1-30-2015

Minutes of 01/30/2015 HSC Board of Directors Mtg

Patrice Martin

Minutes of the Meeting of the
UNM Health Sciences Center Board of Directors
January 30, 2015
Domenici Center for Health Sciences Education Bldg., Room 3010

UNM Health Sciences Center Board of Directors (the "Board") members present: Suzanne Quillen, Chair, Brad Hosmer, Robert Doughty, Michael Olguin, and John "Mel" Eaves.
Board members not present: Ann Rhoades
UNM HSC Leadership present: Paul Roth, MD, MS, Chancellor for Health Sciences, and additional members of the Health System and Health Sciences Center leadership
Others present: members of the UNM and HSC faculty and staff

Chair Suzanne Quillen called the meeting of the Board to order at approximately 9:10 a.m. The Chair announced that a quorum of the members of the Board was present.

Approval of Agenda

A motion was made to adopt the published agenda. The motion was seconded. The motion passed with a vote of 3-0-0. Mr. Doughty was not in the room and did not vote.

Approval of Minutes of Prior Meeting

A motion was made to approve the minutes of the December 5, 2014 meeting of the Board. The motion was seconded. There was no discussion. The motion passed with a vote of 3-0-0. Mr. Doughty was not in the room and did not vote.

Chair Quillen introduced and welcomed Regent Robert Doughty as the newest member of the Board. Director Doughty provided a brief summary of his background.

Chancellor's Report

Dr. Roth welcomed Director Doughty. Dr. Roth provided a summary of the HSC Legislative agenda for the current Legislative Session and announced the recent publication of the "Annual County Report Card." He highlighted how the HSC has successfully commercialized some of its intellectual property through the HSC Research enterprise and noted that Dr. Richard Larson will provide more detailed information during the upcoming Regent orientation. Dr. Roth noted that in the last 10 years, the HSC

has produced 38 startup companies as a result of discoveries in the HSC laboratories. Dr. Larson added that effort has been made over the last two years to not only encourage junior faculty to become involved in this process (now occurring) but to have better representation of the diverse populations of New Mexico, with more women and other minorities involved. Director Eaves asked Dr. Larson about his statement earlier that the University has not realized a return on these 38 startup companies and asked if there was anything the University could be doing to enhance the performance of the potential success of startup companies. Dr. Larson responded, "absolutely yes -- both on the changes that could occur within the University as well as ways we could help private startup" and offered to return to the Board to discuss this further. Dr. Roth commented that, when he was President of the Greater Albuquerque Chamber of Commerce, he had Dr. Larson present at one of their meetings to describe the actual process from invention discovery and taking that invention to the market for these types of companies, describing also the intricacies, etc.

Dr. Roth introduced Vanessa Hawker, PhD, who then briefed the Board on the HSC Legislative Requests. Her summary included information on the request for completion of the Health Education building, the impact of lower oil prices on the state's budget, request for funding to support five additional Internal Medicine residents, two additional Psychiatry residents, one additional Family & Community Medicine resident, and one additional General Surgery resident, request for additional funding for medical school faculty salaries, funding for the Office of the Medical Investigator (to assist with utility bills), funding for the Center for Child Maltreatment, UNM Pain Center, New Mexico Health Care Workforce Analysis, Combined BA/DDS Program, Project ECHO, Expanded Dental Hygienists Education, Rural Medical Education, and the Pediatric Oncology program. Dr. Roth provided background explaining the unique manner (in Higher Education) in which the UNM School of Medicine is funded in the State of New Mexico. All other colleges, schools and universities in New Mexico essentially are funded through the formula funding generated out of the New Mexico Legislature and those funds are allocated through a very complicated methodology but that has never been the case for the UNM School of Medicine. The School of Medicine has always been a separate line item and there is no formula or basis for any changes in funding from the State. Each year, we have to be very specific with our requests to the Legislature regarding what programs we would like to have expanded and what programs we would like to add to the I&G budget for the School of Medicine. There are certain metrics that are associated with each program so that the School of Medicine is held accountable regarding productivity and the validity of our programs. This includes compensation increases. For Main campus, as the Regents begin engaging in issues of tuition, state funding through the formula funding, etc., those are the primary revenue streams for Main campus that will serve as the foundation for next year's budget. From there, Regents make decisions regarding faculty and staff compensation increases, new programs based on those projected revenue streams, etc. For the Health Sciences Center and the School of Medicine, it is very different. Less than one percent (1%) of the Health Sciences Center's operating budget is actually derived from tuition. It is a very tiny part of what we do. About six percent (6%) comes from the State through the appropriation mechanism that Dr. Hawker described. All the rest of the School of Medicine

operating budget (93%) is generated from two other sources: (a) the majority from our business of providing health care services; and, (b) the rest from Research contracts and grants. The mechanism for state support for the School of Medicine is through these separate Legislative requests. The Colleges of Nursing and Pharmacy do receive benefit from the formula funding so their productivity is included in the calculations for the formula funding that results in those dollars coming to the University of New Mexico. Those dollars go to Main campus and then we split out dollars associated with those activities and they are transferred from Main campus to the Health Sciences Center.

At this time, Director Eaves pointed out, "… our Legislative requests and the LFC recommendations tell a very interesting story…." He brought everyone's attention to Tab 7 in the Board book to the pie chart set forth therein. He said,

> "What the Legislature (LFC) recommendations tell you is that we're going to get very little help from the Legislature as compared to the overall budget and this is typical. It is not because the Legislature is not doing their job but it is because they know, as we do, that this Health Sciences Center is a revenue generating operation. They [the Legislature] are using their money in other areas. I don't doubt that there are legislators who would like to give us more money but in a matter of allocating resources, they have other places to put the money, obviously. So if you look at the pie chart, you'll see I&G State 5.97%. That is state money that we receive – very small. As [Dr. Roth] pointed out, tuition and fees are less than one percent. This is a drastic difference from Main campus. It is a very important thing to understand about the Health Sciences Center when you look at the economic contribution it makes for the State of New Mexico. Out of the $1.7 billion budget, the state contribution is tiny. If you look at the sources of revenue (Medicare, Medicaid, Patient Care Revenue, and commercial insurance), those are all monies that are generated by the health care services rendered by the faculty [at the Health Sciences Center]. That is what supports the health care center and when people look at salaries at the medical school and the Health Sciences Center and say those salaries are high compared to New Mexico, what they are not also considering is that the people who are being paid those salaries are providing patient care that generate revenues to support a $1.7 billion enterprise in the State of New Mexico. We get a mill levy from Bernalillo County of 5.76%, which goes to the people of the county. You will see that in past operations the HSC has been very successful because it actually has Reserves which are about $6.4 million (in the pie chart noted) that are used to support the operations of the University. This overall picture is something that in the governance of the Health Sciences Center is critical to understand. Generally, for the University as a whole, if you look at the percent of state revenues supporting the University as a whole, you will see that percentage is declining over the years, not increasing. We are getting less money from the University as a whole and less money

> for the Health Sciences Center from the State. Enterprises like [Dr. Larson] talked about, are very important to stimulate new sources of revenue. One of the enormous sources of revenue we have is grants and contracts…. This helps spawn the new enterprises that [Dr. Larson] was describing. At a time when most Health Sciences Centers and universities around the country are receiving a declining share of federal research funds and grants, [Dr. Larson's] organization is actually increasing. This is a huge source of economic power in the State of New Mexico and really could be an engine for economic development for the rest of the state. When I was in the legislature in 1964-68, we funded the very first four-year budget for the medical school which, at that time, was about $125,000 and it has now grown to $1.7 billion and is dwarfing the budget of the Main campus. Not because they are soaking up State money that could go to other uses but because the money is being generated right here in New Mexico…. This is something that is fundamental to understand. This is more like a private enterprise, except for the public service and the education. We would not have what we have today if it wasn't for the nurses and doctors and researchers, etc. who generate the money that funds this place."

