REGULAR BI-MONTHLY MEETING
OF THE BEXAR COUNTY HOSPITAL DISTRICT
BOARD OF MANAGERS

Tuesday, February 16, 2016
2:00 p.m.
Cypress Room
First Floor, University Hospital
4502 Medical Drive
San Antonio, Texas 78229

MINUTES

BOARD MEMBERS PRESENT:

Ira Smith, Vice Chair
Roberto L. Jimenez, M.D, Immediate Past Chair
Robert Engberg
James C. Hasslocher
Janie Barrera

BOARD MEMBERS ABSENT:

James R. Adams, Chair
Dianna M. Burns, M.D., Secretary

OTHERS PRESENT:

Bryan Alsip, MD, Executive Vice President/Chief Medical Officer, University Health System
Edward Banos, Executive Vice President/Chief Operating Officer, University Health System
James Barker, M.D., Vice President/Clinical Services, University Health System
Jason Bowling, M.D., Epidemiologist, University Hospital; and Associate Professor/Clinical, Infectious Diseases Division/Department of Internal Medicine, UTHSCSA
Sergio Farrell, Senior Vice president/Ambulatory Services, University Health System-Robert B. Green Campus
Don Finley, Senior Writer, Corporate Communications, University Health System
Michael Hernandez, Vice President/Chief Legal Officer, University Health System
Barbara Holmes, Vice President/Chief Financial Officer, Community First Health Plans, Inc.
Reed Hurley, Executive Vice President/Chief Financial Officer, University Health System
Michelle Ingram, Vice President/Chief Quality Officer, University Health System
Leni Kirkman, Vice President, Strategic Communications and Patient Relations, University Health System
Karen McMurry, Litigation Support/Legal Services, University Health System
Armando J. Sandoval, Chief of Police, Protective Services, University Health System
Ronald Stewart, M.D., Professor, Department of Surgery, UTHSCSA; and Department of Surgery, University Health System
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Kristen Plastino, M.D., President/Medical-Dental Staff, University Health System; and Associate Professor, Department of Ob/Gyn, UTHSCSA  
Mark Webb, Chief Executive Officer, Pediatric Services, University Health System  
And other attendees.

CALL TO ORDER, WELCOME, AND RECORD OF ATTENDANCE: IRA SMITH, VICE CHAIR, BOARD OF MANAGERS

Mr. Smith called the meeting to order at 2:00 p.m.

INVOCATION AND PLEDGE OF ALLEGIANCE:

Mr. Smith introduced Mr. Praice George Edpot of Victory Assembly of God for the invocation, and he led the pledge of allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETING(S): NOVEMBER 17, 2015 (REGULAR MEETING)

SUMMARY: The minutes of the regular bi-monthly meeting of Tuesday, November 17, 2015, were submitted for approval.

RECOMMENDATION: Staff recommended approval of the minutes as submitted.

ACTION: A MOTION to approve the minutes was made by Ms. Barrera, SECONDED by Mr. Engberg, and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW-UP: None

APPROVAL OF MINUTES OF PREVIOUS MEETING(S): DECEMBER 15, 2015 (SPECIAL)

SUMMARY: The minutes of the regular bi-monthly meeting of Tuesday, November 10, 2015, were submitted for approval.

RECOMMENDATION: Staff recommended approval of the minutes as submitted.

ACTION: A MOTION to approve the minutes was made by Mr. Engberg, SECONDED by Mr. Hasslocher, and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW-UP: None

CONSENT AGENDA – IRA SMITH

CONSIDERATION AND APPROPRIATE ACTION REGARDING A RESOLUTION SUPPORTING THE VERIFICATION OF UNIVERSITY HOSPITAL AS A LEVEL 1 ADULT AND PEDIATRIC TRAUMA CENTER AND BURN PROGRAM—TRACY COTNER-POUNCY, R.N./LILLIAN LIAO, M.D., PEDIATRIC TRAUMA MEDICAL DIRECTOR/ED BANOS

SUMMARY: University Hospital has successfully re-verified and re-designated as a Level 1 Trauma Center in 2001, 2005, 2007, 2010 and 2013 by the American College of Surgeons (ACS). With support of the Board of Managers and senior leadership, the University Hospital Trauma Program has grown in volume and complexity. University Hospital is the lead trauma facility for Trauma Service Area P, and serves as a tertiary referral center for all of South Texas (Trauma Service Areas P,S,T,U, and V). In August 2012, UHS became a Level II pediatric
trauma center with subsequent Level II re-verification in June 2015. In order to pursue the highest level of pediatric trauma care, University Hospital will have another review by the American College of Surgeons on March 16-17, 2016 for Level I accreditation. It is also the goal of the Health System’s trauma team to pursue accreditation in 2017 by the American Burn Association (ABA) as a pediatric burn program. Quality of care is demonstrated by ACS accreditation which represents the highest level of capability in trauma care and helps to achieve the Health System objectives of the Triple Aim Plus. As a result of this Level 1 Trauma Center accreditation, the Health System has started charging Trauma Team Activation fees in 2012. In addition, the Health System receives funding through the Uncompensated Trauma Care fund from the State of Texas.

