2-27-2015

Minutes of 02/27/2015 HSC Board of Directors Mtg

Patrice Martin

Minutes of the Meeting of the
UNM Health Sciences Center Board of Directors
February 27, 2015
Domenici Center for Health Sciences Education Bldg., Room 3010

UNM Health Sciences Center Board of Directors (the "Board") members present: Suzanne Quillen, Chair, Bradley Hosmer, Robert Doughty, Ann Rhoades, and John "Mel" Eaves.
Board members not present: Michael Olguin
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 10:20 a.m. The meeting was delayed due to inclement weather. The Chair announced that a quorum of the members of the Board was present.

Approval of Agenda

Chair Quillen amended the agenda. The items "Update on HSC Research Mission" and "Proposed Revisions to HSC Financial Thresholds" were tabled. A motion was made to amend the published agenda. The motion was seconded. The motion passed with a vote of 4-0-0. Mr. Eaves was not in attendance at this point and did not vote.

A motion was made to approve the amended agenda. The motion was seconded. The motion passed with a vote of 4-0-0. Mr. Eaves was not in attendance at this point and did not vote.

Approval of Minutes of Prior Meeting

A motion was made to approve the minutes of the January 30, 2015 meeting of the Board. The motion was seconded. There was no discussion. The motion passed with a vote of 4-0-0. Mr. Eaves was not in attendance at this time and did not vote.

Comments from Directors

Chair Quillen thanked Patrice Martin for efforts toward implementation of the board portal. Ms. Martin thanked the Board, Dr. Roth, Ms. Lovell, and recognized Roy Mollenkamp, Nicki Garcia, and Andrea Bizzell for their assistance with the board portal. She then introduced Ms. Debbie Jaeger, Account

Manager, Central Region, for BoardVantage. Ms. Jaeger provided an overview and training for the board portal. Discussions and a question and answer period followed. Dr. Roth led a discussion on the legalities regarding any annotations or notes the Directors or others might make within the board portal that are private versus being legally bound by IPRA, security, etc. Mr. Sauder replied, "Any time you are talking about electronic documents, you have to always have to correlate that over to what would the answer be if the document were in paper form. If someone wrote a margin note or something similar the margin note would be subject to IPRA." Chair Quillen asked, "What if it was not a margin note. What if it is just a personal note, not on the public document. Are your own private notes…." Mr. Sauder answered, "If it relates to the University, it doesn't matter. It depends on the topic in question or the person you eventually communicate the note to … there are exceptions in IPRA that we always examine." Mr. Mollenkamp added, "If you are on multiple boards … for example, if you are on the University Hospital Board of Trustees as well, at the bottom on the portal you can switch between team portals." Discussion.

Chancellor's Report

Dr. Paul Roth introduced Dr. Howard Yonas, Chair, Department of Neurosurgery, who provided an overview of his ACCESS grant – a CMS-funded, three-year contract. He commented on the "uniqueness of the expertise that is here and why it is important for the Board and the University to try address this in the coming months. Can we save money and can we improve care at the same time. The projection is that we will save almost $30 million with their investment of $15 million. Now we will concentrate on producing what was projected." This grant is focused on meeting the needs of rural New Mexico – small hospitals that have no access to complex care for emergency neurological problems. He emphasized the importance of providing necessary surgery and care during what can be a small, one to three hour optimal time for getting the most positive outcomes. If the time that care is received is beyond that timeframe the results are greatly impaired. Dr. Yonas also addressed patients who are not emergencies who, because of no specialists in their rural area, are flown into Albuquerque and this is costly. The goal is to meet the emergent needs, medical and surgical, and at the same time optimize the ability of care in local communities such as education. Dr. Yonas said, "We teach the doctors, nurses, hospitalists at each hospital how to care of these problems when the patient doesn't need to make the trip. It is an educational and communicational program." With Telemedicine capabilities at small, rural hospitals, the specialists in Albuquerque can meet with the patient and their family members, see the films, and make a report. The goal of the grant is to not just do a study but it is structured in a way so that at the end of the grant period, there is an infrastructure in place that will make the program self-sustaining. In the program, specialists will be available 24/7 to small community hospitals. Dr. Yonas said, "We've created the system and it is place. We are contracting with hospitals." He described the process and complexities of the contract with 30 hospitals and creating the funding mechanism – building a complex economic model. He recognized the HSC Legal Office and UNMMG for their expertise. He added that all patients get equal, state-of-the-art care but that work has been done to figure out to pay for patients

