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

Tuesday, July 21, 2015
2:00 p.m.
Corporate Square, 10th Floor, Conference Room A
4801 N.W. Loop 410
San Antonio, TX 78229-5347

MINUTES

BOARD MEMBERS PRESENT:

James R. Adams, Chair
Ira Smith, Vice Chair
Dianna M. Burns, M.D., Secretary
Roberto L. Jimenez, M.D., Immediate Past Chair
Robert Engberg
James C. Hasslocher

BOARD MEMBERS ABSENT:

Robert Gilbert

OTHERS PRESENT:

George B. Hernandez, Jr., President/Chief Executive Officer, University Health System+
Tricia Aleman, Executive Director, Marketing Services/Corporate Communications, University Health System
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
Ted Day, Senior Vice President, Strategic Planning & Business Development, University Health System
Sergio Farrell, Senior Vice President, Ambulatory Services, University Health System - Robert B. Green Campus
Don Finley, Senior Writer, Corporate Communications, University Health System
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
Griselda Sanchez, Associate General Counsel, University Health System
A.J. Sandoval, Chief of Police/Protective Services, University Health System
Mark Webb, Chief Executive Officer, Pediatric Services, University Health System
And other attendees.
CALL TO ORDER, WELCOME, AND RECORD OF ATTENDANCE: JAMES R. ADAMS, CHAIR, BOARD OF MANAGERS

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

INVOCATION AND PLEDGE OF ALLEGIANCE:

Mr. Adams introduced Ms. Norma Garza of Holy Trinity Catholic Church for the invocation, and he led the pledge of allegiance.

CONSENT AGENDA – JIM ADAMS, CHAIR

CONSIDERATION AND APPROPRIATE ACTION REGARDING COMMISSIONING OF A PEACE OFFICER FOR BEXAR COUNTY HOSPITAL DISTRICT—SERGIO FARRELL/CHIEF A.J. SANDOVAL

CONSIDERATION AND APPROPRIATE ACTION REGARDING A RESOLUTION SUPPORTING MEMBERSHIP IN THE CHILDREN’S HOSPITAL ASSOCIATION – MARK WEBB

SUMMARY: The items above were presented as consent items for the Board’s consideration.

RECOMMENDATION: Staff recommended approval of the items on the consent agenda.

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

EVALUATION: The Children’s Hospital Association requires Board approval to join and as a benefit, membership will put the Health System in a network of 220 children’s hospitals across the country.

FOLLOW-UP: None.

CONSIDERATION AND APPROPRIATE ACTION REGARDING SELECTED PURCHASING ITEMS:

DISCUSSION AND PRIORITIZATION OF CAPITAL NEEDS—MARK WEBB/REED HURLEY/GEORGE HERNÁNDEZ

SUMMARY: Staff recently developed a multiple year plan with a number of projects that meet immediate Health System needs and projects that address strategic growth initiatives. Mr. Webb presented a detailed project summary chart associated with the various phases of capital projects, as well as the corresponding funding needs. Some of these projects received limited funding as the reserves were rebalanced each year and others were recently identified. The list of projects includes several that are “shovel ready” (i.e., design is complete or almost complete and construction can begin as soon as a contractor is engaged). Additionally, staff has reviewed alternatives, such as building to current activity needs versus complete build-out for long-term projected activity and reusing/renovating spaces, to minimize funding needs. The initial first year projects that are shovel or near shovel ready include completion of current renovation projects on the hospital campus. Additionally,
although not shovel ready, the Northwest Dialysis and Clinical Services Building in the South Texas Medical Center, as well as Pediatric and Neonatal Intensive Care Unit expansions are also priority projects for the first year.

Neonatal Intensive Care Unit (NICU)
Staff recommends that certain areas of the existing NICU be renovated to keep pace with market competitiveness and the number of NICU beds be immediately increased by 10 to 15 beds while creating future expansion space of another 10 to 20 beds. This will increase the number of NICU beds from 52 to a maximum of 87. This project involves the renovation of existing space and the buildout of new space for both the NICU and the behavioral health unit. The anticipated aggregate cost of the project is approximately $25.0M.