RECOMMENDATION: Staff recommends Board of Managers’ support for verification as a Level I Adult and Pediatric Trauma Center and Burn Program demonstrated by the adoption of a Resolution Supporting the Verification of University Hospital as a Level I adult and pediatric trauma Center and Burn Program.

ACTION: A MOTION to approve staff’s recommendation was made by Mr. Hasslocher, SECONDED by Ms. Barrera, and PASSED UNANIMOUSLY.

EVALUATION: Dr. Stewart and Dr. Liao reiterated that the Pediatric Trauma Center is currently accredited as Level 2. In his professional opinion, the chances of obtaining a Level 1 accreditation are about 95 percent. The trauma team feels strongly that failure is not an option. He also informed the Board that because there is not an existing fellowship available in the country that is directed to pediatric trauma surgery, the Health System does not have a pediatric trauma surgeon on staff nor does it have a pediatric trauma medical director. However, there is no additional training needed by the trauma surgeons at University Hospital at this time, and as indicated by the recent Magnet recognition, surgeons are comfortable that both adult and pediatric registered nurses are appropriately trained.

FOLLOW-UP: None.

ACTION:

CONSIDERATION AND APPROPRIATE ACTION REGARDING OPERATIONS AND FINANCIAL REPORT FOR JANUARY 2016—REED HURLEY/EDWARD BANOS

SUMMARY: In January clinical activity (as measured based on discharges adjusted for outpatient activity) was down 3.5% for the month compared to budget. Adjusted discharges budgeted for January at 4,200, actual 4,053, prior year at 3,998. Outpatient activity for the month was budgeted at 57,238 visits, actual was at 55,398 visits, and prior year was at 56,638 visits. Mr. Hurley reported payer mix for the month as follows: 73.7 percent funded; 7.2 percent CareLink; 3.0 percent UHS; and 16.1 percent unfunded. 2014 YTD actual funded was 68.6 percent; 2015 YTD actual funded was 7.27 percent; and 2016 funded budgeted is 68.6 percent. Staff’s monthly financial performance outlook indicates a budgeted bottom line of ($2,366); actual at $2,466, and a variance of $4,832. Mr. Hurley reviewed monthly financial performance budget to actual in
detail. He reported that Community First Health Plans (CFHP) fully-insured membership was up 0.8 percent due to higher membership in STAR Medicaid and HIE. The bottom line gain excluding debt service was $2.5 million, $4.8 million better than budget and was due to higher operating revenues and higher non-operating revenue. Debt service revenue was $4.5 million which is equal to the budgeted debt service payment of $4.5 million. Mr. Banos provided the following operational update:

- Hired an Executive Director for the Heart and Vascular Institute: Sara Hansen has extensive experience in cardiology, chest pain centers, catheter labs, emergency room management;
- Finishing third LEAN class with Baylor Scott and White LEAN Experts - five physicians and 45 management will have completed the three day course; and
- Implemented patient satisfaction call to action with management team - reviewing admission and discharge process as well as started patient family meetings with key staff and hospitalists to better understand patient and family needs.
- Working with UT:
  1. Critical care consolidation of resources where available to help with night time coverage;
  2. Patient discharge care coordination with the hospitalist group; and
  3. Inpatient new cancer diagnosis navigator to help patients with appointments and continuity of care.

RECOMMENDATION: Staff recommended Board’s acceptance of the financial reports subject to audit.

ACTION: A MOTION to accept the financials as submitted was made by Mr. Hasslocher, SECONDED by Mr. Engberg, and PASSED UNANIMOUSLY.

EVALUATION: Dr. Jimenez suggested that staff consider providing patients with a DVD containing individual discharge instructions, to which Mr. Banos replied that a similar idea is currently being explored - a standard template that the nurse can record and assign a secure link on YouTube, and also link the recording to the NurseLink telephone triage service.

FOLLOW-UP: None.

