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

Tuesday, October 22, 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
Rebecca Q. Cedillo, Secretary
Roberto L. Jimenez, M.D., Immediate Past Chair
Robert Engberg
Ira Smith

BOARD MEMBERS ABSENT:

Alex Briseño
Linda Rivas, Vice Chair

OTHERS PRESENT:

George B. Hernández, Jr. President/Chief Executive Officer, University Health System
Hanna E. Abboud, M.D, Professor, Department of Medicine-Renal Diseases, School of Medicine,
UTHSCSA; and Medical Director, Ambulatory Renal Dialysis, University Health System
Bruce Adams, M.D., Medical Director, Emergency Center, University Hospital; and Professor and
Chairman, Department of Emergency Medicine, UTHCSA
Bryan Alsip, M.D., Executive Vice President/Chief Medical Officer, University Health System
Erik Bednarz, Director, Facilities and Business Services, Texas Diabetes Institute, University Health
System
Ted Day, Vice President, Strategic Planning & Business Development, University Health System
Theresa De La Haya, Senior Vice President/Clinical Preventive Program, University Health System
Peggy Deming, Executive Vice President/Chief Financial Officer, University Health System
Don Finley, Senior Writer, Corporate Communications, University Health System
Roe Garrett, Vice President/Controller, University Health System
Michael Hernandez, Vice President/Chief Legal Officer, University Health System
Sherry Johnson, Vice President, Integrity and Regulatory Services, University Health System
Leni Kirkman, Vice President, Strategic Communications & Patient Relations, University Health System
Mary Ann Mote, Senior Vice President, Chief Revenue Officer, University Health System
John G. Myers, M.D., Professor/Clinical, Department of Surgery, School of Medicine, UTHSCSA; and
President, Medical/Dental Staff, University Health System
CALL TO ORDER AND RECORD OF ATTENDANCE: JIM ADAMS, CHAIR, BOARD OF MANAGERS

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

INVOCATION AND PLEDGE OF ALLEGIANCE:

Chaplain Tomas Hernandez introduced Bishop Terrence White for the invocation and Mr. Adams led the pledge of allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETING:

SUMMARY: The minutes of the regular Board meeting of Tuesday, August 27, 2013, were submitted for approval.

RECOMMENDATION: Staff recommended approval of the minutes as submitted.

ACTION: A MOTION to approve the minutes as submitted was made by Mr. Engberg, SECONDED by Dr. Jimenez, and PASSED UNANIMOUSLY.

EVALUATION: None.

FOLLOW UP: None.

CONSENT AGENDA – JIM ADAMS

Consideration and Appropriate Action Regarding Medical-Dental Staff Recommendations for Staff Membership—John G. Myers, M.D., President, Medical/Dental Staff

Consideration and Appropriate Action Regarding 3rd Quarter 2013 Investment Report—Roe Garrett/Peggy Deming

Consideration and Appropriate Action Regarding Purchasing Activities (See Attachment A) – Francine Wilson

SUMMARY: The items listed above were presented as part of the consent agenda.

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

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

EVALUATION: None.

FOLLOW UP: None.
CONSIDERATION AND APPROPRIATE ACTION REGARDING THE CREATION OF AN EMERGENCY MEDICINE DEPARTMENT AND THE APPOINTMENT OF DR. BRUCE ADAMS AS CHAIRMAN—JOHN G. MYERS, M.D., PRESIDENT, MEDICAL/DENTAL STAFF/BRYAN ALSIP, M.D. /TIM BRIERTY

SUMMARY: The Center for Emergency Medicine was established in September 2012 to provide outstanding clinical care to our patients; to support University Health System and other partners to improve community health; to teach the next generation of physicians; and to develop a culture of academic excellence. To achieve the vision of becoming a premier Emergency Medicine program in Texas, The University of Texas Health Science Center at San Antonio School of Medicine elevated the Center for Emergency Medicine to full departmental status, appointing Dr. Bruce Adams as the Chair of that Department in June 2013. In accordance with Section 11.1 of the University Health System Bylaws of the Medical/Dental Staff, creation of departments within the Health System require action of the Executive Committee and approval of the Board of Managers. In its meeting of September 23, 2013, the Executive Committee of the Medical/Dental Staff recommended approval of Emergency Medicine to be recognized as a Hospital Department and recommended approval of Dr. Bruce Adams as the Chair of Emergency Medicine on October 1, 2013. The University Hospital Emergency Department possesses the requisite elements to be a patient centered clinical practice and become the Emergency Department of choice for San Antonio. The Health System has committed significant resources towards improving the Emergency Department that include:

