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

Tuesday, October 15, 2013
2:00 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
Karen Bryant, Vice President/Operations, University Hospital
Ted Day, Vice President, Strategic Planning and Business Development, University Health System
Theresa De La Haya, Senior Vice President, Community Health and Clinical Prevention, Texas Diabetes Institute/University Health System
Peggy Deming, Executive Vice President/Chief Financial Officer, University Health System
Sherry Johnson, Vice President/Integrity Officer, University Health System
Leni Kirkman, Vice President, Corporate Communications & Patient Relations, University Health System
Bonnie Murrillo, Executive Director, Operational Excellence, University Health System
Griselda Sanchez, Associate General Counsel, University Health System
Christann Vasquez, Executive Vice President/Chief Operating Officer, University Health System
Mark Webb, Senior Vice President, Facilities Administration, University Health System
Sam Bower, The Center for Healthcare Services, Board of Trustees
Dan Barrett, The Center for Healthcare Services, Board of Trustees
Mary Rose Brown, The Center for Healthcare Services, Board of Trustees
Leon Evans, President/CEO, The Center for Healthcare Services
Allison Greer, Vice President, External Relations, The Center for Healthcare Services
Mary Repole, Marketing Consultant, The Center for Healthcare Services

MEDIA:

Peggy O’Hare, Staff Writer, San Antonio Express News
CALL TO ORDER AND RECORD OF ATTENDANCE: JIM ADAMS, CHAIR, BOARD OF MANAGERS

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

INVOCATION AND PLEDGE OF ALLEGIANCE:

Mr. Tomas Hernandez introduced Eduardo Quintana for the invocation and Mr. Adams led the pledge of allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETING(S):

JULY 30, 2013 (REGULAR MEETING)

SUMMARY: The minutes of the regular meeting of Tuesday, July 30, 2013, were presented for the Board’s approval.
RECOMMENDATION: Staff recommended approval of the minutes as submitted.
ACTION: A MOTION to approve the minutes was made by Mr. Engberg, SECONDED by Ms. Cedillo, and PASSED UNANIMOUSLY.
EVALUATION: None.
FOLLOW-UP: None.

AUGUST 20, 2013 (REGULAR MEETING)

SUMMARY: The minutes of the regular meeting of Tuesday, August 20, 2013, were presented for the Board’s approval.
RECOMMENDATION: Staff recommended approval of the minutes as submitted.
ACTION: A MOTION to approve the minutes was made by Ms. Cedillo, SECONDED by Mr. Engberg, and PASSED UNANIMOUSLY.
EVALUATION: None.
FOLLOW-UP: None.

ACTION ITEMS:

CONSIDERATION AND APPROPRIATE ACTION REGARDING THE CENTER FOR HEALTH CARE SERVICES BRANDING INITIATIVE—RUBEN ZAMORA/LEON EVANS

SUMMARY: Mr. Ruben Zamora introduced The Center for Health Care Services (the “Center”) Trustees: Dan Barrett, Sam Bowker, Mary Rose Brown, and Marketing Consultant Mary Repole. He informed the Board of Managers that the Center’s 2013 re-branding initiative was initiated in 2011 during a Board of Trustees Strategic Planning Session. The goal was to position the Center to be more competitive in the changing healthcare landscape by: Changing its image as the “poor man’s clinic;” leveraging existing partnerships to improve outcomes; developing new partnerships to integrate primary and behavioral health care; attracting top talent to work at the Center and to develop a culture of excellence; and improving existing infrastructure and construct new facilities. To improve outcomes for those clients served by the Center, integrating primary and behavioral health care in one location was key. The Center has opened a new
clinic at Prospects Courtyard, Adult and Child Behavioral Health Divisions, and operates a 24/7 clinic at the Restoration Center. Utilizing 1115 Waiver funding to better serve the community, Center staff is committed to bending the healthcare cost curve, increasing patient satisfaction, improve health outcomes, and expanding access to care. The Center has also embarked on an aggressive facilities master plan and capital budget to improve curb appeal and meet the needs of the community by opening a new primary care clinic at The Restoration Center, a comprehensive children’s campus at the Drexel location, adult outpatient facilities at former SAMMinistries property and other locations, crisis transitional unit at Josephine location, and expanded capacity at new and existing clinics to improve access to treatment. To enhance the Center’s culture of excellence, the Center offers a competitive salary and benefits package to attract and retain top talent, offers performance recognition programs, an enhanced retirement plan, new wellness program contests and rebates, additional customer service training programs, and an expanded training class schedule. Mr. Zamora yielded the floor to Ms. Repole who has been working on the Center’s re-branding project for three years now. Ms. Repole shared her analogy of branding. She described it as a shiny apple that is bright red and enticing on the outside. On the inside, there are seeds and there is the meat of the fruit. During a branding project, she tries to get at the seeds. What does the organization stand for? Who are they at the heart? Where does the daily work come from? What’s at the core of the organization? The meat is how the organization does what it does, how it’s able to make the promises that it makes, and deliver on those promises daily. The shiny part is the outside perspective, the packaging of a product, the pricing. When the Center started this process three years ago, it started with the heart of the organization and worked outwards. The staff did not start with trying to re-name the Center. The Board of Trustees said they wanted to hear from people the Center interacts with on a daily basis, its partners, clients, community leaders, its staff, and others. They wanted to find out what these people think about the Center, what they do, what they promise, what makes the Center unique and different, what’s relevant, and what is their common ground. Ms. Repole described the process carried out in identifying a new name for the Center which involved 75 in-depth interviews and group discussions, cumulating in 200+ hours of insight from the Board of Trustees, administrative team and staff, consumers, and outside stakeholders such as state legislators, County Commissioners, Judges, Health System leadership, UTHSCSA leadership, physicians, community partners, city leaders, and contract managers. During these discussions, stakeholders recommended seven (7) operational issues that needed to be addressed, including a name change that identified brand promise and personality. The results from the sessions with community stakeholders are as follows:

- The Center’s name needs to capture essence of brand promise and give people reason to reconsider what they think of us; include “Center” if possible;
- Reviewed names and logos from behavioral health organizations;
- Reviewed 5 new names and logo “concepts;”
- Chose one name from among those presented (unanimously);
- Designed additional “logo bugs” for consideration;
- Tweaked design (unanimously approved at retreat);
- Reviewed by Board of Trustees and unanimously approved;
• Gathered feedback from staff and customers; well received;
• Ongoing presentations to partners to share insight & name;
• Board voted to suspend mention of new name until feedback from partners is received.

The Center’s Board of Trustees arrived at today’s recommendation by identifying what consumers and stakeholders want/need and also by acknowledging what is unique and different about the Center, which Ms. Repole summarized as “Independent Productive Lives.” This phrase is accurate and aspirational in light of the fact that the Center has helped many become independent, productive citizens. Like cancer, the Center is not dealing with diseases that can always be cured, but that doesn’t stop MD Anderson from aspiring to eradicate cancer; it sets the expectation. It is the organizing principal for the entire operation; it measures outcomes in terms of consumers’ ability to get on with their lives. The phrase is also relevant, something employees can take pride in. It is what consumers want; helps diminish the stigma. It is what payers want. It is in the community’s best interest. The phrase is also distinct and describes the comprehensiveness of services and the Center’s understanding of this market segment makes them uniquely qualified to deliver upon this promise. Hence, where there is hope, healing begins. Hope is the active ingredient in helping people live independent, productive lives. Hope is the first step toward recovery; even the smallest belief that we can get better, as others have, can fuel the recovery process. Staff takes pride in carrying hope for consumers, until they are strong enough and well enough to internalize it for themselves.

**RECOMMENDATION:** The Center for Health Care Services Board of Trustees unanimously recommends re-branding under the name The Center for Hope (Partners in Mental Health & Substance Abuse Solutions).

**ACTION:** None.

**EVALUATION:** Mr. Adams reiterated that The Center for Health Care Services operates under the dual sponsorship of Bexar County and the University Health System, and asked if this fact was given any consideration in selecting the proposed name. He clarified that his inquiry is more than one relating to proprietorship and has more to do with describing the entities’ common goals. The Center for Health Care Services is not an independent, stand-alone entity. It is part of other entities, which is what makes it possible for the Center to provide certain services. In 2000, the Board of Managers determined that The Center for Health Care Services needed to be made stronger and a new name today must satisfy the various stakeholders - the patients, community, and taxpayers. Mr. Adams compared this name issue to a current challenge faced by the Bexar County Hospital District d/b/a University Health System. The business name causes some confusion for the public; however, the legal name is what separates the Health System from The University of Texas Health Science Center.

Mr. Smith noted that initially, the Center was named the Bexar County Mental Health/Mental Retardation Board of Trustees. By changing the name to The Center for Health Care Services, the Center got away from the stigma of mental health and mental retardation. Mr. Smith feels that the proposed name gets even further away from the stigma, and wondered if the new name ought to reflect what the Center actually does.