Pediatric Inpatient Beds
Staff has developed a renovation plan that would locate all of the pediatric inpatient units to be located in the Horizon Tower. This would provide for more centralized pediatric services in the same building as the pediatric emergency department, and create a children's tower. This project also addresses the need for additional adult beds in the Sky Tower while allowing for improved emergency department throughput. The anticipated cost of the project is approximately $11.1M.

Northwest Clinical Services and Dialysis Building
Currently, both the Northwest Clinic and Northwest Dialysis are separately leased facilities in the Medical Center area, and are inadequate for current clinical needs and doesn’t provide for future expansion of services, especially in pediatrics. Additionally, the facility housing the dialysis service will require a significant capital investment in the leased building’s infrastructure. The proposed new facility to be constructed in the medical center area would house a 36 chair adult dialysis center, an 8 chair pediatric dialysis center, adult and pediatric primary care and specialty clinics, and other services. The dialysis center is integral to the success of the Transplant Program. Design work would begin this year, with construction beginning in 2016. Scheduled completion is late 2017. The anticipated cost of the project is approximately $32.8M.

FFACTS Clinic Relocation
In an effort to provide a higher level of comprehensive care in a more convenient setting, staff has started discussions with the San Antonio AIDS Foundation about the possibility of building a joint facility that would house the services currently provided by both organizations in addition to a skilled nursing facility and pharmacy. The current FFACTS Clinic Space at the Robert B. Green campus would be repurposed to support adult and pediatric specialty care. The anticipated cost of the project is approximately $6.7M.
Heart and Vascular Institute (HVI)
The HVI project received partial funding for design services in 2012 ($4.1M). Since that time, staff has worked with the design professionals to develop a thorough program and space plan that meets the current and future needs of the cardiology, vascular, and cardio thoracic surgery service lines as an aligned service group. The estimated cost of the current plan is $49.8M. However, in an effort to make efficient use of current space and limited funds, staff has developed a plan to utilize several of the built, but not equipped operating rooms on the 3rd floor of the Sky Tower with an estimated cost of $17.8M. Construction work for this project would begin before the end of 2015 with completion in late 2016.

The other projects proposed at University Hospital various renovation projects associated with clinic areas, common areas, pharmacy, endoscopy expansion, chest pain unit, rehab office relocation, and emergency command center.

Proposed funding priorities (excluding Exploratory Projects) are:

- 2015 - $28.1M
- 2016 - $79.2M
- 2017 - $29.1M
- Total - $136.4M

Exploratory projects include the ExpressMed Clinic at the Texas Diabetes Institute, Northeast Clinic and other Clinics, 6th Floor Build-Out at the Robert B. Green Clinical Services Building, Parking Garage at the Robert B. Green, and University Hospital Cafeteria.

Funding for these projects is still to be determined based on discussions with the Board. The projects would be managed by Health System staff with the assistance of outside project management personnel.

RECOMMENDATION: This report was provided for informational and discussion purposes only.

ACTION: None.

EVALUATION: Mr. Adams encouraged Board members to ask questions, and stressed that today's presentation is part of the capital planning process, the staff is not asking for approval of funds at this time, and the list of capital items and their amounts are subject to change. The staff has performed a lot of internal prioritizing to develop this list and group them based on past Board direction to show the entire picture. They are very important to the Health System and for the community. Staff needs to get facilities up and running so that the services can be marketed. At this time, Mr. Hernandez acknowledged the instrumental work of Mr. Gilbert in the area of marketing. The staff has previously informed the Board regarding areas of concern in the ambulatory setting and at the hospital, for example, with ongoing renovations and the Heart and Vascular Institute, a service line staff would like to grow. Today's discussion is a prelude to the Board's strategic planning retreat that is scheduled for September 30. The items not on today's list are unfunded or only partially funded. The staff is looking for a high level commitment by the
Board at this time. Mr. Engberg reiterated the importance of these projects; they are major items for 2015, 2016 and 2017. In financial planning, this means now, today. If the staff is truly moving fast and the Board needs to make some decisions, to include possible debt financing, the Board must review an overall plan, the minor items and the bigger items alike, capital and debt payments; he and Mr. Smith asked the staff to put these needs into perspective for them. The staff is not looking at debt financing at this time; staff is exploring how the items can be financed with current cash flow. From the staff’s perspective, it is important for the Board to see where the staff is coming from and then whether the Board agrees or disagrees as far as priorities. Again, the dollar amounts may need further refinement.

