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
Tim Brierty, Chief Executive Officer, University Hospital
Theresa De La Haya, Senior Vice President, Community Health and Clinical Prevention, Texas Diabetes Institute/University Health System
Sergio Farrell, Senior Vice President, Ambulatory Services, University Health System
Michael Hernandez, Vice President/Chief Legal Officer, University Health System
Sherry Johnson, Vice President/Integrity 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
Priti Mody Bailey, M.D., President/Chief Executive 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
Shawna Anders, R.N., Trauma Services, University Hospital
Erik Bednarz, Director, Facilities and Business Services, Texas Diabetes Institute/University Health System
Rudy Jackson, Executive Director, Emergency Center, University Hospital
Angela Kent, Operations Manager, Emergency Center, University Hospital
Pablo Riojas, Patient Care Coordinator, Emergency Center, University Hospital
Ebony Weston, Administrative Director, Preventive Health Services, Texas Diabetes Institute/University Health System
Jamie Woodring, R.N., Trauma Services, University Hospital

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

Mr. Adams called the meeting to order at 2:05 p.m.

INVOCATION AND PLEDGE OF ALLEGENCE:

Ms. De La Torre introduced Health System employee Ms. Kathleen Vasquez for the invocation and Mr. Adams led the pledge of allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETING(S):

MARCH 26, 2013  (REGULAR MEETING)

SUMMARY: The minutes of the regular meeting of Tuesday, March 26, 2013, were presented for the Board’s approval.
RECOMMENDATION: Mr. Adams recommended approval of the minutes as submitted.
ACTION: A MOTION to approve the minutes was made by Mr. Engberg. There being NO OBJECTION, the minutes were APPROVED as submitted.
EVALUATION: None.
FOLLOW-UP: None.

APRIL 23, 2013  (REGULAR MEETING)

SUMMARY: The minutes of the regular meeting of Tuesday, April 23, 2013, were presented for the Board’s approval.
RECOMMENDATION: Mr. Adams recommended approval of the minutes as submitted.
ACTION: A MOTION to approve the minutes was made by Dr. Jimenez. There being NO OBJECTION, the minutes were APPROVED as submitted.
EVALUATION: None.
FOLLOW-UP: None.

ACTION ITEMS:

CONSIDERATION AND APPROPRIATE ACTION TO APPROVE A CONTRACT WITH FARBER SPECIALTY VEHICLES, INC. FOR THE PURCHASE OF A MOBILE PRIMARY CARE VEHICLE—THERESA DE LA HAYA

SUMMARY: One of University Health System’s Delivery System Reform Incentive Payment Projects is the establishment of three school-based centers. The school-based health centers will support the expansion of prevention and primary care access for school-aged children and adolescents in Bexar County. As previously reported, school-based clinics are beginning to emerge throughout the country. In Ft. Worth, Texas, Tarrant County has established 19 school-based clinics in 13 school districts while Houston, Texas has established 24 school based clinics
operated by several entities, including Harris County Hospital District, Baylor College of Medicine, and Memorial Herman.

The Health System has developed a health service strategy that will provide access to preventive/primary care through the establishment of static clinical sites that will be centrally located in areas that encompass a large student population. For those schools whose proximity might not extend to the service reach of static sites, a mobile health vehicle will provide an additional and critical entry point into the health system’s school-based health center program and will reduce transportation and access barriers experienced by children and their parents. To help ensure parents and children with affordable and easy access to specialty care, the mobile vehicle will be equipped with capabilities that will allow for telemedicine services. Specialty care will include and is not limited to behavioral health, orthopedics, pulmonary and related health services that are often not accessible to this population.

Establishing school-based/mobile health clinics in underserved areas will result in improved care for the children of Bexar County and addresses the Triple Aim Plus. This includes creating a clinical environment that addresses the health service preferences and needs of children and parents seeking services (Patient Experience), providing timely age-appropriate screening and immunizations services (Quality and Outcomes), improving care coordination and reducing delays in children seeking care (Improved Efficiencies) and providing affordable, convenient and accessible health services (Improved Access).