who do not have insurance. He said, "There is a parallel process of contracting with hospitals where they are going to pay for service … the hospital will pay it as part of the agreement between CMS and agreement on how to structure it … if you are not part of the grant, the hospital must agree to pay for that consult and that service that is going to be provided. That is a sustainable transition model that allows the transition into that when the grant is over so we have the payment structure, the agreement on how to do that, and this will continue…." Chair Quillen asked, "Dr. Yonas, on the 30% of patients, the hospital will pay for it, not the insurance company, for the consult?" Dr. Yonas responded, "The way we structured this is that the hospital will pay for it." Mr. Sauder added, "The hospital then bills the insurance company." Discussion. Dr. Yonas said, "Issues that are now going to evolve very quickly is that we really need some effort toward regionalization of concepts of care between health care providers mandated by this kind of health care breakthrough and we are the only provider…." Director Rhoades added that this grant addresses her past concerns on how few neurosurgeons we had here and that this is a great answer to that issue. Dr. Yonas discussed endovascular therapy, neurosurgery and the need more providers. He stated that hiring is underway for a neuro-radiologist with catheter training and that there is a need to build the team bigger to be on call. Discussion on grants. Dr. Larson added, "Only 12 grants of this type were given out in the country and Dr. Yonas was one of them." Dr. Roth added, "What it highlights is that almost every academic health center in the United States submitted applications. Out of those, only 12 were awarded and this is the only one that is defined by this particular purpose." Chair Quillen asked, "Where are you with implementation?" Dr. Yonas responded, "We are ready to roll out the contracts, do privileging at the hospitals, and move forward…." Mr. Sauder added, "We have contracts that are pretty well ready to be signed by several hospitals across the southern belt of New Mexico." Chair Quillen asked, "Is the main difference between this and ECHO … is this just more specialization targeted…." Dr. Yonas provided an explanation of the difference – that this grant targets emergent, direct patient care. Dr. Roth added, "This is set up to have a communication between ERs and Dr. Yonas' team." Discussion. Director Rhoades asked, "Is that $30 million annually?" Dr. Yonas responded "$30 million projected for the entire project. Discussion. Dr. Roth added, "It is having a virtual neurosurgeon and neurologist, a whole stroke team, present in every hospital in the state of New Mexico." Discussion of equipment utilization for other purposes. Chair Quillen asked, "Do you see this mesh significantly with unneeded transports to the ER … will it help our bed capacity issue?" Dr. Yonas responded that it is critical that we triage correctly, that we need to bring the right patients to our hospital, and that the patients who do not need to travel to our hospital are optimally cared for ideally in their home hospital, in their own community. Chair Quillen asked, "Do you have an idea of how many were accessed to the hospital that did not really need to be here? Do we know how many patients that would be in, say, a year?" Dr. Yonas responded, "From the information I have is that we did a contract with the Indian Health Service a number of years ago and these were all patients who would have been put in an airplane. Roughly half of those patients stayed in their hospital, 20% came into our clinics, 30% got in the airplane that needed to. Percentagewise, what this allows us to do is to avoid that transport that is unneeded…." Discussion on continuity of care, importance of triage, capacity, need for 500-bed hospital, Medicaid/Medicare structure, etc.