Dr. Jimenez expressed that in his view, every one of these projects is incredibly important. His preference would have been to receive information on cost savings, economic impact, and revenue projections. Also, a timing recommendation for each project would help the Board prioritize. Is it worth the investment this year? Next year? Are we losing revenue? Hindering revenue? Impacting the quality of care? Dr. Burns also expressed concern that she was not provided with a baseline or additional data justifying expansion of the NICU and/or the other Pediatric projects. As president of the Bexar Metro 9-1-1 Network District, Mr. Hasslocher was interested in learning more about the Health System’s Emergency Command Center, which Mr. Webb explained is set up in the hospital Board Room, when needed. The hospital is part of a Regional Medical Operations Center (RMOC) that is responsible for coordinating public health, safety, and medical responses during disasters. The command centre is run by Health System staff using hand-held radios, lap tops and cellular phones. It is a smaller project that nonetheless needs to be relocated to a more appropriate space.

Mr. Hernandez responded as follows:

At the present time, the Neonatal Intensive Care Unit (NICU) is licensed at 55 beds and the census has been up to 60 on some days. The NICU was designed in the early 1990’s and does not meet today’s state standards; otherwise, the hospital risks infection control issues. The NICU generates revenue for the Health System and is probably the most viable marketing tool we have. Further, the pediatric congenital heart and cardiothoracic surgery program teams and the NICU team work hand in hand. The pediatric dollars the Health System has includes funds for setting them up with a suitable work area. We must make the current space appropriate for the type of patient the Health System wishes to attract. The pediatric projects all have issues related to getting the right mix of ICU beds, medical/surgical beds, the right payor mix, in the right place. Additionally, the State is now limiting the number of future NICUs by concentrating on those with the highest quality, highest customer service scores, and the lowest costs. To do that they will designate only a hand full of NICUs as Centers of Excellence which will have to be tied to maternal fetal medicine programs, the best program to prevent the number of premature babies. The new structure will not
require that the Centers be attached to an academic medical center; however, an academic medical center has more opportunity because of the number of specialties available. The staff realizes that maternal fetal medicine and pediatrics must all work together as an organization. The Health system has made a commitment to the pediatrics program and these are the other pieces that need to fall into place. Staff must get pediatrics out of the Sky Tower which was never designed for pediatric patients. There are 72 medical/surgical beds that will become available and allow us to operate more efficiently.

Regarding relocation of the FFACTS Clinic, several years ago there was an issue with the County and the operation of a Ryan White HIV grant. Dr. Roberto Villarreal took over responsibility for that grant and has been very creative by forming alliances in the community due to the importance of treating this patient population. While this population is seen at the Robert B. Green in a new, beautiful building, the atmosphere does not address privacy issues. More space is needed at the RBG but it’s also very expensive to finish off the 6th floor of the new building. Rather than finish off the 6th floor, there is a more suitable alternative for this population that is better for them, better for the community, and frees up valuable space at the RBG that is already finished. It’s a high objective but is a double win for the community and the patients.

There is an existing heart and vascular program at University Hospital than can be grown. There is capacity on the ground floor of the 1968 Rio Tower, it’s not a dungeon and is in fact, fairly nice, but it’s buried away in the basement. The area for this program needs to be more accessible. There is approximately one acre of space in the new tower that is unfinished for the future growth of this program. The price tag for developing that one acre is about $50 million. Approximately $17-$18 million of that are equipment costs. There are also nine finished operating rooms that are not equipped on the 3rd floor of the Sky Tower for future growth. Staff proposes to use four of those nine operating rooms by converting them into cardiac catheter labs and installing equipment. The program can be up and running with this speed to market approach. Heart and vascular surgery are very important to the School of Medicine; the lack of space causes issues with competitors and affects the recruitment efforts in this area. Mr. Hernandez described the staff’s proposal as an innovative plan. Further, this approach offers an efficiency benefit in clinical operations since operating rooms and cardiac catheter labs can share FTEs.

At the request of Mr. Adams, Board members provided input following Mr. Hernandez’s explanation:

Dr. Burns, Mr. Smith, and Mr. Hasslocher thanked Mr. Hernandez for the overview; it addressed their concerns and answered their questions.