PRESENTATIONS AND EDUCATION:

REVIEW AND PRIORITIZATION OF ONGOING AND FUTURE CONSTRUCTION PROJECTS—MARK WEBB/REED HURLEY/ED BANOS

SUMMARY: Mr. Webb provided a chart that included projected completion dates, costs and funding sources, currently approved funding levels, and future funding needs for the various ongoing construction projects. Projects initiated as part of the CIP program are all slated to be complete before the summer of 2017, including the Pharmacy Project which still requires Board consideration. The remaining CIP projects consist of the second floor Specialty Clinics (Trauma, Transplant, Neurosurgery, Rehabilitation, Ophthalmology Clinics and the new Pulmonary Function
Testing Lab), new Shops for Plant Engineering, and a replacement for the University Hospital Central Pharmacy. All demolition has been completed and long lead items which include structural steel and air handling units have been acquired. The shops project is nearly complete and the clinics are nearing 50 percent completion. These projects consist of full renovation to provide not only new walls, ceilings and doors but also entirely new mechanical, electrical and plumbing systems in the affected areas. The goal of the Pediatric program is to renovate the existing Horizon Tower to contain the majority of pediatric functions at University Hospital. Mr. Webb summarized the following projects:

- Pediatric Emergency Department project involves partial demolition and reconstruction of the area. The project is well into construction in an expedited fashion with a targeted completion prior to the end of May 2016.

- Preparations are underway to move the Adult Inpatient Rehabilitation unit to the fifth floor of the Sky Tower to make the sixth floor of the Horizon Tower available for a new Pediatric Acute Care Inpatient unit. All patient rooms will be converted to single patient rooms and six new rooms will be constructed at the south end of the floor.

- The eighth floor of Horizon is currently occupied by Transplant Clinics and Offices and Pediatrics Administration. When transplant moves to the second floor specialty clinic area, the Pediatric Outpatient Hematology Oncology and Infusion Program, as well as the Pediatric Specialty Clinics, will be on the eighth floor.

- Until recently, the existing ICU on the ninth floor of the Horizon Tower had been used for the Pediatric Cardiac Care Unit (PCCU). The PCCU was recently moved to the old adult ICU on the tenth floor of the Horizon Tower in order for the ninth floor project to commence. Demolition on the ninth floor of the Horizon Tower is complete and construction of new partitions has begun while final design is being prepared.

- Although the original Adult Operating Rooms on the 11th floor of the Rio Tower have been functioning for Pediatric Surgery for some time, additional holding and recovery beds are needed to accommodate the volume of patients and turnaround times. A new plan is to use one of the existing operating rooms on the eleventh floor of the Horizon Tower for a Pediatric cardiac catheter lab.

- The twelfth floor of the Horizon Tower has been slated as expansion space for the Neonatal Intensive Care Unit (NICU). In the near term, most of the floor has been allotted to the NICU, while 10 of the existing patient rooms have been reserved for Pediatric Inpatients in order to provide a balance of needed pediatric beds. The NICU area requires substantial renovations. Plans for the 28 bed NICU have
been approved and the architect is working to develop the detailed drawings.

Mr. Webb reviewed the status of other major projects currently in process:

- The first phase to repair the exterior wall of the Rio Tower is underway. This work is required due to deterioration of brick work and related brick ties that resulted in brick falling off the face of the building. This repair work will be funded from operations. Total estimated cost is $2,300,000.

- Planning for the Eastside Clinic is in the initial phase of design or “Programming” which is when the scope of the project is established based on a Need/Demand Analysis that includes the population to be served, and a functional/operational plan with a detailed listing of required spaces. A full update will be provided to the Board in March.

- The project for the Northwest Clinic and Dialysis Center has been initiated. Architect/Engineer teams have submitted qualifications statements and the final selection is in process. A recommended firm will be submitted to the Board for approval within the next two months.

Finally, the projects below are envisioned major projects, and funding has yet to be identified:

- Enabling project for relocating Heart Vascular Institute functions for better operational performance.

- Expansion and consolidation of endoscopy and bronchoscopy service.

- Modification of fourth floor labor and delivery suite to provide for an additional operating room, as well as expansion of existing operating rooms.

- Build out of the Sky Tower basement to provide needed storage space and potential relocation of the morgue.

- Investigation of vacant second floor space to be utilized as a centralized inpatient dialysis unit.