- Construction of the new Hospital Tower to open in April 2014;
- Aggressive recruiting and staffing;
- Ongoing facility improvements and a longitudinal consulting contract with nationally recognized quality experts;
- Active support of an Accreditation Council for Graduate Medical Education (ACGME) approved and accredited Emergency Medicine residency program that began on July 1, 2013; and
- Implementation of the use of the Electronic Medical Record to ensure documentation across continuum of care for all patients in the Health System.

University Hospital is one of the premier trauma centers in the nation. While important improvements in performance and patient safety have been achieved many initiatives are being implemented to enhance services to achieve higher levels of success. By elevating the Center for Emergency Medicine to a Departmental level, there is a collective commitment to ensuring that the clinical and administrative leadership will succeed in making this the premier Emergency Department in Texas.

RECOMMENDATION: The Executive Committee of the Medical/Dental Staff recommends approval of the creation of an Emergency Medicine Department at University Hospital and the Appointment of Dr. Bruce Adams as Chairman.

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

EVALUATION: Dr. Bruce Adams addressed the Board regarding his vision for a patient centered clinical practice as the Emergency Department of choice for San Antonio. Dr.
Adams presented seven years worth of trending data for the Emergency Center (January 2005 through September 2013) under the following categories: Number of patients who left against medical advice; number of patient who left without being seen; number of patient that left after their medical screening; and number of patients who left before treatment was completed. He noted that these rates peaked in 2012 to 22.2% from 16.6% in 2005, and are currently at 14%. The national median is 2.0% while the large emergency department median is 2.7%.

Dr. Adams reviewed the patient flow process in the current location of the Emergency Department and described the various issues that impact throughput, such as staffing, specialist availability, and bed availability. Ongoing improvements in the Emergency Department include the new trauma tower, electronic medical record/emergency department system, appropriate staffing levels, bed capacity management and a changing culture. Dr. Adams informed the Board that progress has been made in the emergency psychiatric services area as well and he described some of the improvements that have taken place.

Discussion ensued regarding the trending data presented and Mr. Engberg expressed concern regarding the nurse staffing issue on the units in light of the activity projections for 2014 and beyond. Ms. Vasquez assured the Board that staffing needs are being addressed. She elaborated on the level of flexibility that is required by the nursing staff to move patients out of the Emergency Department. At the present time, every bed at University Hospital is not staffed 100 percent and sometimes the Emergency Department is forced to board patients that need to be upstairs in a bed. In response to this issue, Ms. Nancy Ray, Chief Executive Nurse, is trying to build a float pool of nurses who can be called in to staff beds on the various units when the Emergency Department is backed up. Ms. Vasquez reiterated that the problem right now is the number of operating beds because we do not operate at 100 percent, 24 hours per day, 365 days a year. Further, we do not have a dedicated observation unit and oftentimes, inpatient beds are used instead. We have a small observation area on the 8th floor that is not ideal, however, the new model for the Emergency Department, includes an observation unit. Mr. Adams pledged the Board’s support in the staff’s quest to improve existing throughput issues and improvement efforts.

FOLLOW UP:

Mr. Adams requested a quarterly report from Dr. Adams regarding the Emergency Department. He asked the staff to brief Ms. Nancy Ray on the items discussed today.