Director Hosmer asked, "Can you confirm … were the LFC recommendations based on the December estimate of $140 million?" Dr. Hawker responded, "Yes. Everyone's recommendation was based upon the December revenue estimate. While we are thrilled with the LFC's recommendation … we are holding our breath until we see that new consensus revenue estimate and see how reality may be shifted." Chair Quillen thanked Director Eaves for his comments stating that "this was a nice piece of orientation for our new Regent…." Director Doughty commented, "Dr. Roth did a really good job. We had an F&F orientation and this was brought up at F&F as well. It is very important."

Dr. Roth introduced a new marketing video for the UNM Health Sciences Center and the video was viewed. The video was well received and Chair Quillen commented,

> "It was nice that you opened [the video] with something that I thought about as I see the commercials come through…. you said not a lot of people understand what the Health Sciences Center is. I think the commercials are helping but when I remember us looking at those, part of that was to create awareness about the Mill Levy and I'm not sure that we're getting that with the commercials. Is there going to be something added as we get closer?"

Mr. Sparks responded that "this is a two year effort. The Mill Levy vote is in 2016…. There will be a specific campaign on the Mill Levy."

UNM Health System Update Including a UNM Sandoval Regional Medical Center, Inc. ("SRMC") Update

Dr. Mike Richards provided an update on network development, strategy and contracts, as well as leadership updates. He noted that one of the priorities is to continue to build the integrated clinical network.

Dr. Richards advised that the UNM Health System recently created a new relationship both with the facilities and the providers at CHRISTUS St. Vincent Regional Medical Center. The UNM Health System is are now participating in CHRISTUS St. Vincent Medicare Advantage Program and CHRISTUS St. Vincent is now a Tier 1 provider in the UNM Health Program. He added that this is the type of connection that will benefit both organizations and will help us to build a far more robust network. Dr. Richards expressed his belief that this is just the beginning of some clinical programs that the UNM Health System will be able to build with the community in Santa Fe.

Dr. Richards added that work continues in connection with the UNM Health System's clinical affiliation with Presbyterian Medical Services (PMS) and stated that the UNM Health System is now working on a concierge-type connection for PMS's patients that are seen at SRMC. In this arrangement, SRMC will become PMS's preferred inpatient referral center and PMS is also very interested in helping us expand our educational programs into their clinics. The UNM School of Medicine anticipates increasing its family medicine rotations in Farmington with ultimately the intent of creating a new Family Medicine Residency Program that would be anchored in Farmington. At this time, Chair Quillen clarified for the Board members and others that "Presbyterian Medical Services" is not "Presbyterian Hospital." Dr. Richards continued stating that Presbyterian Medical Services … has about 90 primary care clinic sites around the state and they focus predominantly on primary care, behavioral health, and dental services. They are not located in Bernalillo County. They have a mission and vision that is very similar to [the UNM Health System] and serves a very similar population. Dr. Richards expressed his belief that PMS represents a perfect complement to the kind of tertiary or quaternary delivery system that we provide so, over the last couple of years, have become a very important partner for the UNM Health System.

Regarding ABQ Health Partners (ABQHP), the UNM Health System and ABQHP continue to build their relationship. Dr. Richards stated that most recently, SRMC has expanded its clinical contracts with ABQHP such that ABQHP physicians are now providing additional hospitalist services at SRMC.

Dr. Richards provided an update on strategy items including the completion of the update of the KSA Health System Strategic Plan. Dr. Richards advised that management and KSA are updating the demographics and projections for future health care needs for the UNM Health System. Dr. Richards stated that that data has then been transferred to Dekker Perich Sabattini (DPS) to help produce the updated HSC Master Facility Plan. DPS will be using that data on projected changes in population and health care needs to help the UNMHSC get a clear understanding of the facility needs for the UNMHSC

to complete its overall strategic mission. Dr. Richards advised that management will bring the results of that analysis back to [the Board] in the next four to six weeks. Dr. Richards also stated that management will also be finalizing the Children's Hospital Strategic Plan and this information will be provided to the Board.

Dr. Richards ended his presentation with an update noting that, in terms of clinical contracts, as the UNMHSC has entered into the clinical contracting negotiation period for this year, the institution has been placed on notice by all of its major payers that the UNM Health System will be moving toward value-based purchasing and risk-based contracts. Dr. Richards stated that we will see elements of that in this year's contracting period but the intent is that we will have risk-based contracting, including capitation models, in place with all four of the major insurance companies over the next three years. Chair Quillen asked, "Are we prepared for that – the big switch from volume based to value-based?" Dr. Richards responded that this will be a major transition for us and later today, management will talk about Population Health and the things the institution will need to do to start that transition to ensure that the institution has both the competencies within its health care delivery system and a work force that can help make this transition. Dr. Richards advised that the UNM Health System is doing the things that will set us up for future success. The timeframe that is being proposed is aggressive. He added that our movement toward UNM Health is another important area for us to remain focused on because it will also be a place for us to anchor both the competencies and the capabilities that we will need within our Health Care System to meet these new health care delivery challenges.

Dr. Richards announced that Dr. Irene Agostini has assumed the role of UNM Hospitals Chief Medical Officer effective February 1, 2015 and Dr. David Pitcher will assume the role of Executive Physician in the UNM Health System.

