University Health System

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

Tuesday, July 16, 2013
6:00 p.m.
Conference Room A
Corporate Square
4801 NW Loop 410, 10th Floor
San Antonio, Texas 78229-5347

MINUTES

BOARD MEMBERS PRESENT:

James R. Adams, Chair
Linda Rivas, Vice Chair
Rebecca Q. Cedillo, Secretary
Roberto L. Jimenez, M.D., Immediate Past Chair
Robert Engberg
Alex Briseño
Ira Smith

OTHERS PRESENT:

George B. Hernández, Jr. President/Chief Executive Officer, University Health System
Bryan Alsip, M.D., Executive Vice President/Chief Medical Officer, University Health System
Theresa De La Haya, Senior Vice President, Community Health and Clinical Prevention, Texas Diabetes Institute/University Health System
Michael Hernandez, Vice President/Chief Legal Officer, University Health System
Leni Kirkman, Vice President, Corporate Communications & Patient Relations, University Health System
Mary Ann Mote, Senior Vice President/Chief Revenue Officer, University Health System
Bill Phillips, Senior Vice President/Chief Information Officer, University Health System
Michelle Ryerson, Senior Vice President, Chief Nursing Officer/Chief Operating Officer, Pediatric Clinical Services Administration, University Health System
Christann Vasquez, Executive Vice President/Chief Operating Officer, University Health System
Mark Webb, Senior Vice President, Facilities Administration, University Health System
Francine Wilson, Vice President, Materials Management, University Health System

CALL TO ORDER AND RECORD OF ATTENDANCE: JIM ADAMS, CHAIR, BOARD OF MANAGERS

Mr. Adams called the meeting to order at 6:10 p.m. He announced that he had recently appointed Ms. Rebecca Cedillo as the Board representative responsible for following up on all items brought before the Board of Managers during the Citizens' Participation portion of meetings. Mr. Adams asked the staff to brief Ms. Cedillo on these items for prompt resolution on the Board's behalf.
INVOCATION AND PLEDGE OF ALLEGIANCE:

Ms. Leni Kirkman introduced Health System employee Ms. Norma Garza of Holy Trinity Catholic Church, for the invocation. Mr. Adams led the pledge of allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETING(S):

MAY 21, 2013 (REGULAR MEETING)

SUMMARY: The minutes of the regular meeting of Tuesday, May 21, 2013, were presented for the Board's approval.

RECOMMENDATION: Mr. Adams recommended approval of the minutes as submitted.

ACTION: There being NO OBJECTION, the minutes were APPROVED as submitted.

EVALUATION: None.

FOLLOW-UP: None.

CONSENT AGENDA:

CONSIDERATION AND APPROPRIATE ACTION TO AMEND THE PROFESSIONAL SERVICES CONTRACT WITH PERKINS+WILL FOR ENVIRONMENTAL GRAPHIC DESIGN, RECONFIGURATION OF THE MAIN DISTRIBUTION FRAME, AND THE ADDITION OF A CART WASHER AT THE NEW LOADING DOCK AND OTHER RELATED SERVICES AT UNIVERSITY HOSPITAL (FUNDED WITH PROJECT FUNDS)—MARK WEBB

SUMMARY: The original agreement, with a not to exceed contract amount of $45,310,513, has been amended to include additional design for the remote parking lot, facility hardening, zoning changes, Pavilion IT, mock ups, central utility plant (CUP), payment of permit fees, approved enhancements, the Heart Center study and planning studies concerning medical equipment integration, basement excavation, loading dock revisions, blood bank and Emergency Center design, meeting room and patient room reconfigurations as well as additional designs throughout the University Hospital campus.

Perkins+Will were asked by the CIP team to develop designs and engineered solutions for a number of issues to meet the specialized needs of the University Hospital. Specifically, these items include those listed below which will be funded by project funds (A/E fees).