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

Mr. Steve McKernan noted that the Hospitals' census has been extraordinarily high due to RSV. Discussion on surge capacity and the creativity of staff to manage as well as possible under the circumstances. Mr. McKernan presented metrics on surge capacity at SRMC and the rapid approach to SRMC's inability to help with the Hospitals' surge capacity. Chair Quillen asked, "On SRMC that is great that the census has gone up and we're almost at capacity. Do you have a feel for how many of the patients there are really coming from patients accessing UNMH and that is becoming our overflow hospital or is that truly new patients from that community. Is it still a mix or…." Mr. McKernan responded that it is still a mix. Mr. McKernan said, "SRMC is doing what it was meant to do. It is turning into a regional referral center also. It has more capability than most of the hospitals in rural New Mexico. We can refer patients to SRMC very safely and they are taken care of very well." Discussion on patient satisfaction. Chair Quillen asked, "Aside from the 15 patients from UNM, most of the patients are coming from referral from other …" Mr. McKernan said, "Our doctors at SRMC are building up their own referral network. Dr. Richards added, "They are not necessarily 15 from UNM, they are patients that were referred into the UNM Health System that would have been placed on a wait list to get into UNMH that are now at SRMC." Discussion on referrals to SRMC. Chair Quillen said "it is important to articulate on where those patients are coming from; that the SRMC is building its own, they are becoming something separate but it is viewed by some that SRMC is the overflow hospital for UNMH. We need to be real clear that SRMC is building its own regional referral system even though some patients that would be at UNMH are going there appropriately. But this is an important number for us to know because a way of thinking exists in our state – "they've already got a new hospital and they can just move people over there" – it is important for us to remember this fact. Dr. Richards added, "The other issue here is that we built unique clinical services at SRMC that we no longer are really specializing in at UNMH. SRMC has become a destination independent of UNMH."

Director Eaves joined the meeting at this time via telephone.

Mr. McKernan highlighted the weekly monitor chart for SRMC and recognized Ms. Jamie Silva-Steele for her leadership on this success. Chair Quillen and the Directors recognized her on a job well done. Mr. McKernan highlighted metrics on the Adult Average Daily Census for the entire Health System, length of time in the Emergency Room, efforts on squeezing efficiency out of the operations. Director Rhoades asked, "What is the average ER wait time?" Mr. McKernan responded "Eight hours for an average patient … when you compare to other organizations, UNMH will not be ranked as a good performer in this regard." Dr. Richards clarified that eight hours is total ER process time stating that "we have redesigned our ER because of the demand that patients who walk in the front door actually encounter a provider almost immediately. They are screened and seen by a provider for a medical screening exam within minutes." Dr. Roth added, "There are two wait times. There is the ER wait time when someone

gets registered, shows up before they see a doctor – that is considered one kind of wait time – and then there is the wait time from the point of which the admission order is written and the patient gets up to the bed." Dr. Richards described the two wait times, the current status at UNMH, and added, "The wait time after an admission is about 16 hours for all adults but the reality is that there is a lot of variability in that wait time. Patients that are going into an ICU bed out of our resuscitation room go up instantly. Patients that are going to an intermediate level floor bed can wait 24 – 48 hours in the emergency department waiting for a bed upstairs. Even though the average is 16 hours it is not the same for all patients depending upon their acuity level." Dr. Richards noted that adult capacity issues are the most consistent constraint on the Health System but since we are in the RSV season now we have constraints on Pediatric beds as well, *i.e.,* over the last week we had a peak of 24 Pediatric patients waiting in the emergency department for a bed and admission at one point. Having a fully occupied adult emergency department, can have implications on non-adult patients. Dr. Roth added, "Steve McKernan showed what was budgeted and what the maximum beds are but what he did not include was what is supposed to be the standard of practice for hospitals in the United States and that number is about mid-way between the red and the purple lines [on the chart shown] so it is about 75% occupancy is considered standard of practice. If you are below that, you are probably running into financial problems with the hospital and that is where a lot of California hospitals are. If you are above that, you are running into patient safety and quality of care issues. Where we are on the blue and the black dots exceed what is considered to be a safe environment for patients. This is the total Health System so it includes SRMC. Last year, there was a lot of surge capacity because of beds available at SRMC. That is not the case any longer. We are running into situations … but SRMC had an instance where there were more patients with written orders to admit than there were beds available. We are at saturation point at SRMC…. The entire system is now stretched to the point where (and reports will be provided in the future) it is really the kind of facility that is going to best meet the needs of the entire state when we are sitting on … there were several days where we had over 40 patients in the emergency department waiting for beds. That is unacceptable." Director Doughty asked, "How do you calculate the percentage of your occupancy. When you say "75% occupancy is standard practice," how do you calculate that? And, second, based on that calculation … what is UNMH's percentage of occupancy …." Dr. Roth responded that we have charts that show percentages. Mr. McKernan responded, "80% of 360 is 288 and so the red line is at 303. 75% would be approximately 265 range. How we calculate that is, nationally, we use the AHA data and look at what occupancy is in the United States. We belong to consortiums and when all this is modeled out and we do program planning, what the architects look at is … what we are looking at is what you need in bed capacity to be able to do something cohorting patients. The definition of "cohorting patients" would be: we want to keep all the cancer patients together. We want to keep all the medical cardiac patients together, etc. If we are in a situation where you are taking a medical oncology patient and putting them in with a stroke patient, it causes enormous operational problems because you have to worry about the competency of your nurses. For example, a physician who has a stroke patient would not want that patient cared for by a nurse who is very competent in medical oncology but doesn't have a great amount of training and experience in treating stroke patients. What