Mr. Steve McKernan presented on the operations of the Health System, including that activity levels have been good. He noted that most areas at the UNM Hospital have been very busy with the exception of Obstetrics (OB). "We are continuing to see a reduction in OB at a greater rate that is going on in the community so we are losing market share. OB is incredibly competitive in our community. We have had leadership changes in that area and we are rebuilding that department but it will be a lot of work." Mr. McKernan added statistics on Clinic Visits, Surgical Volume, and Diagnostic Services are up; we are seeing more people enrolled in Medicaid and now that the eligibility issues – as originally delayed people accessing care in the first three to six months of the implementation of the Affordable Care Act – have not been completely cleared up but they are better than they were and some of the people who finally got enrolled from the Jan/Feb/March/April timeframe now have their cards, now they are seeking care, and they are accessing our system. We are seeing that increase. At UNM Hospital, we had our financial assistance program that which was very robust. What we have seen is the patient population that was enrolled in UNM Care has now gone from about 30,000 down to 11,000-12,000 and about 20,000 of those patients are now enrolled in Medicaid. While this has improved the picture relative to

the cost of fully uncompensated care, Mr. McKernan noted that the dilemma with Medicaid is you only get paid half as much as it costs to do the work. Mr. McKernan noted that, comparatively, it is not as good as if you were getting paid on commercial insurance.

Mr. McKernan then introduced Dr. Irene Agostini who then provided a briefing on Health System occupancy. Dr. Agostini noted that what the earlier video did not mention was the day-to-day work and that the charts to be presented will talk about what is happening in our institution with regard to the UNM Health System physicians and nurses who are working incredibly hard. Dr. Agostini's presentation slides included information looking back at the last 15 years of the Average Daily Census at UNMH, creeping up every year. The second graph showed a 91% occupancy rate (industry standard for what is needed for hospitals to be most efficient is a rate of 75% (allows for peaks)). This creates inefficiencies and makes it a difficult work environment. She showed the Average Daily Census by week over the past 12 weeks. Dr. Roth asked Dr. Agostini to describe what "census" means and what is the industry-standard for hospitals like ours for what is needed to achieve to be the most efficient. Chair Quillen asked that Dr. Agostini also describe "total beds." Dr. Agostini responded that the standard is about 75% to be most efficient and that we currently run our physical plant (over a year) at 91% this fiscal year at UNM Hospital. This is a very high capacity. Dr. Roth added:

> "Just to point out some other facts, the percentage of 75% is set, as an average, so you can allow for peaks as well as valleys. As the Trauma Center and the Referral Center for the state in many specialized services …. If there is not the capability to accept critically ill patients from the different hospitals and medical groups around the state, and allow for that surge capacity, then we are failing as an institution and backing up all the other hospitals in the state of New Mexico. Being at 91% essentially means that we have lost the capacity to manage those surges. The other nuance of our system is that we have a number of semi-private rooms and by having semi-private rooms. If we have any empty beds available, that other 9% is very often because the people who need to be admitted don't fit the conditions under which would allow them to be admitted in that particular semi-private room. You might have a patient who might have chemotherapy in a room and might be getting very much immunocompromised and so if you have a patient in the ER with some sort of infectious disease, even if they are of the right gender, they cannot go into that same semi-private room because it will pose a patient safety concern."

Mr. McKernan added that, regarding the 75% optimal level of patient census, when a hospital is at the optimal level, the hospital is better able to cohort patients by medical needs or care to be provided. The data on adult occupancy rate (this is an average rate) and during the weeks the UNM Hospital actually peaked at 98% and that gave 2% of room to move patients. Mr. McKernan emphasized that as a Level 1 Trauma Center in the State of New Mexico and UNM Hospital only has 2% free beds – that is not a good

place to be in case there were a major accident, etc. Mr. McKernan stated that with little to no available beds, it is very difficult to cohort patients. We have Neurology patients, Neurosurgery patients, Trauma patients, Transplant patients, Cardiac medical patients, Cardiac Surgical patients, etc. Mr. McKernan noted that if UNM Hospital are just putting patients linearly in beds for whatever bed opens up, you cannot cohort patients which is not optimal for the caregivers, physician care givers nor the nurses because the nursing units are really built on what type of care. For example, a Cardiac unit -- the nurses are all certified in cardiac care. A Trauma unit – they are certified for Trauma. It does not work well to place a Cardiac patient on an Oncology unit, etc. Mr. McKernan observed that when UNM Hospital is at that level of occupancy, and you must put a patient in a bed, you either moving a whole lot of patients around or you are putting patients in units in which the nurses do not have the highest competencies for those patients. Then nurses must get moved around from unit to unit. For example, Mr. McKernan stated that there are now medicine teams rounding on six different units. The ideal is that you would come in and have a set of patients on one unit, you would know all the nurses, you would know all the social workers, and you would know all the support staff on that unit. If you are rotating to six different units, you will not know all these people you need to interact with to make sure you are working in an efficient manner. This makes it more difficult to manage the populations. Mr. McKernan stated his belief that there are very good reasons for not wanting to be at 95 – 98% occupancy in a hospital that is rated as a Level 1 Trauma Center and as the principle tertiary, which means third level and quaternary which is fourth level of care which is the highest level of care. Mr. McKernan noted that there is primary care, secondary care is community health, tertiary care is a very high level care, and quaternary is where you are in transplant, Level 1 trauma. Having a Level 1 Trauma Center at this level of occupancy is not good.

At this time, Director Eaves asked Mr. McKernan to speak about "the age of our adult facilities in the hospital because not only are we significantly in trouble on occupancy rate, explain what effect on care the age of the facility has and talk to us about the need for a need for a new hospital facility." Mr. McKernan responded that work at the Main UNM Hospital is a platform that has five major parts to it. There is the original 1954 wing which was built by Bernalillo County for a different time – it has small rooms, it has a number of semi-private rooms, the HVAC systems – there are certain requirements by the regulatory and construction entities – we do not meet those particularly well. Rooms are small so you cannot have families with the patient. When you need to do a consult between the physician and the patients (groups of medical students are included since we are a teaching hospital), you cannot fit everyone in a room so frequently those consults are done in the middle of the hallway which lacks privacy. You can't get the equipment into the rooms that you need. There is trouble getting the computerization into those rooms that is needed for the federal standards for meaningful use, etc. The 1966 wing is better, but just slightly. The 1976 wing is a little better, especially for the unit needs. The Pavillion wing is excellent. Also important, most of the operating rooms are in the 1954 and 1966 wing of the hospital. We are finding enormous difficulty when we have to renovate those rooms and bring new equipment in. A tour of our hospital facilities will be provided to the Board.

The HS Strategic Plan is focused on having two main parts: what is going to be the strategy for the clinical Health System as we move into the future; and a Master Facility Plan for the entire Health Sciences Center to look at what we need regarding education, research, and what is needed in the clinical environment here and in the community -- our primary care clinics, SRMC, and other venues we need to build over the next five to ten years. The investment will be staggering.

Director Hosmer asked, "We've heard anecdotes about what the operational costs are of running to capacity. We now have six years of experience on that and we are reaching new highs…. I would ask that we see a document that actually walks through the operational penalties that we're living with because of an occupancy rate of 75%." Dr. Roth responded that is what Dr. Agostini will be providing to the Board on a monthly basis… not only talking about numbers but sharing the operational and patient care indications.