- Revisions as a Result of Renovation Work Re-Sequencing - $15,790
- Design Services for West Parking Garage Storage Room - $4,460
- Reconfiguration of Telecom/Data Room in New Tower - $1950
- Addition of Automatic Cart Washer in New Loading Dock - $17,985

TOTAL $40,185

The project manager has reviewed and negotiated these fees and recommends approval. Previously approved amendments related to this contract are $2,158,026, and the newly revised contract amount is $47,508,724.
RECOMMENDATION: Perkins+Will participation levels are 30% for SMWVBE and 51% local firms.

Staff recommends Board of Managers approval of an amendment to the contract with Perkins+Will in the amount of $40,185.

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

EVALUATION: None.

ACTION ITEMS:

CONSIDERATION AND APPROPRIATE ACTION TO AMEND THE PROFESSIONAL SERVICES CONTRACT WITH PERKINS+WILL FOR ARCHITECTURAL SERVICES ASSOCIATED WITH ADDITIONAL SCOPE FOR EXISTING EQUIPMENT PLANNING AND DESIGN MODIFICATIONS (FUNDED WITH PROJECT FUNDS)—MARK WEBB

SUMMARY: The original agreement, with a not to exceed contract amount of $45,310,513, has been amended to include additional design for the remote parking lot, facility hardening, zoning changes, Pavilion IT, mock ups, central utility plant, payment of permit fees, approved enhancements, the Heart Center study and planning studies concerning medical equipment integration, basement excavation, loading dock revisions, blood bank and Emergency Center design, meeting room and patient room reconfigurations as well as additional designs throughout the University Hospital campus.

During the June 26, 2012, Board of Managers meeting, staff presented three amendments to the Perkins+Will contract that reduced their fee by $2,199,821. The three items consisted of:

a) Reduction of scope of work associated with renovation phases of the project;
b) Design and planning work for the future expansion of additional operating rooms and patient rooms; and
c) Additional scope for medical equipment planning, operating room integration, and deducted scope related to estimate reconciliation and design modifications.

The majority of the previously mentioned fee reduction was associated with the decrease in scope of services for the renovation phases of the CIP. Since the June 2012 Board meeting, the project team has further evaluated the scope of medical equipment planning needed for the project and refined the estimate reconciliation numbers that were used in the development of the fee adjustment (related to item “c” above) with more accurate work and project cost information. Based on the analysis, staff recommends an additional $638,945 be paid to Perkins+Will for those services. With this change, the overall fee to Perkins+Will is 7.6% of the project construction costs which is within industry standards for this type of project. The fee addition for medical equipment is approximately 4%, or $638,945. This amount is based on a percentage of medical equipment involved as well as the staff time involved and is a negotiated fee.

The original contract amount is $45,310,513; previously approved amendments total $2,198,211 and the revised contract amount is $28,147,669. Fees for this contract amendment will be paid from project funds. Perkins+Will participation
levels are 30% for SMWVBE and 51% local firms. Mr. Webb assured the Board that there are not any future, new projects to be proposed for Perkins & Will; this is the last addition related to medical equipment. Perkins+Will are scheduled to finish their work at UHS at the end of July 2014.

RECOMMENDATION:
Staff recommends Board of Managers approval of an amendment to the contract with Perkins+Will in the amount of $638,945.

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

EVALUATION:
Mr. Adams expressed great confidence in the staff’s work, however, stated that he did not understand what services Perkins+Will will provide for the medical equipment planning fee of 4%. Mr. Webb clarified that these services are to be performed in the next nine (9) months, and that equipment needs have been identified. However, not all of the equipment has been purchased, and the fee is related to equipment planning services. Further, none of the changes to this contract were driven by construction issues, but rather, some changes were made by scope, requested by the owner, or necessary from a clinical staff perspective. Mr. Hernandez interjected that when staff identified contract needs last year, the staff did not have enough knowledge of the equipment process before any of the deductions to this contract were made. If staff could do this again, a special equipment planner would be engaged in advance to do this for the Health System. Mr. Adams thanked the staff for the detailed explanation and stated that the Board of Managers has an interest in doing what is necessary to accomplish the mission of the Health System, and Board members will often times ask for assurances from staff for the administration of proper of health care.