Ms. Repole informed the Board that she did not receive direction from the Trustees that would have her take into consideration the dual sponsorship of
Bexar County and University Health System. She added that from a consumer perspective, she is not certain that that the public would understand the alliances behind the creation of The Center for Health Care Services. The proposed name speaks to the brand promise which is helping to build independent, productive lives, and helps erase the stigma associated with mental health. Ms. Repole re-emphasized that what makes The Center for Health Care Services uniquely different is the comprehensiveness in providing a full continuum of care in mental health, substance abuse and to a certain extent, mental disability services. This is all care that partners help to deliver. The Center is distinctly and uniquely qualified to deliver the brand promise. The new name ought to align synergy between helping people live independent, productive lives. The brand promise is in the hope the Center provides. The Center for Health Care Services is vague. On the contrary, the Center is not walking away from the stigma, the new name is meant to be a descriptor to help get away from bureaucratic natures. It is meant to help consumers feel they have not come to the end of the road.

Ms. Mary Rose Brown, Center Trustee, addressed the Board of Managers. Ms. Brown has served on this Board for a number of years. She has seen the organization grow and do more innovative things to become a national and a state model. In the beginning, the Center was a shoddy-looking place with long lines and did not treat its consumers with the respect they deserve. Today, clients are treated with respect and those long lines no longer exist. Consumers really do have hope and many of them go on to do amazing things. People who were drug-addicted for decades are now doing things, for example, like getting their work licenses back. The Center is the Health System’s partner, but they do not want its consumers to get confused with what the Health System does. One of the goals is to keep the Center’s consumers out of the University Hospital emergency room so that real emergencies can be dealt with. At the Restoration Center, police bring people who have had too much to drink and are injured. They are stitched up so they don’t have to go to the emergency room, then the staff tries to get them into rehab, keeping them out of jail and out of emergency rooms. The Center wants its consumer to differentiate between what the Health System does and what the Center does, which is a good reason for the Center’s locations to have an identity of their own. When Bexar County Hospital became University Hospital years ago, suddenly, if there was major trauma accident, University Hospital is where the patient wanted to go because that is where the smartest and best technology is, Bexar County Hospital was transformed. Bexar County Hospital was for poor people who did not have insurance. The Center wants to be that place, where anyone with mental illness and substance abuse issues will want to go to because the Center does a good job. One of the problems with The Center for Health Care Services is it cannot be sold, there is nothing to grasp or hold on to. If the Center has a campaign focused on hope, people will remember, which is why they have opted to have mental health solutions as part of the name. The Center no longer provides mental health mental retardation services, it has gone beyond that. The Center helps with recovery and gives people hope, it is getting past the stigma.

Mr. Hernandez emphasized the importance of the Center’s sponsors weighing in on the name proposal. One of the duties of the Center’s sponsors is to appoint the Center’s Board members and Bexar County officials expect the Health System to take a lead role in the community. The Health System and the Center collaborate
very well with each other on so many issues from NICU to mental health to primary care. One of the reasons there are concerns out there pertains to whether the name Center for Hope is too close to Haven for Hope. There is also a church in town named the Hope Center. If these organizations are nonprofit, the Secretary of State would probably not approve the name Center for Hope unless the Haven for Hope was fully established because the names are too close and will cause confusion. The second issue pertains to The Center for Health Care Services’ very important mission, the mission of the Haven for Hope is quite different. The Health System is also involved with the Haven for Hope and the question is whether the public will confuse the missions. The Haven for Hope deals with the homeless and The Center for Health Care Services has a much broader mission to serve not only the homeless population, but also people who are not homeless. Mr. Hernandez agreed that the name ought to speak to all the things Ms. Repole and Ms. Brown described, however, at the same time, the name should not confuse the public as far as the mission, scope of services, or the various entities that currently exist with the word hope in their names.

Mr. Engberg also expressed concern with the commonality of the name with Haven for Hope, one of the City’s major efforts to fight homelessness. He feels that the name selected must have a certain distinction.

Mr. Briseno has personally struggled with the name “University Health System” for a long time. When he watches the local news every night, they show the RBG campus, and he is very proud. However, no where on the new building or at that campus does it say that the new building and renovations were made possible by the tax payers of Bexar County. Emergency Medical Services and San Antonio Police Department know, however, that Bexar County Hospital and University Hospital are the same hospital. There is a lot of confusion between University Health System and The University of Texas Health Science Center at San Antonio. The Board of Managers ought to be looking at the Health System’s own issue with its name. By the same token, Mr. Briseno explained that when he saw a slide in Ms. Repole’s presentation that says “I have hope,” he read Haven for Hope. He did however, agree with the tag line Partners in Mental Health & Substance Abuse Solutions, because The Center for Health Care Services alone does not communicate what the Center is about. But, with the new name, there will be a Haven for Hope and also a Center for Hope. Which is which? Where do you go for what? Mr. Briseno suggested other words along the hope concept in Spanish, perhaps El Centro de Esperanza. He applauded the process described today and re-emphasized the Center’s critical mission to improve the lives of people with mental health, developmental disability and substance abuse challenges.