CONSIDERATION AND APPROPRIATE ACTION REGARDING SELECTED PURCHASING ITEMS RELATED TO THE CAPITAL IMPROVEMENT PROJECT:

UNIVERSITY HOSPITAL:

CONSIDERATION AND APPROPRIATE ACTION TO APPROVE THE GUARANTEED MAXIMUM PRICE FOR THE ADDITIONAL MRI CHILLED WATER SYSTEM AND INFRASTRUCTURE, TRANSPLANT EXAM REVISIONS, IRRADIATION EQUIPMENT CHANGES, AUTOMATED GUIDED VEHICLE & SERVICE ELEVATOR FLOORING CHANGES, AUTOMATED GUIDED VEHICLE CART WASH AND INFRASTRUCTURE, MRI EXHAUST SYSTEM, AND INTERIOR GLAZING PATTERNED SAFETY GLASS AT THE NEW TOWER AT UNIVERSITY HOSPITAL (GMP #13Z)—MARK WEBB
SUMMARY: The original plan for the new tower included an MRI on the 8th floor. Since that time, accommodations for an Interoperative MRI (IMRIS) have been made on the 2nd floor in the Operating Room area. This enhanced service and equipment requires additional chilled water system infrastructure to support the IMRIS system. This item also includes modifications to 9th floor Transplant Exam area that will enhance patient care and streamline outpatient services. Additionally, the existing Irradiation Equipment was to remain in its current existing building location. However, as the operational plans developed, it was determined that newer equipment was needed and that the new equipment should be placed in the new Blood Bank area on the 1st floor of the new tower to be more operationally efficient. With the inclusion of the Automated Guided Vehicle (AGV) System flooring material changes were required in certain areas including service elevators to provide flooring better suited to meet the heavy traffic demands required as part of the AGV Supply Chain delivery to the New Hospital Tower. Also included is a Cart Wash System and associated Infrastructure to be installed in the basement of the new tower to service soiled AGV Carts. Finally, as an added safety precaution, an additional patterned coating will be added to all interior transparent safety glass walls and sidelites to provide a visual warning to prevent accidental collision with those surfaces. The scope of this twenty sixth GMP is inclusive of the costs for additional MRI chilled water system and infrastructure, transplant exam revisions, irradiation equipment changes, service & AGV elevator flooring changes, AGV cart wash and infrastructure, MRI exhaust system, and interior glazing patterned safety glass, at the owner’s request for a cost in the amount of $1,521,229. The Construction Manager has provided a deductive change order for the item associated with this GMP package. Mr. Webb reviewed all of the GMPs related to this contract in detail with the Board. The proposed GMP #13z is in the amount of $1,521,229 will be paid from owner’s construction contingency. This would decrease the owner’s contingency funds from $3,636,511 to $2,115,282. This expense to the contingency fund was contemplated and included in the projected contingency spend report to the Board. These project changes will improve the workplace environment to best suit the needs of patients and staff in the new Tower providing for more efficient operations and better patient care, as well as increase the operational efficiency of the new tower. These changes were requested by staff and/or are required due to operational changes. The participation goal for SMWVBE is 40% and the local participation goal is 80%. To date, SMWVBE participation of awarded construction projects is 38.1% and local participation is 74.1%. This does not include the dollars associated with the Construction Manager’s Fee or other project administrative costs including this GMP and insurance, bonds, permit fees, etc. The SMWVBE numbers achieved for all construction GMPs to date were also discussed. GMP dollars awarded to date is $502,315,890. GMP dollars remaining to procure is $21,075,791.

RECOMMENDATION: Staff recommends Board of Managers’ approval of an amendment to the Zachry Vaughn Layton Construction Management Agreement in the amount of $1,521,229, for GMP 13z.

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

EVALUATION: Mr. Webb reported that the Clinical Pavilion at the Robert B. Green last week was awarded Gold certification in Leadership in Energy and Environmental Design (LEED), which demonstrates good stewardship of the resources entrusted to the mission of the University Health System. LEED buildings are designed to
lower operating costs and increase asset value, reduce waste sent to landfills, conserve energy and water, be healthier and safer for occupants, reduce harmful greenhouse gas emissions, and qualify for tax rebates, zoning allowances and other incentives in hundreds of cities. The corporate communications department will work with Mr. Webb to publicize this accomplishment.