To Dr. Jimenez, it is clear that the School of Medicine needs the HVI to conduct training and research; however, he asked how the HVI program will benefit the Health System. Approximately 75 percent of this
program will be for care and treatment of Health System patients while training and research will only occur 25 percent of the time. It is a key, signature service that will benefit the entire community. Mr. Smith and Dr. Jimenez expressed concern that patients who reside in other quadrants of the city will have to travel to University Hospital for this type of treatment. They asked the staff to give special consideration to transportation issues.

Referring to construction of a new building Mr. Adams cautioned the staff that a very good justification would be needed and the location must be right. The existing space on Louis Pasteur was designed for use by cardiologists and is not optional for primary care services. The current dialysis clinic on Louis Pasteur is leased property. A dialysis center is needed in the South Texas Medical Center to support the transplant program at University Hospital. The dialysis clinic must have a separate entrance; however, with a well-defined plan staff proposes design of a building that will accommodate the FTE complement that is needed for both clinics in one building. Mr. Hernandez reiterated that there is no more space available at University Hospital and he reminded the Board of a principle they adopted in 2005 to get all ambulatory clinics out of University Hospital. Further, Dr. Bryan Alsip is an Executive Committee member of the San Antonio Medical Foundation, the organization that owns most of the property in the Medical Center. With his help, staff can draft a land donation request for the Foundation’s consideration.

Mr. Engberg asked if there were any other major issues with the kind of prioritization needed as discussed today. There are no higher priorities than those presented today. As a strong supporter of school-based clinics, Mr. Adams reiterated the importance of having accessible clinics since the Health System is more than 90 percent ambulatory-based. He thanked the staff for alerting the Board to these needs and initiating today’s high-level review.

FOLLOW-UP: Board members urged Mr. Hernandez to compile and present a total capital needs program report in the near future, and to work closely with UTHSCSA partners as needed. Staff will brief Dr. Jimenez individually regarding decisions that need to be made regarding the location of cardiology programs not within the Texas Diabetes Institute.

REVIEW AND DISCUSSION OF UNIVERSITY HEALTH SYSTEM’S OPERATIONAL EXCELLENCE SCORECARD REED HURLEY/EDWARD BANOS/BRYAN ALSIP, M.D.

SUMMARY: The Operational Excellence Scorecard is a performance management tool which has been implemented to track a specific set of key metrics on a monthly basis. Mr. Hurley yielded the floor to Dr. Alsip for a review of Quality metrics and measures. These metrics are among the most important and required by the Centers for Medicare and Medicaid Services (CMS) and also looked at by other payors, particularly private payors. They are used to benchmark organizations and to measure quality. These metrics, along with HCAPS and CGCAPS, are part of the
pay for performance programs that all hospitals and health systems must comply with. Not only are they mandated, they help in negotiations with payers when we discuss the type of quality we provide. Today’s focus will be on hospital re-admissions, where we look at the entire patient population and provide a single standard of care. At Dr. Alsip’s direction, the staff has undertaken an effort to standardize quality metrics across the entire health system. The majority of these metrics have in the past been measured on the inpatient and acute side; however, in the last year staff has also started measuring quality on the ambulatory side, where there are some metrics that are mandatory in certain areas. There are also requirements for physicians that relate to Information Technology issues.

Re-admissions are based on 30 days. The challenge is that the data used by staff are often delayed. For re-admission, we must wait at least one month to calculate the need to benchmark ourselves not only against national metrics, but against national standards and those organizations that are doing well. Instead of having a metrics, hospital re-admissions are graded on a curb, based on how everybody else is doing. Those numerical values that appear on the scorecard are in relationship to the value of one (1), where one is as good as the benchmark. If it’s less than one we’re doing better than our benchmark, and if it’s above one, we’re doing poorly or at least not as good as our benchmark. Competency and skill are taken into consideration for these metrics. What the Health System measures is on the higher end of the scale so that we can be in the top 10 percentile or top 5 percentile of organizations nationwide. To eventually achieve these results, staff works closely with physicians, nurses, support staff, infection control - all play a key role in these indicators. Dr. Alsip introduced and yielded the floor Michelle Ingram and Dr. Jim Barker for a discussion on what the staff is doing to influence the metrics in the following Quality categories.