Ms. Rivas expressed concern with the proposed logo and was interested to know how it associates with The Center for Hope because it has been her experience that people will associate and identify with logos and pictures more easily than they will with words. The word “partners” in the tag line throws her off because it makes her wonder if the Center partners to provide services, or if he Center actually provides specialty services? Finally, if The Center for Health Care Services does not identify what type of services the Center provides, The Center for Hope doesn’t either. However, the tag line does. As far as the Center’s various locations, they are important. The Health System has various clinics
throughout the community and the Board often wants to know how those clinics tie its patients back to University Hospital or the Robert B. Green. Ms. Rivas added that two of the Center’s locations are very near the Haven for Hope, which is too close to a prominent building and name. The Center for Hope will make it difficult to distinguish or identify with the Center’s service lines.

Ms. Cedillo agreed that the issue of proximity to the Haven for Hope will cause confusion. SAMMinistries, which is in the vicinity, also has a program called Health, Hope, and Home. In her opinion, the Center for Hope is a center for healing or recovery, which can mean grief counseling or healing of physical ailments. There is something in the new name that can be played upon later, but hope can mean lots of things. It also means faith, and implies you can believe in yourself. Faith and hope are part of the issue. Hope is personal. What hope means to one person can have another meaning for someone else. The name is going to need a lot more than just hope, it will need something that reflects the actual act of healing and recovery.

In response to Ms. Rivas’ inquiry about the logo, Ms. Repole explained that in the recovery process, the patient/consumer does all the work. Staff holds their hand and leads them to recovery and therefore, the Center and the patient are partners. The Center helps them walk down the road to recovery. The tag line is meant to acknowledge all of the partners, such as the Health System, the police department, and all other collaborators. The legal name of the Center remains Bexar County Board of Trustees for Mental Health and Mental Retardation d/b/a The Center for Health Care Services. Regarding confusing the various entities with hope in their name, people refer to Haven for Hope as “the Haven.” The Center’s Board of Trustees’ consensus is that hope is not a proprietary name to any institution.

On behalf of the Board of Managers, Mr. Adams articulated that its members are absolutely delighted with the Center’s leadership for taking the Center to a place worthy of patient and staff pride, which, does not come without the work of the Center’s Board of Trustees. The Board of Managers is completely supportive of the re-branding efforts by the Center. Each of the Board members has expressed their own personal perspective on the name issue, and a consensus has not been achieved with the proposed name. As a group, the Board of Managers’ endorses the re-branding effort. However, the Board of Managers is not ready to take action on the Center’s recommendation at this time, because several Board members do not believe that buy-in of the new name by major stake holders has been achieved. Mr. Adams asked that Mr. Evans, Mr. Zamora and Mr. Hernandez get together to discuss the points made today and any concerns raised by any other the major stake holders Mr. Adams thanked the Board of Trustees for taking the time to attend today’s meeting. For the Health System, Mr. Adams reiterated the need for staff to work closely with the Center to integrate programs as effectively as possible. It is of utmost importance that both organizations understand their respective roles. Further, to address the Health System’s identity issue with UTHCSA, several Board members requested that the staff set this topic on a future Board agenda for a full discussion. Dr. Jimenez echoed Mr. Adams sentiments and stressed the need for the staff to understand the Health System’s responsibility as it relates to the sponsorship agreement. The Center is not totally independent of the Health System.
FOLLOW-UP: As indicated above.

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;
- Transition to value-based payment systems; and
- The expansion statewide of Medicaid managed care is intended to lead to improved access to primary care and more coordinated care for Medicaid beneficiaries.

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: DEVELOPMENT AND IMPLEMENTATION OF A PROGRAM OF CONTINUOUS, RAPID PROCESS IMPROVEMENT THAT ADDRESSES ISSUES OF SAFETY, QUALITY AND EFFICIENCY—KAREN BRYANT