A Request for Proposal (RFP) for a multi-purpose, drivable 45 feet in length motor-coach was issued on Wednesday, May 1, 2013. Two bids were received and reviewed by a cross functional selection committee comprised of several Health System staff members representing administration, service line operations, information systems, providers, and fleet management. Of the two bids received, Farber Specialty Vehicles provided the most cost-efficient vehicle that offered all required options requested in the RFP. Farber has been providing mobile primary care vehicles for over 30 years and has more than 50 vehicles on the road. Farber provided four excellent references from various health care systems (Parkland, Hidalgo County, Ohio State, and Brooklyn, New York). Farber has three service center sites within Bexar County which will facilitate preventive maintenance and will avoid sending the vehicle outside of Bexar Country. Farber utilizes dependable and well-known brands for all engine and transmission parts in their vehicles. The motor-coach will be equipped with the following, two exam rooms with a sink, ADA Compliant restroom with a sink, reception/nurses area with two sinks, custom slide-out room, and ADA compliant automatic wheelchair lift.

This project will ensure that timely age-appropriate screening and immunizations services are provided to school aged children to reduce the likelihood of vaccine preventable diseases and the early detection of adverse health conditions. The mobile health vehicle will provide an additional and critical entry point into the health system’s school-based health center program and will reduce transportation and access barriers experienced by children and their parents. The purchase cost of the mobile primary care vehicle is $513,930 for the motor
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coach, and $31,916 for the telemedicine equipment for a grand total of $545,846. This is a budgeted capital DSRIP item.

RECOMMENDATION: Staff recommends Board of Managers’ approval to execute a contract with Farber Specialty Vehicles, Inc. for the purchase of a mobile primary care vehicle not to exceed $545,846.

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

EVALUATION: The mobile primary care vehicle function will be managed by a project coordinator, who will report to the Director of Preventive Health Services, who in turn reports to Ms. De La Haya.

FOLLOW-UP: None.

PRESENTATION ON REGIONAL HEALTH PARTNERSHIP 6 STATUS — TED DAY

SUMMARY: Two new funding pools are being financed as a result of the Texas Healthcare Transformation and Quality Improvement Program (also known as the 1115 Waiver) for the period October 1, 2011, through September 30, 2016: 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. The four categories for reporting measures that demonstrate the impact of DSRIP activities under the waiver, which are interrelated and complementary, are: 1) Infrastructure Development, 2) Program Innovation and Redesign, 3) Quality Improvements, and 4) Population-focused Improvements. The Texas Health and Human Services Commission (HHSC) divided the state into Regional Healthcare Partnerships (RHP). The Health System was named the “Anchor” of Region 6, which is comprised of 20 South Texas counties. Anchors serve as liaison between HHSC and the regional providers that are participating in the waiver. Anchors are also responsible for conducting a community needs assessment, engaging stakeholders, producing and submitting the RHP Plan and annual reports, and facilitating Learning Collaboratives. University Health System submitted the RHP 6 Plan on December 21, 2012, and maintains the website www.TexasRHP6.com to inform the public about waiver activities. Mr. Day introduced a list of twenty-five (25) providers who are participating in RHP 6 DSRIP activities, which includes hospitals (both public and private), community mental health centers, physician groups, and local health departments. These providers proposed 115 Category 1 and 2 projects to HHSC and CMS, valued at $484 million (net of IGT contribution) over the remaining four years of the waiver period. The projects selected propose achievement of Category 3 clinical outcomes. One hundred fifty seven (157) Category 3 outcomes were proposed, valued at $98 million. To secure the incentive funds in Categories 1-3, providers are “paid for performance” and must achieve the proposed milestone and outcome targets. Participating hospitals are required to report on a standard set of Category 4 measures, valued at $34 million (net of IGT contribution).