- Hospital wide re-admission, overall including planned
- Hospital wide re-admission, unplanned only
- Mortality Rate
- Central Line Associated Blood Stream Infections (CLABSI) Standardized Infection Ratio (SIR)
- Catheter-Associated Urinary Tract Infections (CAUTI) Standardized Infection Ratio (SIR)
- Colon surgery, SSI rate
- Abdominal Hysterectomy, SSI Rate
- Patient Safety Indicators (PSI) #90 - Number of patient safety events

The 30-day readmission metric applies whether the patient is re-admitted to another local facility, or another facility out of state. Staff is looking at opportunities to improve the discharge process and to assure patients receive seven (7) day follow up appointment as close to the discharge date as possible. City-wide, hospitals are looking at how we can help each other. For example by placing a patient in observation status whenever possible to avoid CMS penalties. The re-admission rate for patients with
heart failure is very high for the Health System, they are not necessarily re-admitted at University Hospital, but other facilities in town. The readmission rate for heart failure across the country is 24 percent, and the more common pay for performance conditions tagged are post knee replacements, post coronary bypass, chronic obstructive pulmonary disease (COPD), and heart failure. There are approximately 75-80 measures that must be reported to CMS. Because chronic patients can be seen and managed in a clinic setting rather than on the inpatient side, Ms. Ingram emphasized the importance of ambulatory-based case management.

Dr. Burns noted an advantage for the Health System in providing follow up care within seven (7) days of discharge due to its ambulatory network, and possible liaisons with private physicians in the community. As a provider, she appreciates dealing directly with other providers about a patient’s case, or a hospitalist who treated the patient while at University Hospital, not a case manager.

What the staff is doing to improve the Health System’s statistics? The metrics on this score card have been measured for about 1.5 years, and are monitored by an internal Hospital Performance Council whose goal it is to bring together those groups of inpatient leaders, i.e., physicians, nurses, case managers, quality, infection control, and documentation improvement, who are responsible for helping to correct. The staff uses Lean methodology, a known method for best practices, specifically a tool called A3 for analyzing and finding gaps where improvement is needed for each measure. Staff is trending and standardizing processes to drive rates of infection down to zero. These same Lean practices are now being adopted on the ambulatory side. Further, the Health System now uses Midas, a system for risk reporting and Joint Commission tracer activities, and to report core measures to CMS. It has a greater use and bigger platform that allows for the collection of data directly from the electronic medical record and also allows the staff to proactively look at any patient every day. Midas will help us shift closer to real time, rather than a 30-day lag time for results, and will give us more visibility in the ambulatory setting.

**RECOMMENDATION:** This report was provided for informational purposes only.

**ACTION:** None.

**EVALUATION:** Mr. Adams thanked the staff for the presentation. He cautioned that the Board needs to see trends and improvements and be assured staff is being held accountable, some of the items reviewed today require attention. At the same time, he expressed confidence in Dr. Alsip’s leadership and will look to him to manage the improvements needed in the Quality quadrant of the scorecard.

**FOLLOW-UP:** Dr. Alsip offered his time beyond the scope of the Board meeting to meet with Board members who are interested in learning more or better understand quality metrics and benchmarks.
UPDATE ON OUTREACH/REFERRAL DEVELOPMENT AND MARKETING ACTIVITIES—LENI KIRKMAN/TED DAY

SUMMARY: Due to the market data content in this presentation, it was provided in Executive Session.

RECOMMENDATION: None.

ACTION: None.

EVALUATION: None.

FOLLOW-UP: None.

CLOSED MEETING:

Mr. Adams announced this meeting closed to the public at 4:46 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: Jim Adams, Roberto L. Jimenez, M.D., Robert Engberg, and James Hasslocher. The following staff members were also present: George B. Hernandez, Jr., Ed Banos, Reed Hurley, Ted Day, Bryan Alsip, M.D., and Griselda Sanchez. After discussion, no action was taken in closed session. Mr. Adams announced the closed meeting ended at 5:36 p.m., and he immediately reconvened the public meeting.

ADJOURNMENT:

There being no further business, Mr. Adams adjourned the public Board meeting at 5:36 p.m.

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James R. Adams    Dianna M. Burns, M.D.
Chair, Board of Managers   Secretary, Board of Managers

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Sandra D. Garcia, Recording Secretary