SUMMARY: This project will establish new operational standards within each department based on transparent key performance indicators (KPIs). Visual management boards will be designed specifically for each department so that staff, administration, physicians, and even patients can understand and be encouraged to evaluate the performance for a given department. There will also be a continued focus on training staff/providers on Lean Healthcare Methodologies. These interventions will drive a cultural transformation towards continuous process improvement with staff and physician involvement. The National Strategy for Quality Improvement (developed under the Patient Protection and Affordable Care Act) has identified the current state of the American health care system as being highly fragmented due to poorly designed clinical care processes that have subsequently translated into unnecessary duplication of services, poor patient clinical care, and experience. As a result, the National Quality Strategy calls for health systems to deliver high quality, efficient, safe, patient-centered care. The target population will include all University Hospital patients and staff. Medicaid funded and uninsured patients comprise of 62% of patients who receive services at Health System facilities. This project will implement a quality improvement initiative to improve inefficiencies and/or reduce program variation in DY2. A series of rapid improvement projects will be implemented as well as recruitment of quality improvement champions in DY3 and DY4 culminating in the completion of at least 60 process improvement events by
DY5. In addition, in DY4 a Kaizen assessment will be completed for the one completed patient centered care process project. DY4 will include increased training by process improvement champions. Patients and staff will directly benefit from quality improvement methodologies including Lean that will help to identify waste and non-value adding activities in the system resulting in enhanced quality of care, more efficient processes, and standardization of procedures. Expected category 3 outcomes are a percent improvement over baseline for congestive heart failure (CHF) 30-day readmission rates. DY4 – Decrease CHF 30-day readmission rate by TBD% over established baseline. DY5 - Decrease CHF 30-day readmission rate by percentage that is to be determined over established baseline. Percent improvement over baseline of cost savings. DY4 – Demonstrate cost savings in care delivery by percentage to be determined over established baseline by performing a Cost Minimization analysis for the Cath Lab. Includes costs related to total non-value added nursing time including room turnaround time outside of 20 min goal, extended patient prep time, and late first case starts. DY5 - Demonstrate cost savings in care delivery by percentage to be determined over established baseline by performing a Cost Minimization analysis for the Cath Lab. Includes costs related to total non-value added nursing time including room turnaround time outside of 20 min goal, extended patient prep time, and late first case starts. Status of Current DSRIP Year (DY2) milestones and projection for next year (DY3) milestones were reviewed with the Board. This project will establish new operational standards within each department based on key performance indicators (KPIs) to improve clinical care processes and reduce unnecessary duplication of services. There will be a continued focus on training staff and providers on Lean health care methodologies to sustain these efforts. The intervention will specifically target Medicaid-funded and low-income, under and uninsured patients served by University Hospital to deliver high quality, efficient, safe, patient-centered care. It is expected that this project will expand quality improvement initiatives to reduce inefficiencies and program variation, implement a series of rapid improvement projects, recruit and train quality improvement champions, and result in the completion of at least 60 process improvement events by the end of DY5 (September 2016). Patients and staff will directly benefit from quality improvement methodologies including Lean that will help to identify waste in the system resulting in enhanced quality of care, greater efficiencies, and standardization of procedures. These actions are expected to demonstrate direct cost savings in care delivery, a reduction in the Average Length of Stay for Cardiac Telemetry patients, and an increase in Patient Satisfaction as measured by HCAHPS scores. 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 $2,251,820. To date, this project is on target to cover its cost. The direct cost for the entire 5 year Waiver period is $1,400,000; IGT for other hospitals is $4,012,806, net is $5,412,806; total Net DSRIP categories 1 to 4 is $15,614,439.

RECOMMENDATION: This report was provided for informational purposes only.
ACTION: No action by the Board of Managers was required.
EVALUATION: None.
FOLLOW-UP: None.
DSRIP PROJECT: INCREASE THE NUMBER OF PRIMARY CARE PROVIDERS (NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS) AND OTHER CLINICIANS/STAFF (ALLIED HEALTH PROFESSIONALS)—SERGIO FARRELL

