at a general faculty meeting on December 2, 1953 (44).

"Conversation with department chairmen developed these ideas with reference to the status of full-time people to be added to the Clinical Departments.

The term full-time for these clinical faculty members carries with it the privilege of spending 1/6 time, based on the 44 hour week, for consultation-type practice. Consultation-type practice indicates that these faculty members will see only patients referred to them by other physicians. These staff members are to be urged to see such patients whenever possible with the referring physician. Where this cannot be accomplished, the man is to be urged to see the patient at one of the affiliated hospitals, although it is recognized that some patients may be seen at their offices at the University Hospital, particularly until convenient arrangements elsewhere can be provided. It is understood that in some situations, the faculty member may supervise the care of the referred patients in one of the affiliated hospitals. The income derived from this consultation-type practice is the responsibility of the individual and is not a matter of official recognition by the University.

These full-time faculty members will have no privilege of admitting patients to the University Hospital not accorded any other faculty member."

In the rules and regulations of the first medical staff bylaws adopted in 1956, item number 4 states, “When a patient is found to be able to pay for his services, the Dean may authorize the attending physician to present a bill for his services, as provided in the Regents’ Rules”. (31)

These various changes made it obvious that some patients in the University Hospital could be charged a professional fee and that full-time faculty members could charge a professional fee for services, but these two facts were not necessarily mutually inclusive. As noted earlier, the hospital began to collect patient revenues in 1963 (172) but these rarely came from private patients. Until Unit 4 was opened in 1969, the hospital facilities were not adequate. There were one or two private rooms at the end of most wards, but these were usually used for severely ill or contagious patients. However, some private patients were occasionally admitted to the University Hospital according to Dr. Frederick Paustian who joined the faculty in 1958.

Under these circumstances, there was no specific University or Medical Center plan regarding professional fees or private patients in the 1960’s as the full-time faculty began to increase. Some of the new faculty were considered strict full-time and were paid a salary. Any money they received for professional services was usually returned to their
respective departments. A number of other new faculty retained the professional fees generated from treatment of patients under the aegis of the 1953 policy referred to earlier (44).

It became apparent that some type of policy was needed. Dr. Wittson appointed an ad-hoc committee consisting of Dr. Frederick Paustian, Dr. William Wilson, and Dr. John Jones to develop a “medical service plan” which would address the issues of income from patient-related services and clinical faculty compensation. A plan was developed which was approved by the clinical faculty on March 4, 1971 and the Board of Regents on August 7, 1971 (168). It established the University of Nebraska Clinicians Group, “...a nonprofit, unincorporated association whose voting membership shall consist of all full-time clinical faculty members and participating membership of all part-time and those voluntary clinical faculty members who render patient diagnosis, care and supervision at the University of Nebraska Medical Center” (168).

Each clinical faculty member was to have a Terms of Employment Agreement with the University of Nebraska College of Medicine which was to be renewable or renegotiated annually with the department chairman subject to approval by the Dean. The agreement specified the source of professionally related income as royalties, honoraria, university approved institutional consultantships and professional service fees, and the amount of salary including related fringe benefits. A current strict full-time faculty member could elect to remain in that status. Other full-time clinical faculty members could become essentially geographic full-time. The three categories of clinical faculty: full-time, part-time or volunteer, were defined in the plan. In practice, the plan’s provisions with respect to professional service income applied to the full-time faculty and a few of the part-time.

The plan called for the establishment of a Professional Fees Office by the Nebraska Clinicians Group for the purpose of billing, collecting and disbursing professional service fees generated by the members of the group in accordance with the provisions of the plan. The Professional Fees Office was to be a distinct agency, incorporated and nonprofit with officers and a board of directors appointed by the Executive Committee of the Clinicians Group. Its Articles of Incorporation were filed and recorded in the office of the Secretary of State of the State of Nebraska June 1, 1971 (2).

