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
Ira Smith

BOARD MEMBERS ABSENT:
Alex Briseño

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
Ted Day, Vice President, Strategic Planning & Business Development, 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
Michelle Ryerson, Senior Vice President/Chief Nursing Officer/Chief Operating Officer, Pediatric
Clinical Services Administration, University Health System
Christann Vasquez, Executive Vice President/Chief Operating Officer, University Health System
Mark Webb, Senior Vice President/Facilities Administration, University Health System
Francine Wilson, Vice President/Materials Management, University Health System
Leon Evans, President/CEO, The Center for Health Care Services
Ruben Zamora, Chairman, Board of Trustees, The Center for Health Care Services
Camis Milam, M.D., Medical Director, The Center for Health Care Services
Robert Guevara, Vice President/Business & Finance, The Center for Health Care Services
And other attendees.
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 2:05 pm.

INVOCATION AND PLEDGE OF ALLEGIANCE:

Mr. Daniel Aguirre of Oasis of Light Church said the invocation and Mr. Adams led the pledge of allegiance.

APPROVAL OF MINUTES OF PREVIOUS MEETINGS:

SUMMARY: The minutes of the regular Board meeting of Tuesday, July 16, 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.

SELECTED PURCHASING ITEMS RELATED TO THE CAPITAL IMPROVEMENT PROJECT:

CONSIDERATION AND APPROPRIATE ACTION TO APPROVE A GUARANTEED MAXIMUM PRICE (GMP) FOR PROCUREMENT OF MEDICAL EQUIPMENT, INFORMATION TECHNOLOGY AND THE PURCHASE OF AN AIR HANDLING UNIT FOR THE PEDIATRIC HEART PROGRAM AT UNIVERSITY HOSPITAL (GMP#17D) — MARK WEBB

SUMMARY: Since the Board approved the original GMP in February 2013, work has progressed in developing 23 pediatric beds at University Hospital for the Children’s Health program. Prior to construction of the beds beginning, a clinic, several offices, and call rooms had to be relocated from the 5th and 11th floors of the ’68 building. Many of the moves have taken place, while others are scheduled to be completed later this month. The beds are scheduled to be operational in the September/October 2013 timeframe. Subsequent to the Children’s Health program and associated construction/equipment budgets being approved by the Board in February, improvements that enhance service delivery and capabilities have been recommended that affect the original schedule and budget. These enhancements to service delivery include Pediatric Outpatient Dialysis, Children’s Heart Program, Emergency Services, as well as equipment changes to increase flexibility and capability in providing care. As such, an additional GMP was approved at the June 25, 2013 Board meeting to cover the additional work. Since that time, staff was made aware of unique operating room requirements in order to perform children’s heart surgeries at University Hospital. These requirements include the need to cool the operating room to 62
degrees and specialized equipment. This GMP includes upgrades to the mechanical equipment that services Operating Room 18 to allow the temperature to be maintained at 62 degrees. The GMP also provides for some minor electrical upgrades, as well as the purchase of specialized equipment. These service enhancements will improve quality and outcomes by including a more comprehensive offering of services, as well as providing key services that support other programs. Although there are additional costs associated with these service enhancements, the Children’s Transition Business Plan continues to forecast a positive contribution margin associated with the additional volumes projected with the new service lines. The scope of this GMP includes the cost to convert 11th Floor Operating Room 18, which currently performs adult cardiac surgeries, into a pediatric cardiac surgery unit. In order to meet the service requirements for pediatrics, this conversion will require: mechanical and electrical modifications, information technology upgrades, purchase of an additional air handling unit, and purchase of medical equipment. ZVL (construction manager), in conjunction with RTKL (equipment planners) and the project team have thoroughly reviewed the GMP provided for the work and equipment associated with this package and recommend approval of the following expenses listed below for 11th floor Operating Room #18, medical equipment, information technology, mechanical and electrical modifications and air handling unit:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction Costs and Fees</td>
<td>$1,060,912</td>
</tr>
<tr>
<td>Equipment Purchases and Modifications</td>
<td>77,970</td>
</tr>
<tr>
<td>Information Technology Modifications</td>
<td>50,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$1,188,882</strong></td>
</tr>
</tbody>
</table>

The proposed GMP #17d in the amount of $1,188,882 will be paid from 2014 routine Capital funds. The participation goal for SMWVBE is 40% and the local participation goal is 80%. To date, SMWVBE participation of awarded construction projects is 77.9% and local participation is 74%. This does not include the dollars associated with the Construction Manager’s Fee or other project administrative costs (i.e., insurance, bonds, permit fees, etc.). The SMWVBE numbers achieved for all construction GMPs to date were reviewed with the Board. GMP dollars awarded to date is $523,391,682. GMP dollars remaining to procure is $22,867,834.