SUMMARY: Community Medicine Associates will increase the number of mid-level provider and allied health professional trainees, including Nurse Practitioners and Physician Assistants, in the primary care setting by increasing the number of training slots available to mid-level provider and allied health professional students. Texas ranks last among the six most-populous states in both the ratio of active patient care physicians per capita and the ratio of active primary care physicians in patient care per capita. In comparison to all 50 states, Texas ranks near the bottom of the list: 46th for ratio of active patient care physicians per capita and 48th for active patient care primary care physicians per capita (Source: 2011 State Physician Workforce Data Book, Assoc. of American Medical Colleges). Nurse Practitioners and Physician Assistants can serve as an extension to the primary care physician. The target population will include the CMA patient population which is comprised of 32.4% CareLink, 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay. To achieve Category 1 or 2 expected patient benefits the Health System will increase mid-level provider training programs in DY2 through DY5. While students are in this program, they will be trained in the PCMH model and disease registry use, will focus on population health, and assist providers in managing their panels. Practice and focus in these areas will improve patient experience and outcomes. Category 3 outcomes will reduce avoidable emergency room visits for 4 diagnoses: DY 4 – Reduce emergency center visits for patients with COPD, behavioral health diagnoses, uncontrolled diabetes, and asthma by a percentage to be determined from baseline. DY 5 – Reduce emergency center visits for patients with COPD, behavioral health diagnoses, uncontrolled diabetes, and asthma by a percentage to be determined from baseline. Status of Current DSRIP Year (DY2) milestones and projection for next year (DY3) milestones were reviewed with the Board. This project will increase the number of mid-level provider and allied health professional trainees within Community Medicine Associates. This includes Nurse Practitioners and Physician Assistants working in the primary care setting by increasing the number of training slots available to mid-level provider and allied health professional students. Through this expanded program, students will be trained on the Patient Centered Medical Home (PCMH) model, the use of disease registries, the principles of population health management, while assisting clinical providers in managing their patient panels. Texas ranks last among the six most-populous states in both the ratio of active physicians per capita and in the ratio of active primary care physicians per capita. Increasing the number of primary care trained Nurse Practitioners and Physician Assistants will help address these gaps in access to health care as an extension of primary care physicians. The intervention will specifically target Medicaid-funded and low-income, under and uninsured patients served by Community Medicine Associates. It is expected that this project will improve patient experience and outcomes as well as reduce emergency center visits for patients with COPD, behavioral health diagnoses, uncontrolled diabetes, and asthma. 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 $453,901. To date this project is on target to cover its cost. The estimated cost and funding over the entire Waiver period are: Direct cost
$670,608; IGT for other hospitals $1,425,994; net cost is $2,096,602; total net DSRIP Categories 1 through 4 is $5,548,759.

RECOMMENDATION: This report was provided for informational purposes only.
ACTION: No action by the Board of Managers was required.
EVALUATION: None.
FOLLOW-UP: None.

DSRIP PROJECT: INTEGRATION OF BEHAVIORAL HEALTH INTO PRIMARY CARE—ROBERTO VILLARREAL, M.D.

SUMMARY: This project will increase access to behavioral health specialty care by adding/increasing behavioral health providers at primary care clinics and having patients receive behavioral health services through integrated patient-centered medical home/neighborhood clinics (PCMH). The PCMH is an innovative, evidence-based program to improve primary care. Adding behavioral health capacity in this infrastructure will provide seamless referrals and increase access to specialty care. According to the Bexar County Health Status Report Based on Behavioral Risk Factor Surveillance (BRFSS) Data Collected in 2008, 33% of survey respondents said their mental health was not good for one or more days over the past month and 18% reported five or more days of poor mental health. Depression, drug and alcohol use, and lack of access to mental health services were cited as the most frequent mental health issues. Some respondents shared that mental health care is difficult to acquire due to a lack of insurance coverage. Respondents also mentioned that many Bexar residents do not access care at all because they do not know what mental health services are available. Lack of awareness of services and social stigma around mental health disorders were two major challenges in this area. Education campaigns were suggested as a way to inform Bexar residents about the available mental health services in the community. The target population will be those who receive primary care services within University Health System primary care clinics, and who fall into either Quadrant I or III regarding behavioral health needs. Medicaid-funded (19%) and uninsured (43%) persons represent 62% of the patient population served by the Health System. (Ref. for Quadrant Model: National Council for Community Behavioral Healthcare, 2003). These patients will benefit from increased access to behavioral health services in the primary care setting. Category 1 or 2 expected patient benefits: The Health System will improve access to behavioral health services for the target population, by integrating behavioral healthcare services into the primary care setting and the University Health System patient centered medical home. By integrating these services into the PCMH and neighborhood clinics, patients will be able to receive both primary care and behavioral health services in one location, which will improve coordination of care and patient access to these services. For the baseline year beginning October 1st, 2011 and ending September 30th, 2012, there were 2,663 unique patients that received both physical and behavioral health care at UHS ambulatory clinics. By adding additional behavioral health providers to these clinics, UHS will be able to increase the number of patients receiving both services in the primary care setting. The goal for Category 3 outcomes is to increase access to follow up appointments post discharge for mental illness. DY4 – Increase by a percentage to be determined over baseline the number of patients securing outpatient mental health appointments within 7 days and within 30 days post discharge. DY5 – Increase by a percentage to be determined over
baseline the number of patients securing outpatient mental health appointments within 7 days and within 30 days post discharge. Status of Current DSRIP Year (DY2) Milestones and Projection for Next Year (DY3) Milestones were reviewed with the Board. This project will add behavioral health providers at primary care clinics so that patients will receive behavioral health services through integrated patient-centered medical home (PCMH) clinics. Adding behavioral health capacity to the PCMH infrastructure will provide seamless referrals and increase access to specialty care. The project will target Medicaid funded and low-income, under and uninsured patients who receive services at University Health System. It is expected that this project will improve access to behavioral health services by increasing the frequency of behavioral health appointments, specifically within 7 days and 30 days post inpatient discharge. By integrating these services into the PCMH and neighborhood clinics, patients will be able to receive both primary care and behavioral health services in one location, which will improve coordination of care and access to follow up appointments post discharge for mental illness. 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 $1,054,110. To date, this project is on target to cover its cost. The estimated cost and funding over the entire Waiver period are: Direct cost $1,005,576, IGT for other hospitals is $4,012,806; net cost is $487,943; total net DSRIP Categories 1 through 4 is $15,614,436.