The Professional Fees Office was to be supervised by the Executive Committee of the Clinicians Group through a Board of Directors. The Executive Committee was spelled out in the Medical Service Plan. It was to consist of the following:

- Three members from a medically oriented specialty
- Three members from a surgically oriented specialty
- One member from Pathology
- One member from Radiology
- The Dean of the College of Medicine ex-officio
The departments in the medically and surgically oriented specialties were listed in the plan. Members of the committee were elected by the voting members of the Clinicians Group. Terms of office were to be two years beginning September 1st of each year. Four new members were to be elected each odd numbered year and four each even numbered year. A chairman was elected by the Executive Committee members at the first meeting in September. The committee was to meet at least quarterly.

In the plan, professional medical service fees were defined as, “...those charges for medical care given directly to patients by a specific member of the clinical faculty.” Fees charged to non-referred patients - those referred to the Medical Center not directly to a physician - were assigned to the University of Nebraska Clinicians Group. Fees charged to a referred patient - those referred to a specific clinical faculty member - were to be disbursed to that individual member.

A Medical Center “Use of Facilities Fee” was to be charged each patient for medical care received in facilities under the jurisdiction of the University of Nebraska Medical Center. This applied to outpatient services. Fees could be charged directly to the patient and billed and collected by the Patient Accounting Office of the hospital, or the fee could be indirectly charged through the physician in which case the physician and/or his department would pay the fee to the hospital.

All professional service fees were billed and collected by the Professional Fees Office. These were deposited in a Professional Fee Clearing Fund maintained by the Professional Fees Office. Expenses incurred by the Office relating to overhead were deducted from the Clearing Fund and prorated according to the amount of fees collected among the departments, sections and clinicians using the Professional Fees Office services.

After payment of Professional Fee Office expenses, setting aside a reserve fund to ensure the day-to-day operation and payment to the respective clinical faculty members those fees collected for referred patients, the assigned fees (those from non-referred patients) were to be transferred to the University of Nebraska Medical Center Clinicians Fund. This was a separate account administered by the Executive Committee. From this Fund, payments were made to department, division or section development funds prorated on the basis of the respective funds generated, plus a payment to the College of Medicine Development Fund.

At the time that the Plan was approved, the amounts to be allocated were 70% to the department, division or section development funds and 30% to the College of Medicine Development Fund. The moneys allocated to the departments et al development funds could be used for two purposes: 1) Professional fee income which was paid to certain faculty members of the department as agreed to in their Terms of Employment Agreement; 2) Academic development wherein such money could be used for a number of educational, research and office expenses spelled out in the plan. Additional moneys from these development funds could be allocated to certain fringe benefits in support
of the full-time physician members of the group. These fringe benefits encompassed such things as insurance programs, retirement, professional society dues and even educational benefits for dependents.

This plan was perceived to have a number of problems by the Board of Regents and the University Administration. Accordingly, a Task Force on the Medical Service Plan, consisting of Howard Neville from Central University Administration, as Chairman, and Drs. Frederick Paustian, Francis Land and Dean Robert Kugel met in 1973. The task force considered three prime subjects: 1) disclosure of the amount of income received by full-time clinicians from clinical practice at UNMC administered facilities; 2) the inclusion of all or part of the clinical practice at UNMC administered facilities within the Medical Service Plan, and 3) the administration of the Professional Fees Office. An amended plan was submitted in August, 1973, but because of continued perceived problems further modifications were made and the new plan was finally approved by the Medical Center clinicians on June 27, 1974 and by the Board of Regents on June 29, 1974 (168).