RECOMMENDATION: Staff recommends Board of Managers’ approval to execute the amendment to the Zachry Vaughn Layton Construction Management Agreement for GMP 17d in the amount of $1,188,882.

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

EVALUATION: This project will commence as soon as staff receives Board approval and has an estimated completion date of November or December 2013, due to the lead time necessary for the air handler, which will be custom made. Cooling the room to 62 degrees is the medical standard of care based on scientific evidence that children will have better outcomes when their body temperatures are naturally lowered. Ms. Ryerson informed the Board that many hospitals around the state (Houston, Dallas, Corpus, and San Antonio) have opted to ask the state for waivers of this operating room requirement. The operating room temperature for adults is 68 degrees. Operating Room #18 will not be functional for
approximately two to three weeks and there will be minimal disruption to the other operating rooms. After the work is completed, this operating room can be used for both pediatric and/or adult heart surgeries. Ms. Vasquez reminded the Board that there will be two operating rooms at RBG Ambulatory Surgery Center, as well as those at the Medical Arts and Research Center, opening up very soon. Ms. Rivas asked if one room with this cooling capability would be sufficient in light of the plans to grow pediatric services in the next five years. Ms. Vasquez replied that one room would be sufficient. Mr. Engberg questioned the staff’s plan to budget the project against 2014 capital funds. Mr. Hernandez informed the Board that the staff plans to reduce 2014 capital requests by this amount because capital funds are the only source available at this time, and it is not feasible to delay the project. Mr. Smith suggested that perhaps it would be more feasible to shift or delay other projects until 2014 so that 2013 capital funds would be available to pay for this project now. Mr. Adams agreed and asked the staff to arrange for funding of such items to occur at the end of the 2013 upon re-balancing of capital reserves. Mr. Adams thanked Ms. Ryerson for her knowledgeable input regarding best practices for children’s health.

**FOLLOW UP:** Staff will arrange for funding of this capital item to occur at the end of 2013 upon re-balancing of capital reserves.

**CONSENT AGENDA—JIM ADAMS, CHAIR**

**CONSIDERATION AND APPROPRIATE ACTION REGARDING UHS POLICY NO. 2.01.03, AMBULATORY SURGERY SERVICES OVERSIGHT AND DELEGATION—TED DAY**

**SUMMARY:** Board members were provided with a written copy of this new policy. The purpose is to clarify the lines of authority and oversight of the effective delivery of care at ambulatory surgery centers associated with University Health System.

**RECOMMENDATION:** Staff recommends Board of Managers’ approval of Policy No. 2.01.03, Ambulatory Surgery Center Oversight and Delegation for the Medical Arts and Research Center and Robert B. Green Ambulatory Surgery Centers.

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

**EVALUATION:** None.

**FOLLOW UP:** None.

**PRESENTATIONS AND EDUCATION**

**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.

APPLY EVIDENCE-BASED CARE MANAGEMENT MODEL TO PATIENTS IDENTIFIED AS HAVING HIGH-RISK CARE NEEDS: IMPLEMENT CARE MODEL FOR CLINIC SETTINGS—MARY ANN MOTE