Mr. Smith asked about the balance of the CIP contingency fund after GMP 13z. The balance will be $2.1 million and is to cover one more item related to the new tower. However, the next phase of the CIP project at University Hospital is related to renovations of the old building, which will also be paid out of this contingency balance. Staff will issue an RFP for the renovation work (Phase 4). There are currently teams of architects, besides Perkins+Will, doing some design work for the hospital, and ZVL is doing some renovation work that is tied to the opening of the new tower. There is approximately $30 million allotted for the renovations and Mr. Webb assured the Board that there is clear delineation of this future work. Mr. Smith feels this is an excellent opportunity for local and small businesses and asked to be kept informed of the progress regarding this RFP. Mr. Adams urged the staff to provide as much information as possible with all of the remaining CIP items that come to the Board for approval.

FOLLOW UP:
As indicated above.

CONSIDERATION AND APPROPRIATE ACTION TO APPROVE A CONTRACT WITH SP
PLUS HEALTHCARE SERVICES FOR GARAGE MANAGEMENT SERVICES AT
UNIVERSITY HOSPITAL—MARK WEBB

SUMMARY:
On February 1, 2013, University Health System issued an RFP for the selection of a garage manager for the University Hospital campus. Proposals were received from seven vendors. A proposal selection team consisting of representatives from Hospital Administration, Patient Experience, Protective Services, Financial Accounting, and Facilities Administration evaluated the proposals and shortlisted the following three vendors to be interviewed: Cornerstone Parking Group, Ampco System Parking and SP Plus Healthcare Services. After careful consideration, the selection team recommends SP Plus Healthcare Services as the garage manager. SP Plus Healthcare best demonstrated the ability to efficiently manage the garage and produce reports that will allow staff to constantly improve operations. The customer service focus of the company aligns with the Health System’s customer service initiatives. Relevant experience, qualifications, potential value-added services and capability to deliver a competent parking management concession within a healthcare setting were strong factors that were considered in the selection. SP Plus Healthcare will provide revenue collection for visitor parking initially in the West Parking Garage (WPG) and from the three Pay on Foot devices. When the new tower opens April 2014, the revenue collection operation will be switched to the North Parking Garage (NPG), which becomes the visitor parking garage. The manager will also maintain gate operations in the WPG, NPG and South Parking Garage (SPG). The contract also includes monthly sweeping and ticket supplies. This management contract will improve quality by ensuring that patients/visitors to the University Hospital campus have a safe, organized, and economical parking experience. Before the Health System contracted with Ampco, gross patient parking revenue was $440,000 and net revenue was not calculated. At the
time, garage operational expenses were not tracked so a net number could not be accurately calculated. When Ampco took over the operation, gross revenue rose to $540,000, and net revenue was computed at $336,000. Now with the ability to better track personnel, ticket supplies, maintenance, repairs, liability insurance and other expenses, the net margin for the garage operations can be more accurately determined. SP Plus Healthcare Services submitted a proposal price that is the lowest qualified price based on the evaluation by the selection committee. The cost for the 3 year garage management agreement is $671,595 (or an annual cost of $223,865) and includes the visitor parking revenue collection/management, gate management, ticket supplies and monthly sweeping. This agreement will be funded with garage operating funds. Under SP Plus, gross revenue is anticipated to be $616,850 and net revenue is projected to be $392,985 per year. Mr. Webb reviewed the annual estimated expenses for 2014:

<table>
<thead>
<tr>
<th>Expense</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Expense (24 X 7 operation, cashier and manager during the day, overlap between shifts)</td>
<td>$156,851</td>
</tr>
<tr>
<td>Tickets, Uniforms, and office supplies</td>
<td>$24,355</td>
</tr>
<tr>
<td>Repairs, Maintenance, and sweeping</td>
<td>$11,772</td>
</tr>
<tr>
<td>Liability Insurance</td>
<td>$20,916</td>
</tr>
<tr>
<td>Data Processing, postage, telephone</td>
<td>$4,571</td>
</tr>
<tr>
<td>Management Fee</td>
<td>$5,400</td>
</tr>
<tr>
<td>Total</td>
<td>$223,865</td>
</tr>
</tbody>
</table>

The Board reviewed the vendor’s workforce composition data. The company is a publicly held large corporation and is not classified as a SMWVBE; however, they intend to fill all positions created by the management contract from the local labor market.

RECOMMENDATION: Staff recommends Board approval of a three-year agreement with SP Plus Healthcare Services (Standard Parking) in the amount of $671,595 for garage management services.