FOLLOW-UP:
None.

CONSIDERATION AND APPROPRIATE ACTION TO APPROVE THE GUARANTEED MAXIMUM PRICE FOR RECONFIGURATION OF THE EMERGENCY CENTER RESULTS AND 9TH FLOOR TRANSPLANT WAITING ROOMS; ADDITION OF HYDROTHERAPY ROOM, EMERGENCY CENTER MED GAS, FIRE ALARM, AND INTERMEDIATE DISTRIBUTION FIRE ALARM (IDF) CABLING AT THE NEW TOWER AT UNIVERSITY HOSPITAL (FUNDED WITH CONTINGENCY FUNDS) (GMP #13W) - MARK WEBB

SUMMARY:
The Capital Improvement Program (CIP) as outlined in the adopted Master Facilities Plan includes a new hospital tower, parking facilities, central utility plant (CUP), and renovation of existing buildings at the University Hospital campus. To date, twenty (22) guaranteed maximum prices (GMPs) have been developed for the new Hospital Tower project. These are detailed in the Fiscal Impact section of this memo. This scope is inclusive of owner-requested revisions to the Tower for Reconfiguration of Results Waiting located in the Emergency Center, Reconfiguration of 9th Level Transplant Waiting/Exam Room, Addition of 5th Floor Hydrotherapy Room, Emergency Center Medical Gas Changes, Fire Alarm Changes, IDF Cabling Changes. This is the 23rd GMP and is inclusive in the amount of $867,155. The Tower Project construction manager has reviewed the design drawings, prepared by the AE Team, and has provided a Guaranteed Maximum Price (GMP #13w) for the work associated with this GMP package. The Project Manager has reviewed the GMP and recommends for approval. Mr. Webb reviewed GMP13a through 13w and their amounts in detail. The proposed GMP #13w is in the amount of $876,155. Fees will be paid from owner’s construction contingency in the amount of $876,155.
This would decrease the owner’s contingency funds from $5,464,097 to $4,587,942. This expense to the contingency fund was contemplated and included in the projected contingency spend report to the Board, which was originally proposed to be $846,155. The participation goal for SMWVBE is 40% and the local participation goal is 80%. To date, SMWVBE participation of awarded construction projects is 39.1% and local participation is 74.1%. This does not include the dollars associated with the Construction Manager’s Fee or other project administrative costs including this GMP and insurance, bonds, permit fees, etc. Mr. Webb also reviewed the SMWVBE numbers achieved for all construction GMPs with the Board.

RECOMMENDATION: Staff recommends Board of Managers approval of an amendment to the Zachry Vaughn Layton Construction Management Agreement in the amount of $876,155, for GMP #13w.

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

EVALUATION: None.

FOLLOW-UP: None.

PRESENTATIONS ON 1115 WAIVER DSRIP PROJECTS:

On December 12, 2011, the Centers for Medicare and Medicaid Services (CMS) approved Texas’ request for a new Medicaid section 1115 Demonstration, entitled “Texas Healthcare Transformation and Quality Improvement Program” for the period October 1, 2011 through September 30, 2016. The aims of the 1115 Demonstration, commonly called the Waiver are to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of regional coordinated care delivery systems;
- Improve quality and outcomes while containing cost growth;
- Protect and leverage financing to improve and prepare the health care infrastructure to serve a newly insured population; and
- Transition to value-based payment systems

The expansion statewide of Medicaid managed care is intended to lead to improved access to primary care and more coordinated care for Medicaid beneficiaries.