On May 28, RHP 6 received initial feedback from HHSC. Of the 115 projects, CMS initially approved 92, though some still require technical corrections or additional evidence to justify the proposed value. Between now and October,
providers will be required to modify projects and respond to further clarifications as requested by HHSC and CMS. As the Anchor, University Health System will coordinate this process and facilitate the submission of revised projects. RHP 6 has a potential of $3.6 million (net) remaining in our regional allocation. An estimated $256 million (net) of State-wide unspent funds will first be made available to the regions in which the funds were originally designated, then to priority state initiatives, and last to other regions with available IGT, based on each region’s share of the original DSRIP allocation. The Health System is committed to its role as anchor and is working to support the regional providers and ensure the overall success of the region’s DSRIP efforts. As projects are approved by CMS, providers are proceeding with implementation activities. The first opportunity to report on milestone completion and earn incentive payments is in August. The Health System is also beginning to develop plans for regional Learning Collaboratives to meet an additional requirement of the waiver. Four key areas of focus have been identified to encourage providers across the region to network, share best practices, identify and remove barriers, and achieve outcomes related to the Triple Aim. These Learning Collaboratives may focus on reducing potentially preventable admissions and 30-day readmissions, reducing inappropriate emergency room utilization, and behavioral health and substance abuse initiatives. Opportunities will be presented for the region to collaborate on shared strategies such as primary care medical homes, care coordination, and process improvement initiatives. A formal Learning Collaborative Plan will be submitted to CMS by October 1. The Waiver has presented significant opportunities for additional resources and projects to transform healthcare in our region. The nature of the program also presents its own set of challenges. For example, the five-year waiver period began upon CMS’s approval date and the program continues to be in development. Thus, as we approach the end of the second demonstration year (DY), HHSC and CMS continue to revise rules and protocols and develop processes for reporting, payment, and project modifications, even as the first reporting deadline looms. Further, DSRIP payments for DY 1 were only recently paid on May 24, 2013, eight months following the end of the first DY, and DY 1 UC funds continue to be delayed. University Health System has a strong relationship with HHSC and, as much as possible, is actively involved in shaping the Waiver program.

**RECOMMENDATION:** This presentation is provided for informational purposes only.

**ACTION:** No action is required by the Board of Managers.

**EVALUATION:**

Next steps identified by staff:

- Revise projects to secure CMS approval; continue training on Performance Logic, a web-based tool designed in California to help public hospitals manage DSRIP projects; communicate new requirements as developed by HHSC; finalize and implement plan for Learning Collaboratives; host a public meeting upon final plan approval by CMS; prioritize and select new DY 3-5 projects for region; and submit RHP 6’s first annual report.

**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: EXPAND ACCESS TO WRITTEN AND ORAL INTERPRETATION SERVICES—LENI KIRKMAN

SUMMARY: This project will enhance awareness and establish an integrated interpretation service in order to ensure that health information is provided in a manner that is appropriate to a patient’s linguistic and cultural orientation. This will include enhancing awareness of and access to timely oral interpretation services for patients and family members, in order to improve communication and foster understanding between healthcare professionals and their patients/caregivers with limited English language proficiency. Pronounced demographic shifts in the racial and ethnic make-up of the U.S. population illustrate the need for health systems to proactively find ways to deliver high quality care in a manner that is responsive to the cultural beliefs, language and behavior of an ever diverse patient population. According to the U.S. Census, 43% of Bexar County residents speak a language other than English (primarily Spanish) in the home, compared to 34% across the state. The ability of University Health System (UHS) to provide effective care to linguistically diverse populations will be dependent upon staff capacity (skills, knowledge and awareness) to demonstrate culturally competent care. In 2011, vendor-contracted interpreters were called to come to University Health System locations 1,327 times. Through the use of bi-lingual staff members, who have volunteered to interpret in their work areas and successfully completed a comprehensive interpretation course, UHS aims to significantly reduce the need for contracted interpreters for Spanish-speaking patients. The target population will include the Medicaid funded and uninsured patients who comprise 62% of UHS patients. This will also include the broader UHS service catchment area of Bexar County and South Texas where large segments of the population are economically underserved, uninsured, with a primary language that is other than English. Category 1 or 2 expected patient benefits during DY 2 will allow an analysis to assess gaps in language access and delivery of culturally competent care. This will be followed by development and implementation of a 24/7 web-based video interpretation program and staffing capacity in DY 3 and DY 4 resulting in a total of 150 trained volunteer staff interpreters and an established standard document translation process by DY5. This will promote timely oral interpretation/written translation services, improve exchange of health information and increase patient confidence in adherence to
clinical care and treatment. Category 3 outcomes for DY4 and DY5 are to increase patient satisfaction scores by a percentage (still to be determined) over established baseline of patient satisfaction scores. This project will ensure that health information which is provided to patients and families by healthcare professionals is appropriate to their linguistic and cultural orientation to enhance the quality of communication. This can reduce the likelihood of health care related errors as well as improve the communication provided both in the acute care setting and with respect to discharge instructions for post acute care. This enhanced exchange of health information will boost patient confidence in adherence to clinical care and treatment and increase patient satisfaction scores. 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 $796,490. To date this project is on target to cover its cost. The direct cost for DY2 – DY5 is $1,120,253; intergovernmental transfer for other hospitals is $3,178,266, with a total net value for Categories 1-4 at $11,108,484.