this means is … we can predict relatively well what the total volume of patients will be but predicting how many stroke patients are going to come in, how many trauma patients, diabetic patients, etc…. [is hard to predict.] If we can cohort the patients, then we can assure the highest quality of care because of the training of nurses, making sure the equipment is on the unit, and we have those doctors focused with those nurses and those teams of providers to make sure you have the best outcomes…. In the United States, for a community hospital, they will run between 80 – 85% occupancy because the types of patients they have are relatively standardized. Teaching hospitals tend to want to have 5 – 10% more beds to allow for surge capacity…. It is calculated by the number of beds divided by the number of patients in beds at midnight on any day….” Director Doughty said, “Then the 75% standard … is that a daily calculation, weekly, monthly…?” Response: daily or twice per day. Discussion. Dr. Richards added, “Yes, that is the daily over a longer period of time. Key points are that those numbers are typically calculated at midnight and that may lead to the next question of 75% really doesn't seem like that's running at full capacity. You can take a smaller example and say that the problem with that number and why you have to have that buffer is that the flow of patients through the institution is at its lowest point probably at midnight. You have to have the capacity during high flow times to be able to move patients and this 75% number is the number we use for hospitals but it is actually not unique to hospitals. We find that this is an efficiency number that applies to many complex systems that have interdependencies among multiple nodes on it. An example might be an emergency department: the flow of patients is that 75% of the patients arrive between 10:00 a.m. and 10:00 p.m. In order to take care of all those patients and get them out within four hours, that means that at 3:00 a.m. in the emergency department, the place should be almost empty. That way, you will have enough capacity to be able to manage them when they are at their peak. If you don't empty the emergency department out by 10:00 a.m. the next morning, when the surge begins again, you create this perpetual traffic jam that can take a very long time to clear. That 75% capacity is looking at its maximum capacity utilization at its lowest point. Even with the 75% there will be peaks during the day where we will be much higher than 75% of the beds being used because patients are leaving beds and new patients are coming in.” Chair Quillen added, “Remember as well that we still have a number of semi-private rooms … that number would probably be higher but we can't put opposite sex together, different infections, etc. because it would compromise patient safety. A hospital can't be built today with semi-private rooms.” Discussion on specialized units within UNMH versus community hospitals, cohorting patients, etc. Dr. Roth added, “It is a very important point because from a strategic point of view, this dilemma that we are all facing is one of the principal drivers for how we are developing our Strategic Plan and what will ultimately be part of the Master Facility Plan that we will bring back to you… and opportunities for the Board to participate in discussions. But the concerns that the medical staff have and the nursing staff have – we can sit and talk about the numbers … but the nurses and physicians are facing is their work directly with the patients and they know what quality of care is expected for patients who come to our facility and we get the sickest of the sick and when we have to manage those very complex, highly acute patients in any setting that is less than what is available in standard of practice, then we are doing a disservice to our patients, first of all, and to the state, even if that is just one patient a day, we cannot