ACTION: A MOTION to approve the staff’s recommendation, subject to Mr. Hernandez’s review of issues raised by Mr. Adams and Mr. Smith, was made by Ms. Cedillo SECONDED by Mr. Smith and PASSED UNANIMOUSLY.

EVALUATION: Mr. Smith asked about the three employees who worked in the west parking garage prior to AMPCO’s management of the garage. These employees, with supervisory oversight by the protective services department, were successfully transitioned to other functions within the Health System; none were displaced. Discussion ensued regarding the projected net revenue amount of $392,985 from parking fees for 2014. Mr. Hernandez noted that parking is free at all of the ambulatory facilities, and the fees for parking at University Hospital are in line with those of other parking garages in the medical center. Mr. Adams asked Mr. Hernandez to consider signage at the exits of all garages at University Hospital thanking the Bexar County Commissioners for their support and for making free parking possible. Guests would not have to pay for visiting patients at University Hospital. Mr. Smith echoed Mr. Adams sentiments. Mr. Hernandez did not initially agree with this proposal, citing the fact that Bexar County does not provide free parking at their facilities. He agreed that the matter of parking is sensitive in some situations, and the staff has some flexibility in waiving these fees.

FOLLOW UP: Mr. Hernandez will review the suggestion made by Mr. Adams for possible alternatives.
CONSIDERATION AND APPROPRIATE ACTION REGARDING SELECTED PURCHASING ITEMS:

CONSIDERATION AND APPROPRIATE ACTION TO APPROVE A CONTRACT WITH SOUTH ALAMO MEDICAL GROUP FOR PRIMARY CARE SERVICES PROVIDED TO CARELINK PATIENTS—VIRGINIA MIKA, PHD

SUMMARY: The purpose of this agreement is to continue to secure professional primary care services for our CareLink members who are assigned to South Alamo. Over the past 7 years, these physicians have seen patients for office visits, family planning, immunizations, inoculations, nutritional and obesity control counseling and preventive care. The claims activity report for 2012 indicates South Alamo Medical Group provided services to 2,249 CareLink members. In March of 2012 South Alamo decided to close their panels to new patients; They continue to care for all existing members. The result of this closure has been a gradual reduction in CareLink membership, which was 1,235 members as of June 2013. This Agreement is based on 100% of the current Medicare fee schedule for all professional services. In 2012 CareLink paid South Alamo Medical Group $860,262. As of June 30, 2013 (last month of completed claims data available due to our 90 day lag on claims) CareLink has paid South Alamo Medical Group $332,925. Based on both 2013 projected annualized data, and the anticipated lower number of CareLink members assigned to South Alamo, we anticipate the value of the contract to be $500,000 for a period of one year. This agreement shall be renewed for up to two successive one (1) year terms if South Alamo meets all performance standards, patient satisfactions and quality risk management standards. Based on available information, we estimate CareLink membership with South Alamo Medical Group at the end of 2014 at 800 members. The contract will include provisions for compliance with the Health System utilization review and quality assurance programs as well as eligibility verification, pre-authorization requirements from CareLink. The providers must be credentialed and board certified. Patient satisfaction surveys will be conducted by South Alamo in a format approved by the Health System. The Health System shall be provided a quarterly report of patient satisfaction. Scores are expected to be 80% or higher.

RECOMMENDATION: Staff recommends Board of Managers approval to execute an Agreement with South Alamo Medical Group for a total estimated contract amount of $1,500,000.

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

EVALUATION: None.

FOLLOW UP: Mr. Adams urged the staff to work towards re-assigning these patients from South Alamo Medical Group to Community Medicine Associates for growing of the CMA business.
CONSIDERATION AND APPROPRIATE ACTION REGARDING REPORT FOR SEPTEMBER 2013 FINANCIAL STATEMENTS—ROE GARRETT/PEGGY DEMING

SUMMARY: For the month activity was up 10.0% for the Clinical Services (as measured based on discharges adjusted for outpatient activity). Community First Health Plan (CFHP) fully-insured membership was up 0.9%. From operations, the Health System experienced a loss of $1.6 million which was $2.2 million lower than the budgeted gain of $557,000. Expense increases for the pediatric transition, NICU and transplant programs were due to higher activity and revenue was recognized to offset the higher costs. In analyzing the loss from operations for the month the following were noted:

- Start up costs were incurred for the two Ambulatory Surgery Centers and were not offset by revenue. These costs were not material and were necessary in order to properly train and establish the high level of care that will be provided in these important ambulatory service areas.
- New costs associated with consultants to address the compliance issues for the renal dialysis services, to set up the new employee recognition program and Ambulatory Surgery Center amounted to $424,000 in the month.
- Adjustments recognized that could have been attributed to prior months include the recognition of higher incurred but not reported (IBNR) employee health claims and contracts for security and refuse services. These adjustments totaled $1 million. The IBNR adjustment was 55% of this variance and steps have been taken by CFHP to provide more timely analytical information to recognize health care claims in a timelier manner.
- Higher Medical Services of $1.1 million related to IGT’s for the DSH and UC programs that were higher than what had been budgeted. This was determined to be a budget issue and it has been accounted for in the year end projections.

Meaningful use incentive of $123,000 was recorded for the achievement of incentive awards for the electronic medical record implementation. Investment income was under budget by $49,000 due to slightly lower interest rates than budgeted. An unrealized market gain of $364,000 was recorded in the month due to lower interest rates during October. The bottom line loss excluding debt service of $916,000 which was $1.9 million lower than the budgeted gain of $954,000 were explained in the above comments. CFHP reflected bottom line gain of $1.1 million which was $1.3 million higher than the budgeted loss of $247,000 as significant improvements were noted since July in light of higher membership and recently negotiated contracts. DSRIP Revenue was higher in recognition of a portion of the $2.0 million of FFY12 DY1 payment received earlier this year. Debt Service Revenue was $3.5 million which is equal to the budgeted portion of the Debt Service payment of $3.5 million. Mr. Garrett reviewed notable increases and/or decreases from the Consolidated Balance Sheet in detail with the Board.

RECOMMENDATION: Staff recommended the financial reports for acceptance by the Board subject to audit.

ACTION: A MOTION to acceptance of the financial reports, subject to audit, was made by the minutes as submitted was made by Mr. Engberg, SECONDED by Mr. Smith, and PASSED UNANIMOUSLY.
**EVALUATION:** Discussion ensued regarding September’s case mix index. Dr. Jimenez suggested the use of independent physician consultants to review medical records and appropriately document acuity levels to maximize reimbursement for the Health System. The year to date financial performance view indicates a bottom line gain of $6.4 million, or $4.8 million better than the budgeted gain of $1.6 million due to higher operating revenue. Mr. Adams clarified that this bottom line gain does not mean there are excess pots of money available at the Health System. Rather, it goes to show that the staff works very hard for every dollar to be less of a burden on this community.

**FOLLOW UP:** None.

**PRESENTATIONS AND EDUCATION:**

**REVIEW AND DISCUSSION OF PROJECTED REVENUE AND REVENUE SOURCES FOR FY 2014—PEGGY DEMING**

**SUMMARY:** Mr. Hernandez presented an overview of the 2014 budget process as indicated below, and yielded the floor to Ms. Deming for today’s presentation:

- Oct. 22 Review departmental activity in support of aggregate submitted in tax rate, preliminary capital and debt service
- Nov. 12 Combine revenue and expense, review preliminary income statement
- Nov. 19 Review preliminary budgets
- Nov. 26 Review final budget and obtain Board approval
- Dec. 10 Present 2014 Operating & Capital Budget to Bexar County Commissioners Court