Director Olguin then commented that

> "[t]his explanation today of what is happening regarding occupancy rates and I know about the dialogue going on a couple years ago regarding the 96-bed facility, a comment was made, 'A bed is a bed.' That there were sufficient beds in this community. You discussed semi-private rooms – what would it take to improve those rooms in order to occupy those rooms … these are the types of discussions we need to be having to educate those who make those policy decisions that affect what's happening within our system."

Mr. McKernan responded that preparations are being made on that. Dr. Agostini commented regarding the statement "a bed is a bed." She said,

> "Not only do we get calls from all over the state every day but we get calls from Presbyterian and Lovelace every day, to take care of their children, and Neurosurgery -- we are the only hospital in the state that has the capacity to do very acute, aggressive neurosurgery. Every day we have patients on our list coming from Presbyterian and Lovelace as well as from all over the state. It is very painful … when we cannot take those patients right away. We feel that every day in the building."

Dr. Agostini provided the Board with data on Average Daily Census per Week, the percent of Emergency Department beds that are filled with patients who are admitted to the Hospital, operational costs, impact to faculty and staff due to the peak capacity issues, the constant juggling of patients, "Left Without Being Seen" rate, outpatient centralized scheduling, efficiency on adult length of stay, etc.

Discussion followed on problems with post-acute (defined: skilled nursing, rehab hospitals, long-term acute hospitals, home health, hospice, etc.).

Chair Quillen asked for clarification on acuity increase, length of stay, etc. Mr. McKernan noted that we are now experiencing a reluctance by the post-acutes, in some cases, to take patients (he defined 'post-acute' as skilled nursing rehab hospitals, long-term acute hospitals, home health, hospice, etc. and problems due to a lack of enough post-acute facilities in Albuquerque). His comments continued on the Operational Report with information on Finances which are strong and highlighted SRMC in a positive position.

Mr. McKernan next advised the Board on the activity with the county related to the Lease, Mill Levy and behavioral health, etc.

He advised that a meeting was held and an Operating Plan was set for the next six months; a Strategic Plan which translates into an Operating Plan, gain consensus with all medical directors and directors and that translates to individual performance plans oriented to the objectives of the Health System. Dr. Roth added that one topic that will be discussed during the upcoming new orientation is that these performance plans that are developed within the Hospital, we also have performance plans with every single faculty member. Part of their compensation is determined based on their achieving certain metrics of performance and on the average, for example, the School of Medicine about 30% of the total compensation of the faculty are held at risk for achieving these metrics. That is also different from the regular higher education but not inconsistent with other academic health centers. The foundation of our operating revenues comes from revenue being generated at an individual faculty level. We incentivize our faculty to do what is best for helping patients, including quality. Mr. McKernan ended that at the UNM Regents' Audit Committee, Regent Hosmer had asked three questions and the drafted responses are included in the report and Mr. McKernan reviewed them briefly at the meeting.

Public Comment

There was no public comment.

ACTION ITEMS

Consideration of Resolutions Recommending Approval of the Purchase of One Digital Mammography Unit and the Purchase of Upgrades for Three Existing Hologic Selenia Dimension Digital Mammographic Machines

Mr. McKernan provided background on the request to purchase one digital mammography unit and to purchase upgrades for three existing Hologic Selenia Dimension Digital Mammographic machines to

allow greater capacity in terms of volume and technical capability. He added that this is expensive but does represent the standard of care. Dr. Roth commented that "One of the discussions that has been held in the past, with regard to items that would come to the Board is to try and differentiate between items that had already been built into the operating budget and the approval mechanism/process for those items versus items that were not originally in the budget, had not been approved in coming forward." He asked Mr. McKernan if this item was originally in the budget. Mr. McKernan responded "We have an Operating budget and a Capital Budget for the hospital. This item is in the Capital budget request. We have about a $35 million capital budget for UNMH and about another $3-4 million capital budget for SRMC." Chair Quillen confirmed that this was considered in the Capital Budget and that the budget approved included replacement, as well as additional equipment. A motion was made to approve the Resolutions recommending approval of the purchase of one digital mammography unit and the purchase of upgrades for three existing Hologic Selenia Dimension Digital Mammographic machines. The motion was seconded. Director Hosmer asked, "if equipment uses other technologies for breast cancer detection – sonic or thermal?" Mr. McKernan and Dr. Larson responded that clinical trials are being conducted on thermal and ultrasonographil breast imaging and also other cutting edge studies, *i.e.,* a variety of clinical trial studies and developing new diagnostic techniques relative to using MRI and special coils for breast imaging, using a variety of new nanotechnology techniques, etc. The motion passed with a vote of 4-0-0.

INFORMATION ITEMS

HSC Financial Update

Ms. Ava Lovell provided a summary of the HSC financial statements for half of the fiscal year of 2015 through December 31st. The first page of metrics include Cash Flow from Operations (Health Sciences Center, UNMMG, UNMH, and SRMC). Ms. Lovell noted that the data shown is before we take our Depreciation which is a non-cash item. Dr. Roth commented that when finances of Main campus are reviewed, they do not show Depreciation but when you are running a business, if you have assets, you capitalize those hard assets and then show Depreciation. The Hospitals operate under a different set of accounting rules than universities do. Dr. Roth stated that as we go through the different finances he will call on the UNMHSC's experts, Ava Lovell, Steve McKernan and Ella Watt. Chair Quillen made special note of Sandoval Regional Medical Center's improvements and she brought attention to the current quarter data of last year versus today's data. Ms. Lovell confirmed SRMC's success over past challenges they faced. Her summary continued with data on Operating Net Margin, Depreciation (highlighting differences between entities such as UNMH, UNMMG, SRMC), Net Income – total bottom line. Dr. Roth elaborated noting that we are very careful about making certain that our operating costs to run the programs on the academic side are fiscally sound but that the way we do business on the academic side, which is identical to main campus, is that in addition to what Ms. Lovell described, when the UNMHSC need to hire critical faculty, particularly faculty who are department chairs or in other

leadership positions, the institution will have to engage in a negotiation. If there is a faculty member or a chair of a department who comes into the institution – in order to bring that person of quality that the institution wants into our institution, management has to sit down and not only talk about what their individual compensation would be but all these other attendant costs, *i.e.,* if it is a researcher, they will negotiate that to come here, the institution will have to renovate a whole lab and he/she may bring two or three lab technicians with him/her or additional faculty, because those are people critical for his/her research, you need to buy this mega-piece of equipment, etc. Management looks at this critically and tries to make a determination on whether it is a reasonable investment, etc. and so leadership will create a start-up packet that may stretch over a three year period of time and consist of one-time expenditures in order to recruit and then retain that particular faculty member or chair, etc. A good piece of these red numbers are expenditures that the UNMHSC has planned out over a five-year plan that is tracked on a rolling basis, all of these commitments that have been made to these new hires in addition to the capital acquisitions, etc.