The new plan had several significant changes. Personal income from professional fees of full-time clinicians was to be reported annually as confidential information by income ranges with a statement as to the number of persons receiving income in each range to the Dean of the College of Medicine, the Chancellor of the Medical Center, the President of the University and the Executive Committee of the Board of Regents. Disclosure of income from professional services rendered by individual full-time clinical faculty members was to be reported to the Dean, the Chancellor and the President of the University but not to the Board of Regents. With respect to the Professional Fees Office, it was made more clear that the ultimate authority for policies of the Nebraska Clinicians Group and the Professional Fees Office resided in the Board of Regents. The fact that some full-time clinician members had offices outside of the Medical Center was recognized, and it was specified that these "subunits" must adhere to the Medical Service Plan and submit fiscal information as directed by the Plan. Creation of any new "subunits" would need approval of the Executive Committee of the Nebraska Clinicians Group, the Dean of the College of Medicine, the Chancellor of the Medical Center and the Board of Regents. Under this new plan, the clinical practice of full-time clinicians was more closely controlled with respect to the amount of income, practice within the Medical Center and approved methods for practice outside of the Medical Center.

Although this plan was a significant improvement, as time went on some members of the Board of Regents still perceived problems. When Dr. Neal Vanslow became Chancellor of the Medical Center, he appointed a new committee chaired by Dr. Miles Skultety to review and revise the Medical Service Plan. The revised plan was approved by the Nebraska Clinician Group members on February 9, 1978 and by the Board of Regents on February 18, 1978 (154,169).

Under this new plan, membership of the Nebraska Clinicians Group consisted of voting full-time members and nonvoting part-time and volunteer members who ren-
dered patient diagnosis and care at the University of Nebraska Medical Center. Full-
time members were defined as those, "...whose entire professionally related activities are
conducted under the direction and with the approval of the department or division
chairman or institution director and for which appropriate salaried remuneration is
received." A part-time member was defined as one, a portion of whose professionally
related activities was conducted under the direction and approval of the Dean et al., as
above, and for which appropriate salaried remuneration was received. A volunteer mem-
ber was defined as one, a portion of whose professionally related activity was conducted,
as noted above for part-time but for which no salaried remuneration was received.

Both the Terms of Employment Agreement and the income subject to the plan were
defined in detail. Professional service fees were defined as, "...those charges for care
given to patients by a specific member of the clinical faculty who will charge a fee for his
or her services." The Plan specified that all patients admitted to the University of Ne-
braska Medical Center facilities would be private patients except for those admitted
under special contracts. All patients were to have an identified attending physician. All
professional service fees for full-time clinicians were to be billed and collected by the
Professional Fees Office. With respect to part-time faculty members, the Terms of Em-
ployment Agreement would specify what portion of patient related charges must be
billed through the Professional Fees Office. In addition to operating expenses of the
Professional Fees Office, which were deducted prior to the time of distribution of any
moneys among individual plan members, certain professional practice expenses could
be deducted. These included fees for a Nebraska medical license and federal controlled
substance license, medical staff dues, and medical professional liability insurance pre-
miums.

After deduction of allowed costs, the funds were to be distributed as follows:

1. Between 60%-75% to the physician who generated the income. The upper and
   lower limits were specifically set. For an individual physician, these limits were to
   be determined and specified within the Terms of Employment Agreement.
2. Twenty percent to respective department or division development funds.
3. Five percent to the College of Medicine Development Fund.
4. If the member received less than 75%, the remaining amount was to be divided,
   with 75% to the Department Development Fund and 25% to the College of Medi-
   cine Development Fund.

The disbursement of professional service fee income from the few remaining outside
offices was spelled out as to allowable expenses, reporting requirements, and the distri-
bution of money after expenses in the same manner as noted above.

Allowances were made for the development of medical practice units such as profes-
sional corporations, partnerships or other legal medical practice entities. Disbursement
of fees to and by such entities was spelled out.
In this new plan, the disclosure of professionally derived income to the administration remained essentially the same as it had been in the previous plan. The new plan made it clear that billing for professionally related services by full-time members was to be done through the Professional Fees Office regardless of the location at which the services were rendered. It also indicated that all branch billing offices (outside offices) were to be abolished, however, there was a grandfather clause. This excepted full-time faculty members employed by the University prior to July 1, 1977 who maintained an outside office on that date and continuously thereafter. No new outside offices could be established.