Ms. Deming recapped the October 15 Board meeting at which staff presented preliminary information on the 2014 projected activity including strategic initiatives in place to achieve the increases projected by inpatient service line and for ambulatory services. This activity is the key driver in the development of the net patient service revenue (NPR) which represents collections from federal payers including Medicare and Medicaid, insurance companies and from patients. Total 2014 operating revenue for the Health System is $827.2 million and includes NPR at $412.9 million, plus other sources of funding such as property taxes at $259.2 million, Disproportionate Share (DSH) at $33.6 million, waiver funding that includes Uncompensated Care (UC) at $63.6 million, and DSRIP funding at $19 million, a distribution of investment income allocated from the State Tobacco Trust fund at $5.2 million, trauma funding and other income sources at $31.5 million. The 2013 total operating revenue at year end is projected to be $769.9M. NPR at $360.2 million, property taxes at $244.2 million, Uncompensated Care at $75 million, DSRIP funding at $22.6 million, a distribution of investment income allocated from the State Tobacco Trust Fund at $5.2 million, trauma funding and other income sources at $27.9 million. Ms. Deming presented these different sources of funding with a focus on impacts from Legislative changes and recent changes in funding levels for DSH and UC. Also at the October 15 meeting relative to several capital requests for capital
dollars that are related to DSRIP school based clinic expansion, the Board requested that staff review the entire list of capital to assure the ongoing requests excluded DSRIP projects. The list was reviewed and two capital requests totaling $100,000 were identified. They were removed from the list and $100,000 was added to the contingency amount for 2014 capital. The use of these dollars will be determined at the next capital committee meeting. A detailed discussion ensued among the Board members and staff regarding the legislative changes in funding levels for DSH and UC, two key items in light of recent changes that have caused large swings in estimates that will impact the 2014 total operating revenue. A line by line budget will be available for the Board review after November 12.

RECOMMENDATION: This report was presented for information and discussion purposes only

ACTION: No action by the Board of Managers is required at this time.

EVALUATION: None.

FOLLOW UP: None.

AMBULATORY MATTERS:

STATUS REPORT ON UNIVERSITY HEALTH SYSTEM'S OUTPATIENT DIALYSIS PROGRAM—THERESA DE LA HAYA

SUMMARY: The Health System’s Outpatient Dialysis Program consists of four hemodialysis centers with a total of 91 dialysis chairs, an adult detention dialysis program with three (3) dialysis chairs, and a peritoneal dialysis service that operates out of the Northwest hemodialysis center. In FY 2012, the hemodialysis program served 430 unduplicated patients generating 64,802 individual treatments while the peritoneal dialysis program ended FY 2012 serving 23 unduplicated patients generating 6,162 individual treatments. On May 30, 2013, in response to an anonymous complaint submitted to the Texas Department of State Health Services (DSHS) regarding the UHS Dialysis program, a survey was conducted by DSHS at each of the Dialysis Centers (South, Northwest, West and Southeast). During the visit the DSHS surveyor initiated a full recertification survey at the dialysis West center. This recertification survey had been delayed for two years. Upon visiting all centers the DSHS surveyor found the dialysis facilities to be deficient in six Conditions of Participation for End Stage Renal Disease (for a total of approximately 60 deficiencies across all four dialysis centers):

1. 494.30 Infection Control
2. 494.60 Physical Environment
3. 494.80 Patient Assessment
4. 494.110 Quality Assessment & Performance Improvement (QAPI)
5. 494.140 Personnel Qualifications
6. 494.180 Governance

DSHS submitted an official letter to the Health System with a summary of state and federal deficiencies and recommended a Level II Corrective Action Plan (CAP). A Level II Corrective Action Plan is deemed appropriate if the facility is not in full compliance with the ESRD Facilities Chapter of the Health & Safety Code. Under a Level II CAP the facility is required to develop and implement a
corrective action plan and a state approved monitor shall supervise the implementation of the plan and guide the Health System in improving deficiencies while implementing a long-term sustainability plan. Improvement is expected within 45 days. Upon recommendation of a Level II CAP, the staff responded to DSHS with immediate corrective actions to ensure compliance at all four hemodialysis centers. Respective corrective action plans were created for each dialysis center and specifically tailored to respond to the six conditional findings. Although DSHS requested that the Health System have the required monitors; the staff proactively recruited state monitors (Nurse Educator, Nurse Manager and a Bio-Med Manager) prior to receiving the official state letter, to ensure that performance improvement milestones for both quality and patient safety were readily addressed and documented. On August 8, 2013, the DSHS surveyor concluded a 2-day re-visit survey at the West Dialysis facility to evaluate the progress toward correcting the conditions for coverage that were found to be deficient on the re-certification survey conducted June 10, 2013. After the surveyor’s review, the Health System was notified that all six federal conditions would be lifted; however they requested that the Health System continue with the state Level II CAP conditions with monitors in place to ensure demonstration of a plan of sustainability. During the week of August 19th the DSHS surveyor re-visited the South and Northwest dialysis centers to conduct a 45 day re-visit on the progress toward correcting deficiencies. Again all six federal conditions were lifted. On August 29th DSHS re-visited the Southeast clinic and all six federal conditions were lifted at that location as well.