RECOMMENDATION: This report was provided for informational purposes only.

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

EVALUATION: Mr. Briseno thanked Mr. Hernandez and informed him that he has been impressed with the staff and all of the DSRIP presentations. He also noted was the staff’s professionalism and enthusiasm in their involvement with these projects. Mr. Smith was pleased to learn of the integration efforts of behavioral health with primary care. Mr. Adams thanked Dr. Villarreal for his presentation and expressed tremendous regard and respect for Dr. Villarreal’s work.

FOLLOW-UP: None.

REVIEW AND DISCUSSION REGARDING BEXAR COUNTY HOSPITAL DISTRICT D/B/A UNIVERSITY HEALTH SYSTEM’S PRELIMINARY OPERATING, DEBT SERVICE AND CAPITAL BUDGETS FOR FY 2014—PEGGY DEMING

SUMMARY: Ms. Deming presented information on the 2014 budgeted activity under the headings of Access/Utilization, On-Going Capital and Debt Service Requirement. The revenue and expense budget is still in process. Budget hearings will be held all next week with members of the executive team and department heads. In addition, staff has established a workgroup to better understand the implications of the Health Insurance Marketplace under the Affordable Care Act (ACA). Approximately 20,000 CareLink members are projected to qualify for subsidized insurance under the ACA in 2014. The staff is analyzing the implications of their enrollment to the overall budget. The State of Texas has chosen not to participate in Medicaid expansion. Approximately 26,000 CareLink members were potentially eligible for Medicaid coverage. This affected the poorest and neediest of our CareLink members. The Health Insurance Marketplace affects the higher income groups within CareLink. Future budget presentations will detail the potential impact on activity, revenue and
expenses on the 2014 budget resulting from CareLink member enrollment in insurance plans offered by the Health Insurance Marketplace. Ms. Deming covered the following major factors contributing to activity growth in 2014:

- Overall increases in the population within the service area;
- Full year operation of the RBG and expansion of clinic services;
- Opening of the new University Hospital (UH) Tower on April 14, 2014;
- Full year operation of the ASC’s at the RBG and MARC;
- The impact of DSRIP projects under the 1115 Waiver; and
- Focus on key pediatric strategic service lines transitioning from CHRISTUS.

Focusing on pediatric growth alone, staff projects an overall activity increase rate of 11.5% and the following changes in utilization:

- Discharges include a 9.3% increase over 2013 projections. Strategic service lines reflecting the highest increases from 2013 are Transplant with 15.0%, Pediatrics with 40.1% and Neuroscience with 16.5%.
- Continued focus on managing length of stay in 2014. As a result, average length of stay (LOS) declines from 6.1 to 5.7, a decrease of 6.1%. The impact varies by service line.
- Inpatient days for University Hospital (UH) reflect a 2.7% increase over 2013 projection in spite of a 9.3% increase in discharges. This difference is attributed directly to the lower LOS. Heart and Vascular services anticipate having 13.8% fewer days in 2014. UH outpatient activity is expected to increase by 9.1%. This includes the addition of outpatient Pedi Dialysis and a 14.0% increase in emergency center (EC) visits from 2013. The EC visit increase is due to the new and expanded EC opening which is expected to lower the number of patients who now leave before being seen.
- Although there are differences in the rate of change by strategic service lines no material change in CMI is expected.
- Low acuity hospital outpatient surgery activity (2,500 cases) is shifting to the MARC ASC and RBG ASC. In the past, physician demand for outpatient Operating Room (OR) time could not be addressed due to capacity constraints. The shift of low acuity cases will now allow the Health System to respond more timely to outpatient surgery patient needs. As a result, it has been assumed that hospital outpatient surgery cases will decline and cases that remain will be of a higher acuity.
- Total ambulatory outpatient visits show a 10.9% increase for 2014 over 2013 projected levels in light of the new ASC’s at the MARC and RBG and RBG pediatric services. There is also continued growth associated with the RBG hospital based clinics with 12,515 additional visits (11.7%) and Community Medicine Associates (CMA) clinics with 21,974 additional visits (5.6%) over projected 2013 levels.
- Overall outpatient activity (UH & Ambulatory) is projected to increase 10.4% in 2014.
- Several Business Plans impacting activity: Inpatient Pediatric Transition; Pediatric Dialysis; RBG Pediatric general clinic; RBG pediatric specialty clinic; and RBG and MARC ASC’s are in place and actual activity levels will be monitored against them in 2014.
• The pediatric transition plan is to grow IP discharges by 44.3% in 2014. This is an increase in average daily census from 29 in 2013 to 42 in 2014. In order to accommodate the pediatric transplant business associated with this activity, outpatient Pediatric Dialysis is scheduled to open late 2013. Moreover, as part of the total Pediatric Transition plan, RBG clinics (general and specialty) saw the first patients June 2013. Major area of development for the pediatrics network include: outreach to referring physicians, expansion of referral base, formal tracking of provider customer relationships, formal program results publication. Clinical integration initiatives were also discussed with the Board.