RECOMMENDATION: This report was provided for informational purposes only.
ACTION: No action was required.
EVALUATION: Board members urged the staff to be culturally sensitive in all phases of this project.
FOLLOW-UP: None.

DSRIP PROJECT: EVIDENCE-BASED INTERVENTIONS TO INCLUDE TEAMS, TECHNOLOGY AND PROCESSES TO AVOID MEDICATION ERRORS — MARY ANN MOTE

SUMMARY: This program will create a pharmacist-led, chronic disease medication management model for the Health System. Access to this pharmacist will be in the ambulatory medical home setting. The pharmacist will be dedicated to the provision of education and medication management for patients with chronic diseases (ambulatory care sensitive conditions). Included in this patient population will be those on multiple medications, those whose disease process is not well-controlled, and those who are frequent patients in the Emergency Department and/or require hospitalization for their chronic disease. The Health System dispenses approximately 800,000 outpatient prescriptions per year to uninsured and Medicaid patients who receive their health care within the Health System. Although patients have access to medication counseling at the time a prescription is filled, they often lack understanding of the importance of complying with the prescribed regimen or how their drugs, food and home remedies interact. It is believed that additional pharmacist time spent with the higher risk patients will reduce medication errors and adverse effects from medication use, improve the health of the patient and reduce unnecessary expenses including visits to the Emergency Department and hospitalizations. The target population will be patients who are on multiple drug regimens with a history of non-adherence to medication as reflected by the lack of progression in the improvement of their chronic disease, and those who have multiple emergency department visits/hospitalizations related to their chronic disease. The target population will include the Medicaid funded and uninsured patients who comprise 62% of patients who receive services within the Health System. Category 1 or 2 expected patient benefits will improve access to pharmacist
counseling and medication management. Patient benefit is to increase the number of patients accessing the service by 10% over baseline for DY3, and then 10% each year over the previous year through DY5. These efforts will provide the opportunity to tailor medication education for patients and will benefit their healthcare experience through the provision of safe, timely and effective patient-centered care relative to their medications. Category 3 outcomes include total acute care hospitalizations for ambulatory care sensitive conditions. During DY4 and DY5 the goal is to see a reduction of total acute care hospitalizations for ambulatory care sensitive conditions under age 75 by a percentage still to be determined. Ms. Mote reviewed the status of current DSRIP Year 2 milestones as well as metrics and DY3 milestones. This project will ensure the provision of education and medication management for patients with chronic diseases in the ambulatory medical home setting. For patients on multiple medications, this additional level of care provision will help maximize the beneficial effects of pharmaceuticals as well as reduce the likelihood of adverse effects associated with a poor understanding of medication frequency, dosing, interactions, and potential side effects. These efforts will result in better compliance with medical therapy to improve the health of the patient and reduce unnecessary expenses including visits to the Emergency Department and hospitalizations. 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 $887,904. The direct cost for DY2 – DY5 is $654,461; intergovernmental transfer for other hospitals is $3,001,448; with a net value for Categories 1-4 at $11,681,189.

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

**ACTION:** No action was required.

**EVALUATION:** Board members encouraged the staff to be customer sensitive with a focus on patients who are interested in the education that is available through this initiative.

**PRESENTATION OF LEAN WORKFLOW DESIGN AND WORKPLACE ORGANIZATION SERVICES ASSOCIATED WITH THE MOVE AND TRANSITION INTO THE NEW EMERGENCY CENTER AT UNIVERSITY HOSPITAL CAMPUS - TIM BRIERTY**

**SUMMARY:** A key and challenging component of the overall Capital Improvement Project is the transition from the existing facilities into the new 1,000,000 square foot tower. The current Emergency Center (EC) has a 40 bed capacity of semi private and private accommodations with a footprint of 25,000 square feet serving approximately 5000 patients a month. The current state will be replaced by the new EC opening in April 2014. The new facility will have an 80 private bed capacity on a 96,000 square feet footprint. This transition will require a change in processes of the current department workflow to accommodate for the new footprint, staffing patterns and to allow for improved patient flow. Mr. Brierty introduced and yielded the floor to the following staff members for presentation of a preliminary Lean workflow design for the new Emergency Center:

- Pablo Riojas, Patient Care Coordinator, Emergency Services
- Jamie Woodring, R.N., Trauma Services
- Shawna Anders, RN., Trauma Services
- Angela Kent, Operations Manager, Emergency Services
- Rudy Jackson, Executive Director, Emergency Services
The design team utilized the 3P Lean approach (Product-Process-Preparation) which focuses on eliminating waste through process and/or product design. The transition efforts that are currently ongoing emphasize the preparation for the physical relocation and hand-off of equipment, staff, and patients while providing the continued high level of patient care. The goal of the 3P tool is to generate and document standard work and define efficient flow for processes within the new EC layout. These processes take into account the design, staffing, and resources of the EC. The event touched on many areas in the EC including Fast Track, Trauma, AirLife and EMS, Psychiatric Patient Flow, Nurse and Technician Flows, Imaging, Respiratory, and Environmental Services support. This 3P focused on technology applications, information accessibility, supply storage locations and supply distribution systems within the EC. Sample findings and outcomes include identifying where computers would be located, and how Electronic Medical Record information would be housed. Other results included identifying direct connections between adjacent areas, new Pyxis locations to reduce travel, and a future state capacity analysis on imaging services. Event assumptions, process time durations, recommended staff resources and roles, physical layout changes and equipment needs were also documented for each flow. Work flows documented with the above types of information include Walk-In, EMS, AirLife, Nurse Role, Tech Role, Registration and Discharge, Patient Flow, Med Surg Supply Distribution, Imaging Services, Respiratory Services, Environmental Services. By applying the learned efficiencies to the new floor configurations and through simulations the operational processes staff is challenged to define methods of improvement in process complexity, material utilization, time use, patient interface and care and overall effectiveness that will allow both long-term and short-term benefits to the organization.

RECOMMENDATION: This presentation was provided for informational purposes only.
ACTION: No action was required.
EVALUATION: After the presentation Mr. Adams posed the following questions to the staff on behalf of the Board: How do you think we’re doing with ER operations overall? Are we making progress or not? What is the morale of the team? (Dr. Jimenez) - Are money and/or prestige driving factors in employee satisfaction among the ER staff? Mr. Jackson, the newly appointed Executive Director, was previously a staff nurse in the ER at a time when there nurses waiting for ER positions to open up. Over the course of the last six years since his departure from the ER, something happened. Today, there is a vacancy list that he is having a difficult time filling. There have been some significant strides made in the ER over the last 12 months, but a lot of work remains to be done. Throughput issues continue to exist since the ER is a place where patients come for initial treatment and stabilization. The real care oftentimes takes place on the units. Yesterday, for example, the ER had 60 people waiting to be seen and went on diversion for about six hours. All hands were on deck. He and the educator rolled up their sleeves and went to work. There were only two admissions pending and the remaining cases were pending disposition by the physicians. The complaints out of the waiting room have decreased, but the wait times still need to improve. Staff is breaking down every single entry point to determine where the greatest impact can be made. It is Mr. Jackson’s opinion that the greatest impact will be made by the providers.
As for morale in the ER, Mr. Jackson reported having had recent, significant conversations with staff. The morale is low for several reasons, but the major reason at this time is that some of the staff is over worked. Nurses are working between 120 and 139 hours in a two-week period because staffing is low. The ER has an 80 percent turnover rate, with a 27 percent vacancy. Mr. Jackson is working to fill the vacancies and on various morale-improvement initiatives, such as conducting timely performance evaluations, processing pay raises, and re-introducing employee recognition opportunities.

ER staff agreed with Mr. Jackson’s comments and acknowledged that patient flow in the ER has improved from a time when patients waited 24 hours or more to be seen. One nurse identified the turnover among ER management as another major morale issue. Over the last seven years, there have been seven different directors assigned to the ER. Further, the ER is a difficult place to work. It takes a special kind of nurse to come back after seeing horrible things on a daily basis. University Hospital’s ER is always going to be the busiest with the heaviest patient load and trauma cases. It will help the staff to know that everyone else in the hospital knows they are working extremely hard and trying their best to take care of patients. Generally, prestige and money are not an issue with the staff in the ER.