Qualification guidelines

The savings from the expansion of Medicaid managed care and the discontinuation of previous supplemental provider payments, known as UPL, will finance two new funding pools: the Uncompensated Care (UC) Pool and the Delivery System Reform Incentive Payment (DSRIP) Pool. DSRIP Project funding provides incentives for collaborative initiatives in simultaneous pursuit of three aims: better health care for individuals, including access to efficient, effective care; better health for the population; and lower cost through improvement.

DSRIP PROJECT: IMPLEMENTATION OF A TELEMEDICINE PROGRAM TO PROVIDE OR EXPAND SPECIALIST REFERRAL SERVICES—BILL PHILLIPS

SUMMARY: This project will employ telemedicine services to improve access to specialty care for patients experiencing barriers to such care. With enhanced access and improved care coordination, the telemedicine visits will allow specialists and
other members of the health care team to more efficiently monitor a patient's disease status, adherence to treatment plans, and medication management. Telemedicine technology has become increasingly available to clinical practitioners and holds the promise of providing electronic health care services to increase patient access to care. Vulnerable populations that include economically underserved, minority, and uninsured individuals are less likely to either seek or have access to timely clinical interventions and treatment, resulting in emergency room visits and hospital admissions. In Bexar County, as elsewhere in RHP 6, there is a disproportionate population of low-income, uninsured, and minority individuals, who experience chronic conditions. Without regular primary care and timely access to specialists, these chronic conditions are likely to become acute episodes, resulting in preventable hospital admissions. The target population will include all patients with chronic conditions with a specific focus on adults with diabetes. Medicaid-funded (19%) and uninsured (43%) persons represent 62% of the patient population served by the Health System. According to data provided by the Texas Department of State Health Services, there were 8,863 adult hospitalizations for diabetes long-term complications in Bexar County from 2006 – 2010. University Hospital ranked second in number of admissions. Category 1 or 2 outcomes (or expected patient benefits) for DY4, 10% of adult patients with diabetes referred to specialists from three designated clinics will have received telemedicine visits. By the end of DY5, adult patients with diabetes will be receiving specialty telemedicine visits from five designated clinics and clinics will be performing at least 10 telemedicine visits per month. Category 3 outcomes, to reduce diabetes long-term complications admission rates, were described as follows: DY4 – Reduce Diabetes Long-term Complications Admission Rate by TBD% for adult diabetes patients. DY5 – Reduce Diabetes Long-term Complications Admission Rate by TBD% for adult diabetes patients. The status of current DSRIP year (DY2) milestones and projection for next year (DY3) metrics and milestones were discussed in detail. This project will employ telemedicine services to improve access for patients experiencing barriers to specialty care. The intervention will specifically target University Hospital's Medicaid and uninsured patient population diagnosed with chronic conditions and a specific focus on adults with diabetes. Telemedicine technology has become increasingly available to clinical practitioners and holds the promise of providing electronic health care services to increase patient access to care. Telemedicine visits will also allow specialists and other members of the health care team to more efficiently monitor a patient's disease status, adherence to treatment plans, medication management, and the coordination of care. This project is one of the 23 DSRIP projects submitted under the Waiver. The detailed cost and offsetting DSRIP funding for 2013 (DY2) was included in the budget and the net cost for 2013 is $2,471,665. To date this project is on target to cover its cost. The DSRIP project budget impact for DY2 – DY 5 is as follows: Direct cost: $177,136; IGT for Other Hospitals is $3,410,885; net cost of $9,317,002; and total net DSRIP categories 1 through 4 following chart reflects the estimated cost and funding over the entire Waiver period.

This report was provided for informational purposes only.

Mr. Engberg asked about the quality of the medical care to be delivered via telemedicine visits as opposed to personal visits. Mr. Phillips assured the Board that the interaction between patients and physicians will be of similar quality and also reported that the success rates of telemedicine programs across the country.
are very high, with the use of telemedicine spreading quickly. Dr. Jimenez advised the staff to consider hiring a research person to measure acculturation changes that will result from the telemedicine program, because it raises unknown issues for patients of the Mexican American community who often turn to folk healing such as Santeria or Curanderismo. Mr. Adams commended the staff for their work on this important project and for taking advantage of the various opportunities that will allow the Health System to provide better quality health care.