Regarding capital needs, Ms. Deming reported that based on documented needs over the next four years a total of $111.8 million has been identified for 2014 consideration. This represents a $35.2 million dollar increase from the Tax Rate Budget presentation in August. The increase is due to additional capital requests for facility upgrades of the existing hospital as well as medical equipment for the new Tower necessary to support increased key service line activity budgeted for 2014. The capital budget for 2014 is recommended to be set at $30.0 million. This amount includes $5.0 million in 2013 projects deferred to 2014 to provide funding for the Children’s Health pediatric program. The remaining $25.0 million has been prioritized by the Capital Committee as part of the budget process. In prioritizing the capital needs for 2014, the Capital Committee met and focused on the impact of opening the new Tower in April as well as replacement of end of life assets at other Health System facilities. The bulk of the hospital’s 2014 capital equipment items are related to the OR’s for increased activity projected at the new hospital tower. In 2011 the Board approved project enhancements for nine additional OR’s and 30 additional beds on level 10 of the new tower. Funding for equipment was not included to support these additions. In light of additional surgical activity planned equipping the rooms in 2014 will provide our surgical staff with the finest equipment and in the state of the art operating rooms to meet patient needs. In prior year’s capital budgets, an annual contingency fund of $2.0 million was established to purchase any unforeseen requests that would occur during the year. For 2014, the Capital Committee agreed to forego most of the $2.0 million contingency fund and use these dollars to help purchase critical items for the new Tower and other Health System sites. After prioritization, the remaining balance in the Contingency Fund is $84,000.

The required principal and interest payments on the Health System’s outstanding bonds due in 2014, is $43.1 million. Included are the savings from the Build America Bond (BAB) subsidy of $8.3 million which is net of a 7.2% sequestration reduction ($642,000) and use of $195,000 available in the Debt Service fund to the amount previously provided by the federal government.

RECOMMENDATION: This report was provided for information and discussion purposes only.
ACTION: No action by the Board of Managers was required.
EVALUATION: Mr. Smith suggested a strategic discussion by the Board regarding the new hospital tower. Further, he would like for the Board and staff to discuss, early on during budget planning, what the Health System’s focus will be. Ms. Rivas urged the staff to explore collaborative growth opportunities. Mr. Briseno asked the staff to focus on communicating the points presented today effectively without...
being too technical, or causing confusion. For example, the public will not understand the term *adjusted discharges*, which is an overall indicator used by hospitals as a baseline for a multitude of performance indicators such as occupancy rates, workload on staff, operating costs per patient, and many other critical numbers. A key point in today’s presentation is the projected overall activity increase of 11.5%. Mr. Briseno requested one report that summarizes all of the outpatient visits as well as discharges, perhaps pharmacy visits, and lab visits for a more complete perspective. Mr. Engberg also expressed some concern with the heavy activity that is projected in 2014. He would like to see a more complete budget in order to fully grasp and examine the projections. Regarding the Health System’s capital needs for 2014, Board members agreed that funding for DSRIP projects ought not be built in to the capital budget. The Board’s desire is that $5 million be taken out of the 2013 budget, so that there will be $30 million available for capital projects in 2014. Dr. Jimenez asked why the Health System is not focused on a geriatrics service line, to which the staff replied that Community Medicine Associates currently employs three geriatrics physicians. The plan is to bundle geriatrics and primary care for marketing and other purposes. Board members asked Mr. Hernandez to allocate one upcoming Board meeting for budget discussions. A special meeting was confirmed for Tuesday, October 29, 2013

**FOLLOW-UP:**
As indicated above.

**ADJOURNMENT:**

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

Jim Adams
Chair, Board of Managers

Rebecca Q. Cedillo
Secretary, Board of Managers

Sandra D. Garcia, Recording Secretary