allow that to happen. What we are finding is that in the course of a 24 hour period of time, there are probably dozens of patients who are facing that kind of situation and this is unacceptable. Our medical staff's morale is at an all-time low. The nursing staff is extraordinarily frustrated because they know what they should be doing and they can't do it because of bricks and mortar. They've got the expertise, we have the equipment, we have the capability in every other aspect of patient care delivery except for physical beds in the right environment in the hospitals. These are not just people coming in with colds in the emergency department, or wanting their prescription refilled. These are patients who are critically ill or injured and they are not being treated in the fashion that we would want…. It is a critical situation. We were in a crisis situation at least three (or more) years ago when this became a critical concern and we had a plan to address it. For many reasons, that plan was unable to be achieved but we are now at a point when we are beyond a crisis. We had hoped that SRMC would allow us a little breathing room and it has helped enormously but we are now, as a whole system, in the same place we were much before we were trying to bring up the needs to expand beds for just UNMH. We are at a critical point where our medical and nursing staff are reaching well beyond what their stretch points are…. From a governance point of view we need to be able to inform you in an effective enough manner so that you can understand it. I really appreciate the question because it is probably the number one priority issue that is going to be facing all of us. Within the next several months we have to come to some closure." Director Hosmer asked, "What is our projected growth rate for patient beds?" Mr. McKernan said, "We believe that the demographics of the state of New Mexico will push us up on the inpatient side to around 1-1/2 to 3%." Dr. Roth added, "That question is also important. Nationally, academic health centers are showing a 5% increase. I don't think our numbers will be too much lower than that but the reason that KSA is coming in and we are finishing up their analysis of the market place and the needs for the state looking at the age of our population, types of medical and surgical needs of the community in New Mexico, etc. and they are handing this analysis over to DPS (architects) and the planners to translate those growth data and projected needs into cubic feet. How much space would be needed to address what the projected needs will be going forward. Nationally, the growth rates, as it relates to demand on hospitals fall into two categories. One is community hospitals, *i.e,* Presbyterian or Memorial, will very likely stay flat, if not even drop, because of the kinds of things we are doing in health reform (trying to push more types of services out into the community and to clinics and peoples' homes, getting them out of the hospital as quickly as possible to reduce costs, but for academic health centers that are quaternary, tertiary care referral centers for highly complex care, the national projections are that the demand will increase by up to 5%. Those are very different scenarios and an important distinction. When we get into the Master Facility Planning and the Strategic Planning and we have the consultants here, they can tell us uniquely about New Mexico and UNMH and the UNM Health System but they also come from a perspective nationally. They work with 20 or more academic health centers in many other marketplaces around the country…." Director Hosmer asked, "Is it not true that the ACA produces a surge?" Dr. Richards responded "Yes. The factors that would increase demand are when you give someone access to health care by giving them insurance. Through the insurance reform and the expansion of Medicaid. An initial uptick is seen in health care consumption because of the pent up

demand. Typically, when we work with our actuaries on this, we expect that the demand in the first one or two years, after receiving health insurance, if you can get access into the system (key point), can be one and a half to two times what the utilization rate would be after the pent up demand is but what tends to be the rate limiting factor is that getting an insurance card doesn't mean that you get a doctor or that you get access to a hospital…." Discussion. Dr. Richards added, "Until we have a new physical plant, we are operating at our maximum capacity. The only way we will be able to deliver more service, at this point, isn't by building programs but by creating more efficiencies in our current system. Until we have more physical capacity, we will be rate-limited by our ability only to create efficiencies in the system. The community hospitals are going to see … up to a 10% overall decline in their utilization and academic medical centers expect to see around 6% or about a 1% growth rate." Discussion on the consumption of health care by aging population (over 65), prevalent in New Mexico, systems reform, technology, etc. Director Rhoades added the issue of our aging facility and the fact of the two years or more that it would take to build and open an additional facility. Discussion on UNMH Strategic Plan, shift in medical models, etc. Chair Quillen commented that to a person not in the health care field, 75% occupancy might be interpreted as having a lot of room – she recommended that we need to be aware of explaining that as we go forward. She also noted that "there is a report that the state receives that she keeps hearing about – the Department of Health gets this report … on a daily basis that shows, in the event of a real emergency/crisis, how many people could you move out and how many beds would you have available. For some reason, that number gets circulated widely and it looks like we have even more capacity. Those reports are in the event of a community-wide disaster where you could move people out to other places … so that number that floats around at the Department of Health gets very confused with the true number of what is happening…." Dr. Richards responded "I was at the Department of Health when we implemented that system statewide. The name of that system is "HAVE BEDS" which stands for "Hospital Available Beds During Emergencies and Disasters…. It is a daily or weekly polling that occurs. If there was an event that happened now, they could actually poll, electronically, all the hospitals to say, what is our surge capacity and it really has no connection to daily operations." Chair Quillen said, "No, but it is viewed as our capacity for that day. When that report gets circulated that is the report that people at the Department of Health and beyond, in Santa Fe, look at and say "they have plenty of beds." I don't know how we address that as we move forward but that is a real issue when we start talking about capacity because they have this report in their hands ... this report is not well understood." Discussion on disaster response, etc.