FOLLOW-UP:
None.

**DSRIP PROJECT: IMPLEMENT A CHRONIC DISEASE MANAGEMENT REGISTRY**

--- BILL PHILLIPS

**SUMMARY:** This project will improve patient care quality by developing and utilizing a master chronic disease management registry that will allow providers to more efficiently monitor a patient's disease status, adherence to treatment plans, medication management as well as tailor delivery of appropriate clinical/care coordination interventions. The design and utilization of chronic disease registries are considered the first step in providing a population-based approach to fully evaluate quality of care delivered, coverage of clinical preventive services and their impact on condition-specific outcomes for patients with chronic health conditions. The target population will include all patients with chronic conditions with a specific focus on adults and children with asthma and chronic obstructive pulmonary disease (COPD). These individuals cost the system about $20 million/year in Emergency Room and inpatient visit cost. Category 1 or 2 outcomes (or expected patient benefits) involve enrolling patients from the largest pediatric sites and pulmonologist/allergy specialist sites into the registry. Registry functionality will be available to the three designated specialties by the end of DY3. Patients will be enrolled during DY4, with a goal of approximately 70% of patients with a diagnosis of asthma in the three target clinic sites enrolled by the end of DY5. Category 3 outcomes for DY4 will reduce emergency department visits by 5% (300 visits/yr) for adult and pediatric asthma/COPD registry patients assigned to three target specialties. During DY5, we will Reduce Emergency Department visits by 15% (1500 visits/yr) for adult and pediatric asthma/COPD registry patients assigned to three target clinics. The status of current DSRIP Year (DY2) milestones, metrics and projection for next year (DY3) milestones were reviewed in detail with the Board. This project will improve patient care quality by developing and utilizing a master chronic disease management registry specifically targeting University Hospital's Medicaid and uninsured patient population diagnosed with asthma/COPD, which will allow providers to more efficiently monitor a patient's disease status, adherence to treatment plans, medication management as well as tailor delivery of appropriate clinical/care coordination interventions. Providing excellent care to the residents of Bexar County requires reliable, transparent, time-sensitive data. The design and utilization of chronic disease registries are considered the first step in providing a population-based approach to fully evaluate quality of care delivered, coverage of clinical preventive services and their impact on condition-specific outcomes for patients with chronic health conditions. This project is one of the 23 DSRIP projects submitted under the Waiver. The detailed cost and offsetting DSRIP funding for 2013 (DY2) was included in the budget and the net cost for
2013 is $7,036,971. To date this project is on target to cover its cost. The project budget impact for DY2 through DY 5 was reviewed. The direct cost for the project is $10,309,120, the capital cost is $5,305,316, the IGT for other hospitals is $4,012,806; the net cost is $19,627,242; and total net amount for DSRIP Categories 1 through 4 is $415,614,436.

RECOMMENDATION: This report was provided for informational purposes only.
ACTION: None.
EVALUATION: None.
FOLLOW-UP: None.