Different from Main campus, Ms. Lovell stated that the UNMHSC does not show its Reserves as a revenue stream. We show Reserves as below the line in addition to the Operating budget of the whole operation. On Main campus, if they have a commitment, for example, they had $2.3 million of expenditures that they were using Reserves for, they would show on their Revenue $2.3 million from Reserves. Ms. Lovell stated that the UNMHSC does not show it that way because management does not see that as an operating budget. Ms. Lovell also advised the Board that the UNMHSC is using its Reserves for those expenditures. Ms. Lovell noted that, on Main campus, you will always see a zero bottom line, but that does not show how much of Reserves are actually being used. The UNMHSC is careful in showing how much of Reserves are being used because you cannot use them forever. She continued her presentation with information on Uncompensated Care, true cost of delivery of care, national comparisons and the Affordable Care Act and environment in New Mexico (for every 1% it represents $10 million of costs). Chair Quillen asked what was the national average. Response: about 8% uncompensated. Ms. Lovell continued with information on Days Cash on Hand, Accounts Receivable Greater than 90 Days (discussion on SRMC's Accounts Receivable), Research operations, Review of Year-to-Date Summary (discussion on Research Park Corporations), and the Consolidated Summary. Director Eaves asked "Regarding SRMC, what is the mix on the patient – how much is commercial insurance and how much is Medicare/Medicaid? Is that affecting our outpatient percent?" Lovell responded: "I think we have a little bit of timing in the mix, too." Mr. McKernan noted that the Accounts Receivable and the Revenues are going to be a little different but commercial insurance on the outpatient side, which is about 60% of our total revenue, is above 50%, Medicare is about 35%, Medicaid is about 15-18% and then a little bit of other stuff. On the inpatient, it is significantly different – insurance about 25%, Medicaid about 85%, and Medicare about 30%. Discussion on SRMC regarding … did they drop so much on that 9%? Because it is a startup, we booked very conservatively so we collected more cash than we had receivable out at SRMC. This is simply 'catch up.' Discussion on differences on mix of insurance at SRMC versus UNMH; connections with private medical community. Ms. Lovell ended with a review of

Research. Dr. Roth added that the UNM Medical Group and SRMC are both University Research Park and Economic Development Act Corporations and noted that Mr. Scot Sauder will be providing a briefing to the Board that will review all the technical aspects of this status as well as implications. In this connection, Dr. Roth advised that

> "[t]he University has a consolidated financial statement that incorporates all of the finances of all those Research Park Act Corporations and that is what goes to the founding agencies, etc. When we do our annual audits, the auditing firms look at these corporations much in the same way they would the rest of the University. It all bubbles up into a single and finally audited financial statement.

Ms. Lovell added that at F&F Committee the financials presented will not have UNMMG or SRMC included. They only have the Hospital and the academic side and Main campus does not, on a normal basis, bring in any of their Research Park Act Corporations. Because, at the HSC, everything is so dependent on everything else, Ms. Lovell noted that UNMHSC cannot separate that out. She advised that the institution must show all of its finances together so it is a little different from Main Campus. Ms. Lovell reviewed the Consolidated HSC Operations with a positive total bottom line of $2.1 million. Ms. Lovell stated her belief that the UNMHSC's financials are in good shape and that the strategic work management has implemented since 2012 to get here is positive. She thanked the Board and that their support shows in the financials. Ms. Lovell also noted her view that the Balance Sheet is strong.

<u>HSC Fiscal Year 2016 Budget Planning and Timeline</u>

Ms. Ava Lovell provided an overview on budget planning and reviewed the budget timeline. HSC budget planning is currently underway. In February, every HSC department and its respective budget is reviewed. April 10th is the Governor's veto and from there we will know what we do or do not have from a state perspective. Important dates are May 1 for the HSC Board of Directors meeting to approve the 2016 HSC Budget and this Board will be seeing much information prior to that date. May 8th is the UNM Board of Regents' meeting to approve the budget. New Mexico State Statute dictates that all budgets must be submitted by May 1, however, the Higher Education Department (HED) allows extra time. Ms. Lovell reviewed the information provided in the agenda book and discussed the impact of a 1% compensation increase for the total academic enterprise ($2.5 million), a 1% increase in compensation for UNM Hospitals would be approximately $4.8 million (includes the UCP), a 1% increase in compensation for SRMC would be about $313,000, etc. Dr. Roth added that the difference here is that the Regents will ultimately be required to approve compensation increases for next year and that is where understanding the different revenue streams and the different business model between Main campus and the HSC is very important. For Main campus, they will have to demonstrate to the satisfaction of the Regents that whatever their revenue streams that they will be able to support whatever compensation on the part of the faculty might be. For the UNMHSC, Mr. McKernan must be

sure that, since he is operating in this market place, if he wants to keep his nursing staff, for example, he is going to need to address certain compensation issues that would be very different from the demands on Main campus. It is the same thing for the UNMHSC faculty whose compensation has never married with faculty compensation changes on Main campus, because the UNMHSC operates in a different business model. The UNMHSC has different targets for total compensation, the way the faculty are compensated are very different and so ultimately management will be coming to the HSC Board with recommendations for faculty compensation which will likely be different than what is coming forward to the Regents on faculty compensation. For staff, however, whatever the Regents approve for staff compensation changes are 100% applied to the UNMHSC as well. Dr. Roth advised that this applies to all UNM staff at the UNMHSC but alerted the Board that it should keep in mind that there are also staff compensation changes at UNM Hospitals – Mr. McKernan deals with a different set of Human Resources demands at UNM Hospitals, the UNM Medical Group, as a separate corporation, has separate compensation demands, and SRMC will have different compensation demands. Dr. Roth reminded the Board members that the UNMHSC operates with four different Human Resources systems and each one has a different set of demands. One of the strategic objectives that will be discussed in the HSC Strategic Plan is a way to get three of those HR systems in complete alignment . Working with UNM Human Resources, the UNMHSC is trying to come as close as possible to the rest of the enterprise as well. This is a unique challenge.

Ms. Lovell then continued her presentation with information on UNMHSC faculty compensation data if we were to bring faculty up to the 25th percentile, up to the mid-50th percentile, or up to the 50th percentile nationally. For the School of Medicine (all physicians and basic science researchers) it was estimated that the cost to bring all full professors to the 25th percentile would be $992,000; to bring them to the mid-way point between the 25th and 50th percentile would be $2.9 million; and to bring them to the 50th percentile would cost $4.9 million. All ranks, total, would be $11.5 million. For the College of Nursing and the College of Pharmacy, the faculty, for the most part, are already at the 50th percentile. She continued with data resulting if there was a tuition increase or decrease, etc.