Dr. Meghan Brett provided an update on the Carbapenem Resistant Enterobacteriaceae (CRE), noting that it is a persistent 'super-bug' (resistant to most antibiotics) and that recently CRE has been found on specific types of endoscopes. This represents a post-antibiotic era because we do not have drugs to treat this well. Mortality within basic infections is approximately 50%; if drugs are administered early it drops mortality to 20%. The challenge is that CRE is becoming much more common in the U.S. There have only been two cases at UNMH. People can be colonized – they can have the bacteria but it is not causing an infection but puts them at risk for developing a more severe infection. Discussion regarding

the scope, difficulty in cleaning appropriately, etc. To date, incidents of CRE in New Mexico are quite low but work is being done on best practices on cleaning the scopes and discussing what types of resources we need to do the best we can with the current available information, monitoring processes, etc.

Public Comment

There was no public comment.

Information Items

Health Care Workforce Needs of New Mexico

Dr. Richard Larson's presented on workforce needs in New Mexico. He said, "Two years ago there was legislation passed that has allowed us to analyze the workforce in ways that other states can't and has shown some very interesting things about New Mexico." He discussed background on this legislation, what its implications are for education and training, some of the financial incentives that this workforce committee has thought about in terms of addressing these shortages, and some issues related to recruitment and retention of health care providers in New Mexico. In 2012, House Bill 19 was passed ... and did three significant things: 1) required all licensing boards to attach a survey to practitioner's submittal of renewal gathering additional information that gives a more accurate account of where practitioners practice and characteristics of who practiced in New Mexico or characteristics of their practice; 2) made the UNM Health Sciences Center to receive this data yearly from the licensing boards and are allowed to analyze it; and 3) established a statewide Health Care Workforce Committee. Dr. Larson said, "Every year we are required by law to provide a report back to the Legislature by October 1st regarding our activities and analysis for that year. Discussion included UNM HSC is the steward of the data but directed by the Health Care Workforce Committee. Dr. Larson highlighted that "in New Mexico we have 8,405 licensed physicians with only 56% practicing in the state …; 64% of Nurse Practitioners who are licensed in New Mexico actually practice in the state; we now have a three year complete set of data and have been through a full cycle of renewals." He reviewed the map of a variety of specialties and showed the shortages, many severe, in the state. New Mexico leads the nation in the oldest physician workforce in the country; one in every three physicians in New Mexico is over 60 years of age. Director Rhoades asked, "Is our shortage compared to national shortages state by state much higher?" Answer: yes. Dr. Larson highlighted two caveats on the data, *i.e.,* we have are that we have not been able to get an accurate number on Indian Health Services physicians. He discussed the number of first year resident slots that are available in the United States for graduating medical students and DO students, a number that is dramatically increasing, and by 2017 there will be a substantial problem with U.S. graduates and not enough positions available to them. Dr. Larson added, "One of the things that we were very pleased by is that our state was willing to fund nine state-funded residency slots…." This