Ms. De La Haya outlined the following corrective actions to date:

- Started the hiring process for a staff educator to revise the centers’ renal dialysis orientation training program to ensure the highest quality of training for all newly hired staff and hire a quality assurance nurse to perform periodic audits to ensure that all renal dialysis centers are adhering to state regulations.

- Clinic managers will continue to conduct regular performance evaluations of personnel in the areas of infection control, hemodialysis nursing procedures, technical skills and procedures, and other patient care processes;

- Reassignment of one current patient educator to meet with patients regularly to ensure that all patients understand the importance of cleansing their access sites to prevent infection;

- Train additional bio-med staff to support state water treatment regulations;

- Establish processes and tools to promote consistency in all renal dialysis facilities;

- Enhance current dialysis EMR to add features that automate vital signs and treatment measures to ensure that staff concentrates more time on the clinical quality of the dialysis treatment;

- Implement a dialysis specific development program for clinic nurse managers to encourage them to be stronger leaders in their practice;
Searchings for a new renal dialysis director that has strong clinical experience.

DSHS/Federal regulations are met; and

A newly formed overarching team representing administrative and management.

Assignment and Performance improvement initiatives.

Detail follow-up will occur with all items discussed at the Quality Assessment and Performance Improvement meetings;
of the machines. Ms. De La Haya reiterated that the negative findings have to do with processes not level of care.

As far as the overall morale of staff in the dialysis centers, Ms. De La Haya compared it to what has been seen in the Emergency Department, where there are cultural changes taking place and there has been loss of low performing staff, with the higher performing staff taking on more responsibility. She is presently actively recruiting additional competent and professional staff. She is also searching for a strong, clinical person to take charge. The correction and improvement process will take at least 18 months to two years. The present situation is a major change, with the staff being watched every second of the day by a monitor, but those high performing staff members were very happy to see these changes. Ms. De La Haya is going through the same training as the staff so that she can be as knowledgeable as possible in this area. Further, each dialysis center has its own medical director, and they are all being re-engaged. It has been a painful, embarrassing, and costly process but Ms. De La Haya feels the Health System is moving in a positive direction, having identified all of the deficiencies.

Mr. Hernandez expressed support for the staff and informed the Board that Ms. De La Haya had actually inherited the dialysis centers and all the issues associated with them. He is confident that the staff is working hard to get past these issues and that all the right people are in place now. Further, all of the efforts described today will ensure the Health System continues to provide the highest quality of care to its patients.

Mr. Adams expressed the Board’s expectation to be kept informed of any significant findings that State surveyors might find during site visits to any of the Health System’s facilities.

FOLLOW UP: As indicated above.

INFORMATION ONLY ITEMS:

REPORT REGARDING YEAR 2013 MEDICAL-DENTAL STAFF COMMITTEES AND DEPARTMENTS—JOHN G. MYERS, M.D., PRESIDENT, MEDICAL/DENTAL STAFF

UPDATE ON CAPITAL IMPROVEMENT PROGRAM ACTIVITIES—MARK WEBB

REPORT ON RECENT RECOGNITIONS AND UPCOMING EVENTS—LENI KIRKMAN

QUARTERLY REPORT ON HOSPITAL INPATIENT PERFORMANCE METRICS—BRYAN ALSIP, M.D.

SUMMARY: Mr. Adams directed the Board’s attention to the written reports above. He urged his colleagues to contact staff with specific comments, questions, or suggestions.

RECOMMENDATION: These reports were provided for informational purposes only.

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

EVALUATION: None.

FOLLOW-UP: None.
ADJOURNMENT:

There being no further business, the public meeting adjourned at 3:45 p.m.

__________________________________ ______________________________
Jim Adams     Rebecca Q. Cedillo
Chair, Board of Managers   Secretary, Board of Managers

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Sandra D. Garcia, Recording Secretary