<u>Importance of Population Health and a College of Population Health</u>

Chair Quillen noted that there had been a prior presentation on College of Population Health and that at that time the Board had additional questions and considerable debate, therefore, this is a follow-up to that earlier presentation. Dr. Helitzer commented that today's presentation changed to more of clarification on the definition of "Population Health" and how it involves the entire Health Sciences Center. Dr. Roth provided background on the history of "College of Population Health," noting that this proposed college has had a very colored past. He stated,

> "The original proposal was to create a College of Public Health and [Dr. Helitzer] and the HSC pulled together a team of faculty and leaders of public health to discuss this and since that point we have morphed the original notion of a College of Public Health into a

> more relevant discipline of Population Health. As [Dr. Helitzer] and other speakers will talk about today, particularly as it relates to the Health System, the work force and the capabilities for the Health System to function successfully in this new era of Health Reform, looking at a risk-based organization and value-purchasing, requires a particular skill set that is rare to find. It draws heavily on some of the principles of Public Health but it goes beyond that to look at how an organization and properly managed a group of individuals for whom that organization is responsible for from the time they are conceived through end of life. That is a very different mindset and skill set than what would be usually considered part of Public Health. What I've asked (Dr. Helitzer and other presenters) to do is to re-visit the concept and discuss what is "Population health." No action is being asked for today. And they will present on what has been done up to this point and what we believe the direction is that we should take."

Dr. Helitzer presented on the definition of Population Health and, at future meetings, will discuss more on how it can best be done. Traditionally, the term "Public Health" has been used but because of the Affordable Care Act and Health Reform and the attention on the balance between keeping people healthy and taking care of them, the term now used is "Population Health." Dr. Helitzer advised that this integrates with the health delivery systems. The sort of skills that people need in this new era are slightly different from what was previously given in the Public Health arena. Use of data sets, Health System design, health policy reform, health economics, different types of health providers at all levels, from the community all the way into the tertiary care facilities, some preventive health education and also environmental health because we cannot do it all. For example, children with asthma may be coming from a sick environment so we must work together with all systems in place to provide the best care for these children. Over the last century, there has been a tremendous amount of progress in Population Health, *i.e.,* improvements in immunization, motor vehicle safety, etc. Dr. Helizter discussed "Triple Aim" that was established as a paradigm for Population Health and it has three interdependent aims: 1) improving care for the individuals; 2) improving the health of populations; and 3) the costs of doing this.

Director Hosmer asked for clarification on the statistic in New Mexico of 890,000 reported cases – are these new cases? Dr. Helitzer responded "yes." This data was shared in order to give perspective costs of about $11 billion to care for these to take care of all these people throughout the state. She continued that we want to take care of these people before they get sick. Dr. Helitzer noted the institution wants, through population health approaches, to prevent a lot of the cases and tackling them upstream is best accomplished by collaborating with the other sections, *i.e.,* education, housing, environmental health. Dr. Helitzer then turned the floor over to Dr. Mike Richards, Dr. Richard Larson, and Dr. Arthur Kaufman, who discussed how Population Health affects the HSC communities. Dr. Richards discussed the concept that Population Health will be affecting our health care delivery system

and “while it is a complex topic, he focused on a central drivers – health care reform and the changing economic model and how we will have to adapt to it….” He added,

> “The primary way that we’re delivering care right now is essentially a transaction-based health care system. A patient shows up, we deliver care, we get paid. We negotiate contracts on what that rate is, but it really is every episode of care that we provide, we get a unit of payment. The way that it is set up now is that even within an episode of care, you might get a bill from all of the individual components…. Each increment of care generates a bill. In this fee-for-service model, there is a concern that this will drive increased consumption, especially increased consumption of high cost health care and the reason for that is that when you look at the spectrum, the insurance plan is paying for each of the elements of care and the area of care that receives the lowest level of reimbursement, now, is the primary care physician. The things that generate the highest margins in health care systems are high complexity care, *i.e.,* inpatient based services, pharmaceutical services and the specialty care. We are a very typical health care delivery system; that is where our financial margins are right now, too. That high complexity care allows the UNM Health System to deliver much of the primary care which we now deliver actually at a loss. What will shift and what is happening now is that we know that New Mexico is a little behind on this but that we are rapidly moving into an evolving health care financial model which dictates us to be a risk-based model and the most extreme version of that is what we refer to as a capitated model. This means is that, instead of getting paid for each of these units of care, we then get a panel of patients, or a population of patients, and they give us a fixed amount of money to manage those populations of patients. This is exactly the sort of work that insurance companies used to do. They would get a fixed amount of money and then they would need to make sure that all the care was delivered. The new model is that not only the insurance companies are going to behave that way but the health care delivery system. Our population of patients will give us a fixed amount of money, that population is attached to a primary care network, we get a fixed amount of money per month for every patient that is in primary care, all of the health care that is then consumed from that point on comes out of that fixed amount of money, and this completely turns upside down the financial model. In the past, while these inpatient services and complex care, the pharmaceutical services, etc., might have been the revenue generators, in the new model they become expenses. In order to be able to make this transition, we must now be able to do things that typical health care systems aren’t really good at doing but insurance companies are good at doing – being able to look at a group of individuals and being able to recognize which ones are going to get sick and then try to intervene before they get sick and then consume lots of health care and expense onto the system. We are now looking at a completely different model of care.

In order to be able to do this, we now must create new IT systems, that allow us to be able to risk stratify these individuals to know who is at risk of consuming health care, we now must develop care models which allow us to be able to manage the disease so that we prevent hospital admissions; because we are predominately a tertiary/quaternary-care facility, this helps drive the idea that we have to create networks and partnerships in New Mexico so that we can be part of larger primary care networks. In order to make this big transition, we have to now develop new models of care, new financial models within the system, and new competencies which are typically within the realm of insurance companies. This is all Population Health. This cannot be done overnight. What we are being asked to do is to make this leap over a three to five year period. What will need to happen to help us make this transition – this is where the concept of pay for performance, pay for outcomes and pay for value comes in. We will gradually move from a fee-for-service model to adding in performance metrics which say "as you meet these quality metrics we will either give you an incentive or a penalty, however it might be structured, as you start driving costs down, we will share some of that savings with you and that is the concept of the shared savings program, and then as you start to get better outcomes we will either give you an incentive or a penalty based on those. In the meantime, as we start to ramp up into this, we will start to run a capitated system as a shadow/parallel system to say, "if we had only given you a fixed amount of money during this period of time, this is what the financial impact would have been."

Director Doughty asked, "When you say 'better outcomes' is that based on the outcome of that particular institution or is it a national outcome comparison?" Dr. Richards responded

"This is actually based on national comparisons, but it can be more complex than that. Often times the way it is structured is that they will look at your current performance levels and then they will set comparison goals based upon your current performance levels designed to get you to these national benchmarks. It is a mix of both." He added that this means that we will need to develop new models of care, new delivery systems of care, and that is when we talk about moving from the current episode-based health care system to population health. This is the framework that we are discussing. This completely shifts our focus from being able to episodically intervening with diseases to now wanting to both manage diseases and outcomes and ultimately getting to a point where we will want to prevent disease and promote wellness. The current health care delivery system and economics do not reimburse for that. This system does. The tightrope that we will walk, as we move into this, is that in some markets and some physician groups and networks, they may be 85 or 90% in this capitated model. Doubting that we will ever be in an 85-95% capitated model, maybe more than half of all our reimbursement will be tied to some outcome or performance as opposed to only

transactional-based but we will always have a significant part of our business which will be fee-for-service. There will always be patients that will come to UNM to get care regardless of whose health plan they are in just because of the nature of care we provide as the State's only Level 1 Trauma Center, the Neurosurgical services, etc. I imagine that we will probably land in something that ultimately be a 50-50 for us. Then how do we survive and what is the strategy to be used when you've got two, apparently very conflicting financial models and we're going to be 50-50 in both? The answer is that we must focus on delivering high quality care and containing costs (rewarded in both systems).