Mr. Adams thanked the staff for the tremendous progress that has been undertaken. The arrival of Dr. Bruce Adams as medical director is also helpful from a provider perspective. He urged Mr. Jackson to continue to deal with issues in a transparent manner. Not for criticism, but rather, to learn how to further improve. The Board is very interested in what the ER staff has to say, and so are the President/CEO and the COO. Nursing and physician input is critical to real success in the ER. The morale of workers is exceptionally important to the Board because the staff plays a valuable role in what the Health System does. Mr. Adams urged the staff to continue to provide counsel to senior leadership. The Health System is a leader in many ways and does not need to advertise the tremendous work that happens in the ER. The community is getting much better service these days thanks to the staff. Board members were pleased to hear directly from the staff that they are concerned with the financial aspects of ER operations, but also with customer service. Dr. Jimenez expressed his appreciation for the staff’s work and urged them to continue to work to address the problems. The ER staff received a round of applause from the Board as they exited the room.

FOLLOW-UP:
This team will meet three more times over the next nine months to work on the Future State and refine the ideas outlined in this event as well as to define additional processes that occur. Dr. Bruce Adams will be scheduled to present an update at an upcoming Board meeting.

PRESENTATION ON AMBULATORY SERVICES GROWTH TO ENSURE PRIMARY CARE ACCESS THROUGHOUT BEXAR COUNTY — SERGIO FARRELL/Theresa De La Haya

SUMMARY:
The University Health System’s Ambulatory Services Growth strategy focuses on all elements of the Triple Aim-Plus and ensures the provision of high quality and safe health care to meet the current and future health services needs of residents of Bexar County and its surrounding communities. By improving access to primary and preventive health services, reducing gaps in the public
health system, and the expansion of services, the ambulatory network will improve metrics that demonstrate improved outcomes such as reduced emergency room visits, patient- and family-centered care satisfaction, improved population health management, integrated behavioral health services, and new educational methods that encourage patient engagement. These efforts will improve the health of the patients of University Health System and enhance the health of our community. Today’s presentation is the first in a series of four and will focus on access to primary care, prevention, and education and outreach throughout Bexar County.

Staff reviewed a timeline starting in 2008 when ten preventive health clinics were transferred to the Health System from the San Antonio Metropolitan Health District, the RBG Express Med Clinic was initially staffed by Community Medicine Associates (CMA), and the Anti-coagulation and Connection clinics were established at the RBG. In 2009, CMA was asked to staff Bexar County’s Employee Health Clinic. In 2010, the Health System started a transformation to patient-centered medical homes, CMA leased specialty providers through UTHSCA (endocrinologists, neonatologists, neurologists, psychiatrists), the Health System established a mobile mammography program, the behavioral health program at RBG, expanded breast health services/funding and development of patient navigation, and CMA partnered with Methodist Healthcare Ministries. In 2011, a geriatrician, psychiatrist and two endocrinologists were hired. In 2012, endocrinologists were hired directly under CMA, the process to formally apply for ACQA PCMH recognition was initiated, and implementation of various DSRIP projects originated. Ms. De La Haya reviewed the local ambulatory networks in Bexar County as follows:

- Christus Santa Rosa – one location. This is the new Santa Rosa Family Health Center opening up in Westover Hills, relocating from downtown due to the children’s hospital.
- Methodist Health System – three locations
- Baptist Health Systems – 10 locations with a total of 22 providers
- University Health System Ambulatory Network – 19 locations and a total of 139 CMA providers

Staff reviewed ambulatory activity between 2008 and 2012 which indicates that primary care encounters have increased 7%, 11.5%, 12.5% and 16.7% respectively. In 2008, there were 263,383 primary care visits and 412,947 in 2012 (primary care data includes all CMA primary care visits plus Behavioral Health, Pediatrics and Express Med). In 2008, specialty service encounters were at 170,013 and in 2012 were at 224,711. Specialty services include data from women’s health services and dialysis. Other services provided and measured at 205,902 for 2012 and include NurseLink, Outreach and Education (Health Promotion, Health Education, Diabetes Education, all non-billable), Senior Services, Nurse Family Partnership, and Child Health & Safety. In 2012, total primary care visits (acute plus chronic) were 412,947; preventive encounters, including well visits, immunizations, nurse visits, health education, and NurseLink were at 205,902; primary care (chronic) encounters were at 313,108; Express Med (primary care acute) were at 99,839; specialty care (i.e., gastrointestinal and cardiology) were at 224,711; and Emergency Room visits for emergent trauma issues were at 61,510.
Staff compared primary care/emergency center visits for 2008 through 2012. During 2012, primary care visits peaked at 412,947 and emergency center visits peaked at 61,510. Year 2011 emergency room visits were compared against Harris County, Christus Santa Rosa, Baptist Health System, Memorial Herman, NW, and Methodist Hospital. Regarding costs, at the present time, the fiscal impact of a primary care visit is $90, an emergency room visit is $950, and an admission to University Hospital is $11,420.