SUMMARY: This project establishes an interdisciplinary care coordination team within the ambulatory network of care. The teams will be comprised of Registered Nurse (RN) Case Managers, Social Workers, and Patient Educators. The care coordination team will work to identify and support patients with chronic illnesses and other health care needs at their respective regional medical home clinics. This interdisciplinary model of care will also be tailored to addressing the health needs and preferences of the patient population including: appropriately accessing use of community and organizational resources, enhancing the patient’s knowledge of the disease process(es), and facilitating healthy decisions to reduce risk for chronic disease and or disease self-management. The Community Needs Assessment reported that approximately 470,000 residents in RHP 6 remain uninsured (C.N.3), and that their foundation for care is dependent on the services offered by University Health System. Leading causes of death in RHP 6 include cardiovascular disease, cancer, and diabetes (C.N. 2). This project was selected because the incorporation and partnership of RN’s, Social workers, and Patient Educators (Care Management model) all working at the top of their skill sets can better assist with provider shortages (C.N.3), improve patient outcomes, and with improve provider and patient satisfaction. Final outcome of the Care Management model also result in a reduction in hospital admissions and EC visits. The target population will include the CMA patient population, specifically those patients dealing with 2 or more chronic conditions (50%). CMA is comprised of 32.4% CareLink, 31.9% Medicaid, 12.6% HMO/PPO, 12.1% Medicare, and 10.9% self pay. Category 1 or 2 expected patient benefits will establish and expand a comprehensive care management program in the primary care clinics during DY 2 and DY 3. The coordination team will then continue to expand their services to a larger patient population during DY4 and DY5. Furthermore, during DY5, 50 percent of eligible patients will have a documented self-management goal in the Electronic Medical Record. These efforts will result in improved clinical outcomes and reduced EC utilization for patients served under the care management model. Patient benefits from established care coordinated processes and procedures will include enhanced quality of care and patient experience. Category 3 target options for
this project are currently under review by CMS. Staff reviewed the Status of Current DSRIP Year (DY2) Milestones and Projection for Next Year (DY3) Milestones in detail with the Board. This project will establish an interdisciplinary care coordination team within the ambulatory network of care composed of RN Case Managers, Social Workers, and Patient Educators. These teams will work to identify, support patients with chronic illnesses and other health care needs at their respective regional medical home clinics. The project will specifically target the CMA patient population, specifically those patients dealing with 2 or more chronic conditions to specifically address the health needs and preferences of the patients. It is expected that this project will establish and expand a comprehensive care management program in the primary care clinics during DY 2 and DY 3. The coordination team will then continue to expand their services to a larger patient population during DY4 and DY5 with the expectation that during DY5, 50 percent of eligible patients will have a documented self-management goal in the EMR. These efforts will result in improved clinical outcomes and reduced EC utilization for patients served under the care management model. Patient benefits from established care coordinated processes and procedures will include enhanced quality of care and patient experience. 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 $345,420. To date, this project is on target to cover its cost. The estimated cost and funding over the entire Waiver period is as follows: IGT for other hospitals is $1,677,640, Net Cost is $1,677,640; Total Net DSRIP for Categories 1 – 4 is $6,527,952.

RECOMMENDATION: This report was provided for informational purposes only
ACTION: No action by the Board of Managers was required.
EVALUATION: Dr. Jimenez suggested the establishment of a protocol that will allow coordination with Adult Protective Services for those patients who are non-compliant.
FOLLOW UP: None.

**DEVELOP, IMPLEMENT AND EVALUATE STANDARDIZED CLINICAL PROTOCOLS AND EVIDENCE-BASED CARE DELIVERY MODEL TO IMPROVE CARE TRANSITIONS—MARY ANN MOTE**