Dr. Larson presented that one of the big differences between Population Health and Public Health, is that Population Health is bigger. Population Health in the current world is driven very much by the Triple Aim and the changing business model. The demands and the changing landscape within the Research mission will also occur because of the emphasis on having to manage population health. In many ways, they will parallel the same demands that Dr. Richards described on the clinical side. Dr. Larson advised that this new paradigm won't eliminate the past model in Research, but it will open up areas such as comparative effectiveness research which is research about the best way to do things and how to deliver the best quality in things called implementation research, which is the best way to practice and how to establish the best way to practice, and in defining the metrics of how we should best measure health within your health system. Not only within a health system but the health of communities outside that system. Dr. Larson advised that UNMHSC is moving in this direction, taking advantage of this (one reason the Research mission has grown) and you cannot address these issues on the clinical side (public or private sector) unless you have a Research mission being driven from academic health centers that actually figures out the best way to do that. Beyond a system doing it, there are already networks being developed in the U.S. where researchers are trying to interface with other health care systems and other universities in order to study how their population might look relative to ours. To this point, Dr. Larson pointed out that the UNMHSC has done this with the health care system in Denmark as well.

Dr. Art Kaufman, the Vice Chancellor for Community Health, stated that the UNM Health System only affects about 10 or 15% of what makes up community health. He stated that what does impact health in a much larger sense is the social determinants, *i.e.,* housing, education, poverty, etc. Dr. Kaufman advised that the UNMHSC is entering into contractual relationships with managed care organizations and they are now beginning to invest in these determinants and, in Dr. Kaufman's view, they are seeing a return rather quickly. Dr. Kaufman announced that the UNMHSC is hosting a national conference in April 2015 on this subject bringing in academic centers from all over the country. Dr. Kaufman stated his belief that the UNMHSC should partner with policy makers, legal systems, New Mexico State Cooperative Extension, etc. At this time, the UNMHSC has a whole group of community health workers, health extension agents all over the state who are partnering locally with other sectors

and other stakeholders in the community. Dr. Kaufman stated that a College of Population Health would mean working with the UNM Departments of Education, Nutrition, Architecture and Planning, etc. in training many other sectors in how to have an impact on health which ultimately helps improve the health of the whole system.

Dr. Helitzer added that because of the education that is needed for Population Health, the new medical college admissions test will include new domains of nonmedical influences on health and health care delivery and a deeper education in social and behavior sciences. Once we get into the context of medical and nursing school curricular and pharmacy, we are going to have a much greater emphasis on Population Health and the science of health care delivery and quality and safety. They will have to learn more about economics and health policy, disease prevention, global health, etc. Other students who are not interested in becoming doctors, nurses, pharmacists or PAs also need to help their communities stay healthy. The new kinds of domains that they will have to learn will be risk assessment, surveillance, new data analysis, policy and strategic initiatives, health improvement and program evaluation, communicating health to communities, etc. She stated her belief that the University of New Mexico has a responsibility to provide education on health and health care delivery to all of these different sectors. The UNMHSC wants to emphasize the importance of Population Health going forward and how important it is to talk about Population Health in our State.

Chair Quillen commented that the Nurse Practitioner's Program in the 1980s had the cornerstone of health promotion and disease prevention. Chair Quillen therefore noted her view that the concepts underlying Population Health is not new. Chair Quillen then posed several questions: Why do we have to make it so complicated? Why can't we just start doing it? In this regard, Chair Quillen noted that the UNM Health System has so many methods and avenues to do this, starting with UNM Health. She stated her view that the UNMHSC has all the components right here better than anybody else in the State to embark on this now and do it in a very significant way to impact patient outcome and, hopefully, our reimbursements. She then posed the question of why aren't we just doing it instead of just talking about it? Dr. Helitzer responded that we are doing it in little pieces that are disaggregated. Dr. Helitzer noted that the UNMHSC is trying to be thoughtful about resources and not duplication and trying to synergize. Chair Quillen noted that the private sector is ahead of the UNMHSC and hey are already doing it in this state. Chair Quillen again observed that the UNMHSC is so much better positioned with talent to be the leader but is not the leader right now. Dr. Helitzer responded that she has been talking with members of the private sector and they are wondering what the UNMHSC is waiting for. Director Eaves asked what was the objective -- a whole new school in Population Health? Dr. Helitzer responded that we are trying to find the best mechanism for educating the workforce. Dr. Roth concurred and added that the UNMHSC is getting into doing this and every other health system is as well. To this end, Dr. Roth stated:

We've got two perspectives: one as a set of providers in delivering the health care product in completely different ways and we're finding that in order to implement the kinds of changes we need, we are finding that we don't have the numbers from the workforce who are talented individuals, who actually can do the work. In order to actually implement the systems necessary to address all of the points that Dr. Richards discussed, those who want to go into Research that Dr. Larson discussed, and who would reside in communities that Dr. Kaufman discussed, we need a massive increase in numbers of individuals who select that as their career. That does not exist in the U.S. today. As a provider, we are seeing weaknesses that we're having a hard time finding people to do the things we want and so are others in the state, *i.e.,* Presbyterian, Lovelace, etc. On the academic side, to be consistent with our mission in helping to provide the next generation of the health care workforce, this is an area we believe is absolutely essential for us to help fill the gap. Creating a College of Population Health we believe is quite consistent with the mission of the HSC and meets a serious and critical need in the community. The method by which we are going about implementing it, the Board needs to know that it has already gone through the University process through the Faculty Senate that approved a college. We need to now move it through this Board and to the UNM Board of Regents for approval of creating the college. Our hope is to create a curriculum beginning with a Bachelor's degree and Dr. Helitzer is closing with the other colleges and faculty so that those faculty who have an interest and some background and experience doing this already will be able to be pulled together so that we can provide a defined curriculum, that it has a focus in Population Health. We do not plan on building buildings; we don't plan on hiring any separate staff. We will be able to pull on the expertise of the Masters of Public Health program and existing faculty with secondary appointments who can help redefine what their career goals are and at least for the next several years, we think we can deliver the curriculum in a very cost efficient way but then begin addressing some of the gaps in the workforce that we're hearing from every employer, insurance companies, other hospital systems that they need.