**DSRIP PROJECT: INCREASE AND EXPAND ORAL HEALTH SERVICES—THERESA DE LA HAYA**

**SUMMARY:**
This project will establish an affiliated/integrated dental health services program that incorporates patient navigation within the medical home model of care by partnering with two local Federally Qualified Health Centers (FQHCs), CommuniCare and CentroMed. These efforts will result in delivery of timely, accessible, integrated and patient-centered preventive dental health care services for economically underserved populations with chronic disease residing in Bexar County, Texas. Oral diseases ranging from dental caries (cavities) to oral cancers and cause pain and disability for millions of Americans (Healthy People 2020). Studies link oral health, particularly periodontal (gum) disease, to several chronic health conditions that include diabetes and heart disease. Such conditions may be prevented in part with regular preventive visits to the dentist. Economically vulnerable populations that include minority adults, persons with a chronic disease are also significantly less likely to have access to oral health care compared to their non-poor and non-minority peers. For example, a recent survey conducted on leading oral health indicators found that less than half (44.5%) of eligible individuals have had a dental visit within the past 12 months (Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality, 2007). In Bexar County, Texas, 22% of residents live at or below the poverty level ($22,557), 17% receive no medical care due to cost, and 23% have no form of health insurance coverage, highlighting the need for increased access to clinical preventive services. Recent health assessments of the population find that residents with less than a high school education and an annual household income of less than $15,000 are significantly less likely to rate their oral health status as good to excellent (25% and 20%, respectively). Hispanics and African-Americans and individuals living in the Southeast and Southern regions of Bexar County are less likely to rate their oral health status as good to excellent or report having adequate dental health coverage (Bexar County Health Collaborative, 2010). The project will focus on CareLink enrollees diagnosed with chronic disease that seek services at our FQHC partner sites. Category 1 or 2 expected patient benefits entail an anticipated 5 year goal to increase the proportion of economically vulnerable individuals with chronic disease that access quality dental health services following a referral from a primary care/medical provider. The secondary goal is to improve clinical linkages (integration and coordination of health services), enhance referral pathways (primary care to dental provider) and establish an infrastructure for delivery of oral health services between the Health System, FQHCs and the target population. Proposed category 3 outcomes (pending HHSC and CMS review and approval) are to increase by a
percentage (to be determined) of chronic disease patients who following dental treatment have improved oral health status. The status of current DSRIP year (DY2) milestones, metrics, and projections for next year (DY3) were reviewed in detail with the Board. This project is one of 23 DSRIP projects submitted under the Waiver. The detailed cost and offsetting DSRIP funding for 2013 (DY2) was included in the budget and the net cost for 2013 is $596,969. To date, this project is on target to cover its cost. The DSRIP project budget impact for DY2 through DY5 was reviewed: The direct cost is $1,824,486; IGT for other hospitals is $840,717, net cost is $2,665,593; total net DSRIP Categories 1 through 4 is $3,271,359.

RECOMMENDATION: This report was provided for informational purposes only.
ACTION: None.
EVALUATION: It is anticipated that 800 patients will benefit from this DSRIP project. During Year 1, 100 patients will be referred to each FQHC and allotted 7 visits each for a total of 700 visits. During Year 2, the patients will be allowed three visits each, and during Year 3, two visits each. Currently, the wait time for dental appointments (outside of this DSRIP project) at the FQHCs is 6-8 months due to limited resources. Mr. Adams cautioned the staff of the need for a strong, detailed and objective oversight function for this project. Dr. Jimenez suggested the use of a basic oral screening tool for use on all Health System patients diagnosed with chronic disease.
FOLLOW-UP: None.

CLOSED MEETING:

Mr. Adams announced this meeting closed to the public at 7:44 p.m., pursuant to TEX. GOV'T CODE, Section 551.085 (Vernon 2004) to receive information on and/or deliberate regarding pricing, market data and/or financial and planning information relating to the arrangement or provision of proposed new services and/or product lines. The following Board members were present: James R. Adams, Linda Rivas, Rebecca Q. Cedillo, Roberto L. Jimenez, M.D., Robert Engberg, Alex Briseño, and Ira Smith. The following staff members were also present: George B. Hernandez, Jr.; Christann Vasquez; Peggy Deming; Richard Rodriguez; Bryan Alsip, M.D.; Ted Day; and Michelle Ryerson. After discussion, no action was taken in closed session. Mr. Adams announced that the closed meeting ended at 9:05 p.m., and the public meeting reconvened.

ADJOURNMENT:

There being no further business, Mr. Adams adjourned the public meeting at 9:06 pm.

Jim Adams
Chair, Board of Managers

Rebecca Q. Cedillo
Secretary, Board of Managers

Sandra Garcia, Recording Secretary