**RECOMMENDATION:** This report was provided for informational purposes only; no action was required by the Board.

**ACTION:** None.

**EVALUATION:** None.

**FOLLOW-UP:** None.
HEALTH SYSTEM QUALITY REPORT – JAMES BARKER, MD/MICHELLE INGRAM, RN

SUMMARY: Foremost among the regulatory and external agencies that influence policy and payment related to healthcare quality and patient safety is the Centers for Medicare & Medicaid Services (CMS). With passage of the Patient Protection and Affordable Care Act (PPACA) in March of 2010, the role of CMS has expanded and is driving change in healthcare to improve both accountability and quality. Ms. Ingram summarized 25 CMS quality programs across three settings: hospitals, ambulatory, and post-acute care units, and focused on the Hospital Acquired Condition (HAC) Reduction Program, which is divided into two domains.

Domain 1 is a composition of conditions from the Agency for Healthcare Research and Quality’s Patient Safety Indicators (PSI). These PSIs are pressure ulcers, central line infections, post-op conditions (hip fractures, pulmonary embolism or deep vein thrombus, sepsis), surgical wound rupture and accidental punctures/lacerations.

Domain 2 addresses hospital acquired infections such as urinary catheter related infections, central line infection, surgical site infections, methicillin-resistant staphylococcus aureus (MRSA), and clostridium difficile infections.

The weighting has steadily shifted more to Domain 2, such that the next anticipated reporting will include 15 percent score from Domain 1 and 85 percent score from Domain 2. As with all of CMS hospital value based programs, the data for the HAC Reduction program currently represent time delay from results to reporting. For example, HAC Reduction program report for 2015 represent the results of hospital data that occurred from 2012 through 2013. Health System quality improvement oversight is provided by a Hospital Performance Council (HPC) and a Hospital Performance Subcommittee. She reviewed the functions of each in detail.

Ms. Ingram and Dr. Stewart reviewed colon and hysterectomy surgical site infection data for 2014-2015, with the SSI goal of zero and described the quality improvement activities connected to colon bundle implementation, physician leadership involvement, anesthesia support and education, and operating room improvements. She also reviewed Central Line and Catheter Infection Data for 2014-2015, with the SSI goal of zero, and she described the quality improvement activities for other infections in detail. She also reviewed patient safety metrics tied to quality improvement activities, and the HAC Reduction Program Timeline from 2014 to FY 2018 for improving clinical documentation and coding. Also reviewed were quality improvement activities for other infection as well opportunities for improvement.

Ms. Ingram yielded the floor to Dr. Barker for review of the characteristics of hospitals penalized by the HAC Reduction Program, according to the Journal of the American Medical Association (JAMA),
which all described University Hospital, and he also reviewed national quality strategy priorities. Dr. Barker reviewed HAC Reduction Program results for federal fiscal year 2016, patient safety indicator (PSI) 90 composite scores for Quarter 1, 2015 through Quarter 3, 2015; PSI 12; and PSI 15.

The Quality Metrics Improvement Team (QMIT) meets biweekly to analyze trends, review individual cases, and develop action plans. The QMIT group includes clinical documentation improvement nurses, Quality nurses, Infection Control Preventionists, Certified Coders, and Physician Champions. During the past year the QMIT team reduced the number of cases inappropriately coded as Patient Safety Indicators (PSIs) by 65 percent. Another 4.5 percent (18 of 400) were found to no longer be true PSIs after documentation clarification. These proactive interventions improve the acuity levels for the Health System’s patient case mix index and reduce penalties for inaccurately coded complications significantly. Staff expects to increase the scope of these efforts across the Health System in 2016.

RECOMMENDATION: This report was provided for informational purposes only.

ACTION: None.

EVALUATION: Dr. Alsip introduced Dr. Jason Bowling, University Hospital’s Epidemiologist. There were approximately 135 colorectal surgeries performed last year at University Hospital. Dr. Jimenez asked about a cost estimate/per patient for changing instruments and gowns in these cases. Although changing gowns and instruments is the standard of care, cost can be measured in time because the cost to treat one surgical site infection is approximately $10,000/patient, which is significant and worth the investment. Indirect costs include penalties that will be imposed by CMS. As far as such patients who are already contaminated at arrival, staff performs risk adjustments, reviews risk factors, and follows best practices. However, CMS does not risk adjust, and because documentation is still part of the equation, staff is cautioned to be cognizant of all elements and is asked to document “present on admission.” Mr. Smith agreed that education and training for staff and Board members is the key to success in this area.

FOLLOW-UP: Regarding the quality reporting structure for a proposed Board of Managers Subcommittee to serve as a forum for discussion on quality performance and improvement initiatives, Dr. Alsip will provide the Board members with a list of expertise/talent areas of those physicians and staff members who will serve, as requested by Ms. Barrera.