The makeup of the Executive Committee of the Nebraska Clinicians Group was changed to consist of three department or division chairmen, one from each of three categories which were designated as medically oriented, surgically oriented and other. The latter consisted of Anesthesiology, Pathology and Radiology. The departments or divisions in the first two categories were specified with provisions for change if any department or division were added or deleted from the College of Medicine. In addition to the three chairmen, there were to be five non-chairman members, two each from medically and surgically oriented specialties and one from the other. The Dean of the College of Medicine was a member ex-officio. All members except for the Dean were elected and each was to serve two years with staggered terms.

An Arbitration Committee was specified which was to have final jurisdiction to adjudicate disputes over interpretation of the plan and charges of noncompliance if these matters could not be resolved informally.

The uses and distribution of department or division development funds was not changed significantly except with respect to what was previously called, “professional fee income.” This was abolished as such and replaced by a category called, “salary supplement.” Under this heading, it was indicated that the Dean and the department or division chairman could supplement income of an individual plan member from development funds. Such supplements were to be in addition to state salary and the members pro rated professional service fees. Such supplements were to be agreed upon in the Terms of Employment Agreement and subject to the same university approval procedures as salary paid from other university sources.

The Medical Service Plan essentially established a group practice of geographic full-time physicians at the University of Nebraska Hospital. Both the hospital and the staff had now developed systems in keeping with the rest of the community for appropriate reimbursement for services rendered. No further significant changes occurred until 1986 when the University Hospital elected to discontinue the maintenance of hospital outpatient clinic facilities and turned these services over to the clinical faculty. A Clinical Practice Board (CPB) was established at that time, “...to coordinate and govern the clinical practice affairs of the College of Medicine clinical faculty including, but not
limited to, management of ambulatory care programs and entering into contracts for patient care related services..." (7). In essence, the CPB took over the management of, and financial responsibility for, most of the outpatient clinics both on and off the campus. A few have remained under hospital management.

The Clinical Practice Board consisted of all of the College of Medicine clinical department chairmen, the Ambulatory Care Medical Director, the Chief of the Hospital Medical Staff, the Associate Dean for Clinical Affairs who acted as chairman, the five non-chairman members of the Nebraska Clinicians Group Executive Committee, the Dean of the College of Medicine, without vote, and the Hospital Director, also without vote.

An Executive Committee was established which consisted of two representatives of medically oriented departments, two representatives of surgically oriented departments, and one representative of the other clinical departments. All five members were from the Clinical Practice Board and were elected by the Board. In addition, two of the five non-chairmen Nebraska Clinician Group members of the CPB were to be appointed to the Executive Committee by the Nebraska Clinicians Group Executive Committee. The Associate Dean for Clinical Affairs was a member of the Committee and served as chairman. The Dean, Hospital Director, Medical Director, and Executive Director of the CPB were members of the Executive Committee all without vote. The departments in each of the three categories were listed in the bylaws, and provisions were made for changes where departments were added or deleted by the College of Medicine.

In a unique arrangement, the bylaws specified that the Associate Dean for Clinical Affairs was to be elected by the Clinical Practice Board. An individual or a list of individuals was to be nominated by the CPB Executive Committee. The Dean of the College of Medicine had the right to approve all nominees prior to election, but the Dean no longer had the right to appoint an Associate Dean for Clinical Affairs. However, an individual could be removed during his or her term at any time by the Dean or by a two-thirds majority vote of all members of the Clinical Practice Board. The Associate Dean for Clinical Affairs would serve for a three year term and could be reelected to successive terms.