Director Eaves asked for information on "…projected costs and how a college will be funded. Will this be a revenue generating portion of the HSC?" Dr. Roth responded that it will be funded much like the College of Nursing and the College of Pharmacy are funded. There will be credit hours, degrees being awarded, and this will fit into the formula funding. As they develop their curriculum, as the faculty generate research grants and contracts, it will be funded via the typical tuition, formula funding, extramural funding. Dr. Roth advised the Board that management has prepared pro forma financial statements that will show the actual budgets over subsequent years and the College will be funded.

Director Hosmer asked, with respect to the referral to Education that "there is a potential body of data in the country as a whole that correlates health with level of education. Do we have any kind of in New Mexico that gives us an idea of how many of the more acute issues of which we have 800,000 per year, break out by level of education?" Dr. Kaufman responded that the number one social determinant of ill health is lack of education. Director Hosmer asked, "The question is this … you are exactly right. But the people who are organizing and funding education in this state do not know that. Is there a way to put a value, in terms of health, and the cost of health, for improving education levels?" Dr. Kaufman responded that one of our nurse leaders, Dr. Damron, just became the Secretary of Higher Education and she has a health background and makes that link very well. Dr. Roth added that, to specifically answer Director Hosmer's question, the answer is "no." He has not seen any specific, good, analytic, scientific data that says the rate of diabetes in the state of New Mexico is linked to 35% based on low or poor education." Dr. Roth added that that sort of skill set and capability that the faculty of the College of Population Health would be dedicated, particularly around health issues in New Mexico.

Chair Quillen added that "College of Population Health" is goes hand in hand with the Affordable Care Act … a lot of entities embarking on it with still no proven outcomes that are cost effective or improves patient outcomes – this is all yet to be determined and it could all change before we get a College open. Chair Quillen asked why would we wait a year or two, establish a college, pay for it, etc.? Now is the time to be trialing it, to see if it is even effective. If it even begins to address the problems that we think and that the Affordable Care Act thinks that it is going to. It may be obsolete in a year – this whole methodology. Probably not because it is not new (in the 80s we were doing capitated health care) – we are just getting reimbursed differently – if we wait we will be so far behind and may shift underneath our feet if this doesn't prove to be, it could be over in a year with our policy makers, etc."

Director Eaves asked if existing curriculum in the medical school, etc. includes this type of education. Dr. Roth responded that it includes pieces of it but to remember that Nursing and Pharmacy and Medicine generate providers whose job it is to provide care for individuals. This discipline creates a set of skills and capabilities that look broadly at populations so while a Nurse Practitioner, say in a community, may understand a lot of these ideas, what they do minute-to-minute is to see patients only. What the health care workforce lacks are individuals who have the skill set that does the kinds of things that have been very broadly described where that is only their job, career, profession, and to continue doing the kinds of research and academic approaches to refine this to the point where it has meaning and relevance throughout the state of New Mexico. He added that Chair Quillen is correct that the UNMHSC cannot predict how things will change, given the political changes, etc., as we learn more about what health reform means in the U.S., to what extent will the ACA change through statutes, law changes, but noted:

> "but those that I confer with at a national level … no one actually believes health reform isn't going to happen. It will continue and this element, this understanding of what constitutes health of a group of individuals, regardless of what we call it, that will be a

permanent piece of how we define health care industry and health care delivery system in the U.S. whether it goes back to insurance companies that have to do it, whether it is something the Health Sciences Center has to do, and as the health care industry continues to mature … the overall health statistics … is not going to change. It is incumbent upon us, as health professionals, to make these advances. And it will mean that we will have to change the way we provide health care, it changes how we conduct our research, and there is also a piece of the workforce that we have to prepare, as much as we prepare doctors for the new world, we have to prepare another piece of the workforce that does this other function which, unfortunately, we have very little of. That is the point of creating the College of Population Health. As a provider, we are doing it now but we are finding that whenever we open positions there are very little candidates who have the experience to do what we need them to do so we are improvising. The long term solution is to create a workforce that is skilled, who understands what's necessary in this idea of managing a population, and then over time we will be much more sophisticated as providers in being able to deliver what society is asking us to do."

Chair Quillen asked, "Why would we need a college to do that? We have all the components, all the providers in Allied Health, etc., already in place. Why would we not just add curriculum, shift curriculum, etc.?" Dr. Roth responded,

"It is just like saying why would we need a College of Education versus asking somebody who is an engineer to provide math education in high school. It is because the engineer is not trained to do that. An engineer may know a lot about math and could probably deliver some aspects of math but they don't know the principles associated with being able to deliver the curriculum. It is the same concept here. We have to have a workforce that has a focus on this particular aspect of health care and while we could probably take a Nurse Practitioner and have them work in the hospital or in an insurance company to look at certain aspects of a population that they have an obligation to serve, it is not as the same caliber as someone who has been trained specifically for that job. Plus, it takes a Nurse Practitioner out of seeing patients and we're already in a workforce shortage in clinicians and providers. To answer your question, if we wanted to do it on the fly today, we are doing it that way and it is insufficient. All of the people that [Dr. Helitzer] has talked to and as I sit down with colleagues around the country, the recognition that as the health care industry is continuing to evolve and mature, there is an appreciation of the fact that we have to do things very differently and that impacts the type of person we have to employ to actually do these things. In the meantime, we're doing exactly what you're saying. We have to do this anyway, but we're finding that it is tough to find someone who would

actually want to do it and it is tough to find someone who is actually got the broad skill sets necessary."

Chair Quillen commented that in her institution they are finding out how to adjust and manage on the continuum instead of on specifics. She then thanked Dr. Helitzer for her presentation.

Executive Session.

A motion was made to close the open portion of the meeting and for the Board to convene in executive session for the reasons and to cover those items specified in the published Agenda. The motion was seconded. The motion passed with a vote of 4-0-0 in favor.

Return to Open Session.

Following the executive session, a motion was made for the Board to reconvene in open session and to certify that only those matters described in agenda item X were discussed in executive session. The motion was seconded. The motion passed with a vote of 4-0-0 in favor. Director Eaves was not in the room and did not vote.

A motion was made to ratify the renewal of Chancellor Paul Roth's employment contract. The motion was seconded. The motion passed with a vote of 3-0-0.

Regent Quillen indicated that the "Update on Research Mission" and the "Health Care Workforce Needs of New Mexico" information items will be placed at the beginning of the next agenda. The HSC Board of Directors' Action Required Log was then reviewed.

Adjournment.

A motion was made to adjourn the meeting. The motion was seconded. No discussion; with a vote of 3-0-0 in favor. Motion passed. Regent Eaves was not in the room and did not vote.

Minutes were prepared by Patrice Martin and finalized on February 10, 2015.

Approval of Minutes:

_____ _____

Regent Suzanne Quillen, Chair Date

Attachment: "Resolutions Approving and Recommending the Purchase of One Digital Mammography Unit and the Purchase of Upgrades for Three Existing Hologic Selenia Dimension Digital Mammographic Machines"