CMA provider growth was reviewed for the period 2008 to present. In 2008, CMA had a total of 42.5 physicians and 30.2 mid-level providers. As of April 30, 2013, CMA has 74.75 physicians and 65.15 mid-level providers. Service types, by the various categories, i.e., primary care, specialty, acute care, ancillary, and other, were discussed and reviewed in detail with the Board.

Finally, staff briefed the Board on upcoming innovative technologies, initiatives, expansions, and continued community partnerships.

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

**ACTION:** No action was necessary.

**EVALUATION:** Mr. Adams noted that the Health System had recently been approached by members of the east side community with concerns about access to health care. Questions raised thus far by the group have been addressed by Mr. Smith.

**FOLLOW-UP:** None.

**PRESENTATION ON TRANSITION OF UNIVERSITY HEALTH SYSTEM’S CHILDREN’S HEALTH SERVICES — CHRISTANN VASQUEZ/TED DAY/MICHELLE RYERSON**

**SUMMARY:** Since February 26, 2013, when Board of Managers approved the agreement with UT-Medicine for Children’s Transition Services, staff continues to execute its strategy to expand the reach and effectiveness of its ambulatory network and inpatient pediatric services to serve the pediatric populations. Health System facilities will serve as the pediatric clinical service and teaching sites for UT Medicine. In this update, staffing, medical staff, facility construction/equipment and volume will be reviewed, and in some cases, compared to the Business Plan assumptions and timeline presented to the Board of Managers in February 2013. First, Ms. Vasquez defined the transition period as 2013 through latter part of 2016 or opening of the new children’s hospital. She reviewed an updated inpatient and outpatient service matrix and identified those pediatric services which are currently provided, or will be provided during the transition period, and those which the Health System plans to provide on a long term basis. Future, long term, planned services include expanded outpatient specialty clinics with timing and specifics still to be determined. A cystic fibrosis clinic is a long-term service that the Health System plans to provide, but the location remains undefined. Staff has been working with various clinical work groups to assist with insuring the clinical needs of the various pediatric service lines are met. The pediatric work groups include Transplant, Inpatient, Emergency Room, Ambulatory, Hospital Based Physicians, Specialty Surgery, Cardiac, Pharmacy, Dialysis and Information Technology. The clinical work groups include physicians, nursing and administrative representation from specialty areas with the primary goals to identify and review, space, equipment, staffing and supplies.
that as we transition this patient population. The current number of faculty, residents and fellows, and mid-level providers was reviewed and discussed in detail. The running total of general pediatric providers for June 2013 was 50, increased to 60 in July (with five being incremental providers in CF pulmonology). The running total of providers for 2014 is projected at 79, plus 24 incremental providers. Average daily census and patient days for Pediatric Units (PTU/PICU) ad NICU for 2013 were reviewed and compared to 2012, as was the pediatric EC and pediatric trauma volume. Outpatient visits were reviewed, broken down by location and providers’ schedule through May 21, 2013. Finally, Mr. Day reviewed a budget summary for construction and equipment. Staff will recommend the following funding approach for purchase of the equipment:

- 2012, 2013, and 2014 Routine Capital contingency and fund balances - $4.0M
- CIP Enhancement Funds dedicated for the Heart and Vascular Institute - $3.2M
- CIP Funds - $3.5M

With exception of the pediatric dialysis area, the equipment needs on the list are either pre-purchases of equipment that would be required when additional beds in the new tower are opened or the Heart and Vascular Institute is equipped.

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

**ACTION:** No action was required by the Board of Managers.

**EVALUATION:** Senior leadership is very pleased with the arrival of Michelle Ryerson as CNO/COO of pediatric clinical services, her role and relationship with the physicians is instrumental for the organization. Mr. Adams thanked the staff for the enthusiasm; it is obvious to the Board that the delivery of pediatric care is very important to the staff. He is also glad to have both Ms. Vasquez and Ms. Ryerson working on this initiative. Because of past experiences, he asked staff to be prepared to justify any capital equipment expenses for the non-ambulatory piece of this initiative, keeping in mind that investments must complement the Health System’s long term goal.

**FOLLOW-UP:** None.

**ADJOURNMENT:**

There being no further business, Mr. Adams adjourned the meeting at 4:40 pm.