An Ambulatory Affairs Committee was established within the Clinical Practice Board, "...to ensure interdepartmental coordination of the day-to-day operations of the ambulatory care programs." Membership consisted of one physician clinic manager from each department with at least one ambulatory care practice site, one representative each from Pathology and Radiology, the Ambulatory Care Medical Director who was to be Chairman, the Executive Director, the Associate Dean for Clinical Affairs and any other members of CPB management deemed appropriate by the Board. The department chairman appointed the physician clinic managers who would represent their departments. The Ambulatory Care Medical Director was appointed by the Clinical Practice Board by a majority vote from candidates nominated by the Executive Committee. The director served for a term of two years and could serve successive two terms.
The Clinical Practice Board hired an Executive Director to manage the business and financial affairs of the Board. The director reported to the Executive Committee through the Associate Dean for Clinical Affairs.

As noted, the Clinical Practice Board was organized mainly to run the outpatient services for the clinical faculty. The Nebraska Clinicians Group remained as the fiscal organization of the faculty and its Professional Fees Office was still responsible for the billing, collection and distribution of all professional fees whether collected for inpatient or outpatient services.

When the Clinical Practice Board started, the extant Associate Dean for Clinical Affairs, Dr. Charles Dobry, was elected to that position under the board’s bylaws. He had originally been appointed by the Dean of the College of Medicine and also had been elected to serve as Chief of the Hospital Medical Staff under its bylaws. After two years, the position of Chief of Staff and Associate Dean for Clinical Affairs were separated, since another individual, Dr. James Newland, was elected Chief of Staff.

A number of other problems became readily apparent, and Mr. Andy McDonald, who had served as a consultant at the time of the original organization of the Clinical Practice Board, was called in to help with reorganization. Ultimately, the bylaws were revised and the name of the group was changed effective March, 1993. The name, “University Medical Associates” (UMA) was adopted and the significant bylaws changes were as follows. The membership of the University Medical Associates’ Executive Committee consisted of the Associate Dean for Clinical Affairs and the members of the Nebraska Clinicians Group Executive Committee as determined in the Medical Service Plan. This established a single governing organization for both groups. The Associate Dean for Clinical Affairs was again appointed by the Dean of the College of Medicine and served as the University Medical Associates’ medical director. Dr. Ward Chambers was appointed to this position.

A Clinical Chairs Advisory Committee was established. It reported to the Dean of the College of Medicine and, “...is to advise the Dean on policy matters regarding the patient care programs, including their interrelationship with teaching and research programs. The Committee shall also receive and review quarterly reports of the activities of the UMA Executive Committee and make recommendations to the Dean on medical practice-related matters impacting multiple clinical departments.” Membership consisted of all College of Medicine clinical department chairs, the Associate Dean for Clinical Affairs and the Dean of the College of Medicine. The Dean or a designee acted as Chairman of the Committee.

The Ambulatory Care Committee was unchanged except that the position of Ambulatory Care Medical Director was eliminated and the chair of the Committee was to be appointed by the UMA Medical Director. Also, this Committee and the Medical Staff Ambulatory Affairs Committee, were one and the same, establishing an appropriate coordination between the Hospital Medical Staff and the University Medical Associates.
The UMA Medical Director/Associate Dean for Clinical Affairs was appointed by the Dean of the College of Medicine after consultation with the UMA Executive Committee and the Clinical Chairs Advisory Committee. The Director’s duties, among others, included serving as the University Medical Associate’s liaison with the Dean, Hospital Director, and clinical departments to resolve matters related to the development of an effective patient care delivery system; overseeing day-to-day activities of the Chief Administrative Officer and ensuring adequate medical input to administrative matters; providing oversight and direction to Ambulatory Care Committee Chair and identifying clinical practice policy issues and seeking decisions from the appropriate physicians or committees as necessary.

The management position consisted of a Chief Administrative Officer who managed the business and financial affairs of not only the University Medical Associates, but also of the Nebraska Clinicians Group Professional Fees Office.

The present organization reduces the number of independent groups influencing the fiscal and patient care delivery aspects of faculty medical practice and significantly increases the efficiency of the entire operation.