SUMMARY: This project will implement a Care Transitions Program to improve access to quality care. The program will involve follow up telephone calls and/or home visits to better activate patient engagement by a Transition Coach following a routine visit and/or discharge from an acute setting. This will be part of a broader care coordination model tailored to improve and meet patient preferences thus avoiding an emergency department visit. The automated post discharge telephone calls will be conducted through the Illuminate system. Through this mechanism all users who indicate dissatisfaction or a concern will be contacted by a Transition Coach within 48 to 72 hours. Currently there is no consistent process for identifying and addressing patients at risk for readmission. There is increasing evidence to support the need for immediate follow-up for patients post discharge from acute care, to address the needed education not heard or understood during the discharge process, and to assure that services coordinated in the discharge process have been delivered. A sampling of data specific to all Medicare and Medicaid discharges between December 2010 and November 2011 reflects larger percentages of readmissions within the first 14 days post discharge, often times before the scheduled follow-up provider appointments.
The target population will include the Medicaid funded and uninsured patients who comprise 62 percent of patients who receive services at University Health System including those patients identified as high risk for readmission discharged from University Hospital. To achieve Category 1 or 2 expected patient benefits in DY2, best practices (such as Partnership for Patients discharge checklists and protocols) will be implemented for effectively communicating with patients and families during and post discharge. Dedicated coaches to this program will be utilized to improve adherence to discharge and follow-up care instructions. In DY3 through DY5, care transitions processes will be reevaluated for improvement,hardwired and expanded resulting in improved care coordination and transition of patients. Furthermore, the transition of care team will work to increase the total patient population reached throughout the lifespan of the project. The category 3 target options for this project are currently under review by CMS. Status of current DSRIP year (DY2) milestones, metrics, and projection for next year (DY3) were reviewed in detail with the Board. This project will implement a Care Transitions Program to improve access to quality care by involving follow up telephone calls and/or home visits to better activate patient engagement by a Transition Coach following a routine visit and/or discharge from an acute setting. The automated post discharge telephone calls will be conducted through the Illuminate system to ensure that all users who indicate dissatisfaction or a concern will be contacted by a Transition Coach within 48 to 72 hours. The project will specifically target Medicaid funded and uninsured patients who receive services at University Health System including those patients identified as high risk for readmission discharged from University Hospital. It is expected that this project will improve communication with patients and families during and post discharge, hardwire and expand the care coordination and transition of patients, and be part of a broader care coordination model tailored to improve and meet patient preferences thus avoiding an emergency department visit. 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 $789,456. To date, this project is on target to cover its cost. The estimated costs and funding over the entire Waiver period are: IGT for other hospitals, $3,210,245; net cost $4,856,279; total net DSRIP Categories 1 through 4, $12,491,550

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

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

**EVALUATION:** None.

**FOLLOW UP:** None.

**PROVIDE NAVIGATION SERVICES TO TARGETED PATIENTS WHO ARE AT HIGH RISK OF DISCONNECT FROM INSTITUTIONALIZED HEALTH CARE:**

**ESTABLISH A PATIENT CARE NAVIGATION PROGRAM—MARY ANN MOTE**

**SUMMARY:** This project will establish a patient navigation model comprised of Social Workers, RN Case Managers, and other appropriately skilled staff within the ambulatory setting to enhance quality of care, and increase access to clinical and social support for medically complex patients The Health System’s ambulatory network is comprised of regionally-developed patient-centered medical homes that are located in an area of the county where large segments of the population are economically underserved, uninsured and who have been diagnosed with
multiple chronic health conditions. Medically complex patients in particular carry a higher burden of disease and require extensive care coordination support to ensure adherence to clinical preventive care and treatment. The proposed patient navigation model will enhance the system’s effort to redesign delivery of care in a manner that provides the right care in the right setting. The target population will include the medically complex Medicaid funded and uninsured patients who comprise 62% of patients who receive services within the health system and who frequently utilize the emergency room. This segment of patients more often carry higher disease burdens (clinical and behavioral) that with appropriately tailored patient-navigation interventions can benefit both in terms of access to appropriate clinical care and community resource support. Provision of patient navigation services tailored to medically complex patients will occur in DY2 to DY5 resulting in an increasing patient population of patients enrolled in the patient navigation model by DY5. The secondary goals are to enhance care coordination and reduce overall emergency room visits, hospital admissions, and hospital readmissions. Category 3 outcomes will decrease ED appropriate utilization throughout DY4 and DY5. The status of current DSRIP Year (DY2) milestones, metrics and projections for next year (DY3) were reviewed in detail with the Board. This project will establish a patient navigation model composed of Social Workers, RN Case Managers, and other appropriately skilled staff within the ambulatory setting to enhance the quality of care, and increase access to clinical and social support for medically complex patients. Medically complex patients carry a higher burden of disease and require extensive care coordination support to ensure adherence to clinical preventive care and treatment. The proposed patient navigation model will enhance the system’s efforts to redesign delivery of care in a manner that provides the right care in the right setting. The project will specifically target medically complex Medicaid funded and uninsured patients who frequently utilize the emergency room. It is expected that this project will provide patient navigation services tailored to medically complex patients resulting in enhanced care coordination and a reduction in overall emergency room visits, hospital admissions, and hospital readmission rates. 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 $1,309,646. To date, this project is on target to cover its cost. The estimated costs and funding over the entire Waiver period are: IGT for other hospitals is $3,611,525, net cost is $7,728,025, and total net DSRIP categories 1 through 4 is $14,052,993.