effort was driven by Governor Martinez. Residency is the strongest predictor of retention of a physician but this is not true for a Nurse Practitioner that is driven by where they live. Another big driver for getting practitioners into rural environments is ensuring they come from a rural environment and they have an interest in Primary Care and there are high hopes that the current BA/MD Program will have this outcome. Director Rhoades asked, "I thought there was a national move to shorten that." Dr. Larson responded on many schools' analysis on whether or not they can shorten the eight year experience it takes to become an MD. Currently, it would be eight years plus three years of Primary Care residency. Dr. Larson said that a group that is not licensed professionals but is emerging as a potential key element of the new health care environment is our community health workers. It is estimated that New Mexico will need to 2,000-3,000 of these individuals – high school trained individuals who help with the mid-level functions. We are one of the six states that are currently putting into place a certificate program to make sure that these individuals have training. Dr. Larson mentioned that debt is a big driver for medical students … debt and income potential play little role in the medical student's choice of specialty or their practice location, however, debt repayment plays a big role in their initial decision on where to practice and whether they are retained there. He said, "One of the big problems that has happened nationwide is there is a variety of loan repayment programs. The one for physicians historically is $25,000 a year for seven years has now shrunk to $35,000 a year for two years. What happens under a two-year program is that many people go into a community and don't move their family there. Much data shows that you really need to incorporate a physician and his/her family for about three years if you want them to be well incorporated into the community." He added that taking efforts to make the physician and his family feel part of the community seems to be a big driver in retention in the community. New Mexico has a tax credit for a variety of health care professionals and our Department of Health and Tax & Revenue Departments are beginning to coordinate their activities so that we can do an analysis of how this will impact us. Pharmacists have been left out of this data and a pharmacy group as well as this Committee recommended this year that they be included. Dr. Larson discussed best practices, communities whose leadership gets involved, address social barriers to physicians coming into a new community, and the recurring message that rural practitioners raised repeatedly was their access to Telehealth services at the HSC and access to specialists and the feeling of support helps retain them in rural communities. Chair Quillen added, "Very interesting statistics but a little concerning for our state." Discussion on systematizing our recruitment and strategies for retaining physicians; perhaps publish "play books" to communities that will assist them in recruitment, resources for recruitment, investments in physician start-up packages, collaborations with Sandia National Laboratories on building a projections/population models, etc. Chair Quillen mentioned that Representative Dr. Terry McMillan is introducing a bill on non-compete. She asked, "Do you think that will impact this data for our state and will that help us if the bill gets passed?" Dr. Larson responded "the Medical Society brought in a number of players who are looking that legislation, including us, and we (Dr. Larson and Mr. Scot Sauder) worked very closely with the Medical Society and the others who were interested in developing that so that we would have a bill that would also suit our needs as well as the needs of the community. The bill actually provides a pay-back agreement. It is good for rural

communities as well as for the HSC – if you put in hundreds of thousands of dollars into a provider and 12 months later they leave but want to stay in practice, the bill mandates that if you pay us back you can stay and practice. That seems very fair and everyone agreed that was reasonable way to proceed." Discussion.

Materials Management

Ms. Purvi Mody presented information on the 2014 audit of the Materials Management Department. This department oversees and is responsible for ordering, receiving, warehousing and delivering medical supplies and inventory to meet patient needs, restock, maintain inventory, pick up and launder linens, provide courier services to both onsite and offsite locations, and operate the print shop. Two reports were submitted to management for both UNMH and SRMC for the period January 1 through August 31, 2014. UNMH was last audited in 2011. Ms. Mody provided details of what the audit reviewed and findings. Director Hosmer asked, "Was there any resistance from management on the recommendations?" Answer: no. Discussion.

HSC Financial Update

Ms. Ava Lovell provided an overview of the HSC financial documents for the period through January 2015 or seven months of the fiscal year. She reviewed Cash Flow from Operations and noted, "We were at only about $6.3 million favorable on Cash Flow basis and now in January we are at almost $14 million and that is the booking of spring tuition. We booked about $6.5 million of spring tuition that we did not have in December but now we have in January." Discussion. She continued her overview with information on total bottom line, non-recurring expenses, TriWest dividend, UNMMG, UNMH, SRMC, uncompensated care, expanded Medicaid, Days Cash on Hand, Research, etc. She concluded with "Bottom line, we're doing well; people are working hard on any problem areas."

Chair Quillen addressed the meeting stating that Director Eaves would need to leave the meeting due to a prior commitment and asked for a motion to move the agenda item "Review of Turnover of HSC Faculty and Staff" to the next meeting and a motion was then made. The motion was seconded. The motion passed with a vote of 5-0-0.

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. Director Eaves was no longer in attendance in the meeting telephonically and did not vote.

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 IX were discussed in executive session. The motion was seconded. The motion passed with a vote of 4-0-0 in favor.

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.

Minutes were prepared by Patrice Martin and finalized on March 5, 2015.

Approval of Minutes:

_____ _____

Regent Suzanne Quillen, Chair Date