COMMUNITY FIRST HEALTH PLANS, INC., OPERATIONS REPORT—GREG GIESEMAN

SUMMARY: Mr. Gieseman reported that Community First Health Plans (CFHP) had achieved progress and success in 2015 towards the majority of the strategic initiatives approved by its Board, and he provided the following update:

Medicaid STAR market share consistent for 2015 in the Bexar Service Delivery Area, data compared against Superior, Aetna, and Amerigroup. For CFHP, membership ranged from 44.06 percent in December 2014 to
44.02 percent in December 2015. STAR Membership Decreased by 1,673 (1.5 percent) versus a total market decrease of 1.4 percent from December 2014 to December 2015.

Slight increase (0.8%) in CHIP market share from December 2014 to December 2015. CHIP membership Increased by 1,027 (6.2 percent) versus a market growth of 4.8 percent from December 2014 to December 2015.

CFHP’s 2015 year to date financial performance includes a net income of $12,467,715 which is a variance of $8,983,167 (257.8 percent) as compared to the budgeted amount of $3,484,548. Financial performance exceeded HHSC’s profitability allowances. In addition, similar to previous years, CFHP has recorded a reserve from 2015 operations of $2.6 M given that CFHP will not know until late 2016 its performance and any liability to HHSC for the 2015 premium at risk measures.

The Board reviewed 2015 financial drivers and the details regarding premium revenue that was below budget by $16.4 M, and was attributed to 80,154 fewer member months, or $15.1 M due primarily to statewide enrollment decline in Medicaid, and lower premium yield $1.3 M. CFHP exceeded prior year performance by $9.7 M. Also reviewed were 2015 financial driver details for medical expenses, which were favorable to budget by $23.3 M (vs. $16.4 M unfavorable variance in premium).

Medicaid revenue (without pharmacy) ranged from 189.53 in 2011 to $173.36 in 2015 per member per month. Medicaid Expense (without pharmacy) ranged from 159.77 in 2011 to $145.04 in 2015 per member per month. CHIP Revenue (without pharmacy) ranged from $86.50 in 2011 to $87.04 in 2015 per member per month. CHIP Expense (without pharmacy) ranged from $72.12 in 2011 to $70.35 in 2015 per member per month. Also reviewed were percentages of facility cost and admission to University Hospital for the period 2012 through 2015.

Balance sheet highlights were reported as follows: total Assets are $119 M (11% over prior year); cash and investments at $110 M; days cash and investments on hand are at 115; days of claim expense are 33; total surplus - $73 M (21% over prior year); and risk based capital (RBC) is approximately 600 percent.

A major 2015 accomplishment in providing high quality health care was CFHP’s achievement of a full three year NCQA accreditation for all product lines (commercial, Medicaid and marketplace). To foster a culture of operational excellence, staff implemented a process for identifying CFHP’s core operational IT system needs and developed a recommendation for presentation to CFHP Board in early 2016. In maintaining financial stewardship, staff implemented benefit designs, pricing and outreach activities that resulted in over 6,400 members (4,900 paid) selecting CFHP marketplace products for 2016 (a fourfold increase over 2015 enrollment). Further, CFHP maintained market share leadership position for Medicaid (44.0 percent) with 108,900
members and CHIP (62.7 percent) with 17,500 members. In expanding coordination with the Health System’s delivery system, CFHP participated in NAIP program implementation and revisions to provide improved care access to Medicaid patients and an additional revenue stream to health system and health plan. Mr. Gieseman summarized all 2015 accomplishments for the Board.

Among other 2016 initiatives to provide high quality health care, a primary initiative is to review and revise necessary Key Performance Indicators (KPI), and the implementation of data reporting and support to increase the number of providers/groups that achieve the performance goal for Well Child and Adolescent Well Child visits. To foster a culture of operational excellence and to implement the STAR kids program, CFHP is currently adding staff for network development and credentialing, care management protocols, processing of LTSS claims, coordination of reporting and data flow among various State agencies and outreach programs.

RECOMMENDATION: This report was provided for informational purposes only. No action was required by the Board of Managers

ACTION: None
EVALUATION: None.
FOLLOW-UP: None.

ADJOURNMENT:

There being no further business, Mr. Smith adjourned the public Board meeting at 4:00 p.m.

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Ira Smith      Dianna M. Burns, M.D.
Vice Chair, Board of Managers   Secretary, Board of Managers

Sandra D. Garcia, Recording Secretary