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

IMPLEMENT A CARE TRANSITIONS PROJECT FOR THE CONGESTIVE HEART FAILURE POPULATION—MARY ANN MOTE

SUMMARY: This project involves the implementation of a Care Transitions Program for patients identified as having congestive heart failure as a primary or secondary diagnosis. A core component of this program is the training of primary care physicians in a patient centered medical home by a culturally competent, board certified cardiology specialist. This training will focus on treatment guidelines,
algorithms, and other specialty care for CHF patients that can be delivered during routine primary care, which expands the benefit of a patient centered medical home. Within the project the target population and existing pre and post acute services will be identified for more comprehensive engagement, and protocols will be established to prevent hospitalization and/or readmissions. Data shows approximately 15 trillion USD was spent over a 12-14 year span by CMS for Congestive heart failure and this diagnosis is one of the three most costly readmissions to hospitals across the nation. University Health System cares for approximately 800 patients annually with a primary diagnosis of CHF. Readmission data presented by CMS in 2010 showed a 30.1% readmission rate. Patients admitted into University Hospital with primary or secondary diagnoses of congestive heart failure. DY2 and DY3 will be the years for identifying and establishing relationships with pre and post acute services whose interventions are targeted to this population for prevention of hospitalization. Protocols at discharge that are evidenced based will be implemented and training of primary care providers by a cardiology specialist will occur. Processes will become documented and hardwired across the Health System. Furthermore, throughout the life of the program the project will work to increase the total number of patients reached. Category 3 outcomes are to reduce the Congestive Heart Failure 30 day readmission rate. Status of Current DSRIP Year (DY2) milestones, metrics, and projection for next year (DY3) milestones were reviewed in detail with the Board. It is expected that this project will establish working relationships among pre and post acute services whose interventions are targeted to this population for prevention of hospitalization, the use of evidenced based protocols at discharge, and the implementation of more comprehensive engagement of these patients with the goal of reducing the 30 day readmission rate for patients with congestive heart failure. 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 $636,390. To date, this project is on target to cover its cost. The estimated costs and funding over the entire Waiver period are: IGT for other hospitals, $3,288,771; net cost is $3,288,771; total net DSRIP Categories 1 through 4 are $12,797,107.

RECOMMENDATION: This report for provided for informational purposes only

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

EVALUATION: None.

FOLLOW UP: None.

ESTABLISH PRIMARY CARE CLINICS—THERESA DE LA HAYA

SUMMARY: The Health System will partner with Federally Qualified Health Centers (FQHCs) to increase access to women’s health services for residents of Bexar County, Texas by establishing a clinical site and increasing the number of primary care visits to enhance access to early preventive care. Combined, these efforts can encourage and empower individuals to make healthy decisions that can lead to improved health outcomes in the area of maternal, infant and child health. Women and children with limited financial resources are much less likely to have access to timely and appropriate health care. The rate of uninsured in Bexar County is 23 percent highlighting the need for increased access. In addition, providing women and children with access to timely clinical preventive screenings can prevent and detect illnesses and diseases in their earlier, more treatable stages, which can lead to reduced risk of illness, disability, early death,
and medical care costs. Economically vulnerable women, children and adolescents in need of evidence-based clinical preventive screening and primary care access that reside within the Health System service area. In particular, focus will be placed on residents located in rapidly growing areas of Bexar County and in particular the central Northern sector of the county where almost four out of ten individuals have no usual source of medical care or have not received a medical checkup in the past year. This area also has a high number of low income, uninsured, minority residents who suffer from multiple chronic conditions. The anticipated five year goal is to expand geographical reach through delivery of primary and preventive care translating into improved health outcomes in women, children and infants. For University Health System, partnering with FQHCs to increase access to primary care and women’s health services in Bexar County will result in improved care for the women and children of Bexar County and addresses the Triple Aim Plus. This includes shifting from a focus of purely clinical service provision to one that integrates the patient, their families, and their community (Patient Experience), helping to establish a long-term, trusting relationship that assures that patients receive the right care, including recommended clinical preventive services at the right time and in the right setting (Quality and Outcomes and Improved Efficiencies), and providing affordable, convenient and accessible primary care services ( Improved Access). Category 3 outcomes are anticipated to increase timeliness of prenatal/postnatal care by a percentage that is to be determined from baseline; increase frequency of ongoing prenatal care by a percentage that is to be determined from baseline; and decrease the percentage of low birth-weights by a percentage to be determined from baseline. The status of current DSRIP year (DY2) milestones, metrics and projections for next year (DY3) milestones were reviewed in detail with the Board. This project will establish a new clinical site to enhance access to early preventive and primary care by partnering with a Federally Qualified Health Center to increase access to health services for residents of Bexar County. This will provide women and children with access to timely clinical preventive screenings to detect illnesses and diseases in their earlier, more treatable stages, which can lead to reduced risk of illness, disability, early death, and medical care costs. The project will specifically target economically vulnerable women, children, and adolescents in need of evidence-based clinical preventive screening and primary care access that reside within the Health System service area. In particular, focus will be placed on residents located in rapidly growing areas of Bexar County including the northern sector of the county where almost four out of ten individuals have no usual source of medical care or have not received a medical checkup in the past year. It is expected that this project will encourage and empower individuals to make healthy decisions that can lead to improved health outcomes in the area of maternal, infant, and child health including the timeliness and frequency of prenatal/postnatal care as well as reductions in low birth-weight infant rates. 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 $1,276,800. To date, this project is on target to cover its cost. The estimated costs and funding over the entire Waiver period are: IGT for other hospitals, $3,812,165; net cost is $5,550,522; total net DSRIP Categories 1 through 4 are $14,833,713.

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

**ACTION:** No action was required by the Board of Managers
EVALUATION: Mr. Smith identified sex education and prevention as a topic of interest to the community, and Dr. Jimenez encouraged staff to invest in educational pamphlets regarding depression, anxiety, and stress.

FOLLOW UP: None.

PRESENTATION REGARDING THE CENTER FOR HEALTH CARE SERVICES 2014 OPERATING BUDGET - LEON EVANS

SUMMARY: The Bylaws and Interlocal Agreement for Sponsorship of The Center for Health Care Services (“Center”) stipulate that the Center’s Board of Trustees shall report, annually, to its sponsoring agencies on the activities of the Center as well as the proposed budget for the ensuing year within 30 days prior to Board approval. The Center shall present the proposed budget to the Board of Managers for review and comment. The Health System shall perform its review of the Center’s proposed budget with care, skill, prudence and diligence. It shall thereafter report to the County its findings and conclusions regarding the Health System’s contribution toward the Center and the associated level of ad valorem tax support required. Mr. Leon Evans, President/CEO, introduced the Center’s Board Chair, Mr. Ruben Zamora; Dr. Camis Milam, Medical Director; and Mr. Robert Guevara, Vice President of Business and Finance. He yielded the floor to Mr. Guevera for the following update:

The Center by the Numbers – In 2013, served over 26,000 patients and provided 520,000 services, and employed 900 individuals with a total payroll of $47 million. In 2014 staff projects the Center will serve 35,000 patients and provide 712,000 services utilizing 1115 Waiver funds, and will employ 1,100 individuals with a total payroll of $60 million.

1115 Waiver Projects – Ten (10) DSRIP project descriptions were presented, the number of patients to be served, and the benefit to the community were discussed with the Board. The 1115 Waiver budget is $26,426,922 for DY 3 with a FY 2014 budget of $15,836,313. The amounts include unspent capital outlay for DY 2 and the Center’s 40 percent match.

Program Budget Comparison- Program budget for FY 2013 was $77,954,739 as compared to 2014, which is $88,616,380. The variance is $10,661,641. The Center’s administrative costs are among the lowest in the State of Texas. Also reviewed was a breakdown of the number of individuals served per year, by division, from 2011 (actual) to 2014 (projected). The number of individuals served per year and by division was reviewed from 2011 (actual) to 2014 (projected), as were the number of client visits per year, by division. Also, Mr. Guevara conducted a comparison of earned/billed, state, and federal revenue for the time period 2010 (actual) to 2014 (budgeted) – does not include the local match made by University Health System. Since 2007, the Center’s budget has increased by 71 percent, while customer base has increased by 81 percent. Funding by source and agency were discussed. The Center has a total of 95 funding sources. The Health System provides 4 percent of the Center’s funding, or $3,422,145; the State provides 47%; the City provides 3%, Bexar County provides 2%, Federal sources provide 24%, Foundation Grants provide 1%,
Medicare/Medicaid provides 17%, and other sources provide 2%. Mr. Guevara provided a breakdown by funding agency. 88 percent of these funds are known as designated funds, used to provide certain services to certain patient populations.

2012 – 2014 Operating Budget - 2012 (actual), 2013 (annualized actual) and 2014 (budgeted) operating budgets were presented. While the state requires the Center to submit a zero-based budget, the 1115 Waiver projects impact the Center’s cash reserves. However, Mr. Guevara emphasized that the Center is currently debt-free. The 2014 capital budget is $11,428,810. Also described in detail for the Board were the collaborative programs between the Health System and the Center for 2014. Four (4) percent of the operating budget is designated for pharmaceuticals obtained at a 340B discounted price from the Health System. For those clients who are CareLink members, CareLink covers the cost of medications.

Center’s Partnerships – Successful partnerships with University Health System include:

- Project Carino (Mommies) - 84 moms treated in 2013; over 76 percent are still drug free after one year;

- Opioid Addiction Treatment Services (OATS) - 150 patients received medication or treatment through Health System funding. After six months in treatment, patients displayed a 93 percent negativity rate for illicit opiate use; 85 percent have no involvement in the criminal justice system once in treatment; 87 percent are still in treatment after 12 months; and 111 OATS moms have participated in Baby U, a 13-week course sponsored by the Health System; and

- Emergency Room Diversion - Over 1,200 people per month diverted from the criminal justice system and expensive Emergency Room visits and treated in acute care services at The Restoration Center, an annual cost savings to Bexar County of $6M.

Next Steps – The following timeline will be adhered to as part of the Center’s 2014 budget process:

July-September, 2013 – Obtain Center’s Board approval, Health System and Bexar County review of preliminary budget;
September 2013 - Develop final budget after state allocations are determined;
October 2013 – Obtain Center’s Board approval, Health System and Bexar County review of final budget.

RECOMMENDATION: This presentation was provided for informational purposes only.
ACTION: No action by the Board of Managers was required.
EVALUATION: In the interest of measuring success of services provided by the Center, Mr. Adams requested a presentation on their outcomes data for opioid addiction treatment services beyond 6 months. Dr. Jimenez urged the staff to commission a local economy study that includes an estimate in terms of savings to the community related to crime and/or the decrease in crime rates when the clients served by the Center get well. Often, the public asks why the Health System
would want to help drug addicts without realizing that helping them will improve crime rates in the community. Ms. Vasquez informed the Board that one of Dr. Sally Taylor’s tasks in her new role as Chief of Behavioral Health Services is the development of a metrics sheet that will ensure both the Health System and Center staffs are focused on successful outcomes. Board members thanked Mr. Evans and Mr. Guevara for the informative presentation. Dr. Jimenez commended the Center’s staff for being one of the most transparent organizations of its type in the nation. Mr. Adams asked Mr. Evans to return with this presentation on an annual basis at budget time with their income statement and balance sheet so the Board will better understand the financial condition of the Center. Mr. Adams requested a second presentation six months after the budget presentation for an update on the Center’s activities.

FOLLOW UP: As indicated above.

CLOSED MEETING:

Mr. Adams announced this meeting closed to the public at 3:35 p.m., pursuant to TEX. GOV’T CODE, Section 551.085 (Vernon 2004) to receive information on and/or deliberate regarding pricing, market data and/or financial planning information relating to the arrangement or provision of services or product lines. The following Board members present: Jim Adams, Linda Rivas, Rebecca Cedillo, Roberto L. Jimenez, M.D., Robert Engberg, and Ira Smith. The following staff was were: George B. Hernandez, Jr.; Christann Vasquez; Peggy Deming; Bryan Alsip, M.D.; Ted Day; and Michael Hernandez. After discussion, no action was taken in closed session. Mr. Adams announced that the closed meeting ended at 4:07 p.m.

ADJOURNMENT:

There being no further business, the public meeting adjourned at 4:08 p.m.

Jim Adams
Chair, Board of Managers

Rebecca Q. Cedillo
Secretary, Board of Managers

Sandra D. Garcia, Recording Secretary