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Minutes of 04/08/2015 HSC Board of Directors Mtg

Patrice Martin

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**Minutes of the Meeting of the
UNM Health Sciences Center Board of Directors
April 8, 2015
Health Sciences & Services Building, Room 316**

UNM Health Sciences Center Board of Directors (the “Board”) members present: Suzanne Quillen, Chair, Bradley Hosmer, Robert Doughty, Ann Rhoades (by phone), Michael Olguin, and John Eaves.

UNM Leadership present: Dr. Bob Frank, President

UNM HSC Leadership present: Paul Roth, MD, MS, Chancellor for Health Sciences, and additional members of the Health System and Health Sciences Center leadership

Special Guest: Maggie Hart-Stebbins, Bernalillo County Commissioner

Others present: members of the UNM and HSC faculty and staff

Chair Suzanne Quillen called the meeting of the Board to order at approximately 2:10 p.m. The Chair announced that a quorum of the members of the Board was present.

Approval of Agenda

A motion was made to approve the agenda. The motion was seconded. The motion passed with a vote of 5-0-0.

Approval of Minutes of Prior Meeting

A motion was made to approve the minutes of the February 27, 2015 meeting of the Board. The motion was seconded. There was no discussion. The motion passed with a vote of 5-0-0.

Comments from Directors

There were no comments from Directors.

Chancellor’s Report

Dr. Paul Roth presented on hospital capacity and the dilemmas we are trying to contend with that relate to the number of beds we have that we believe to be insufficient for the demand for services and how that is impacting our institution. He reviewed what the institution does from a volume point of view and the role we play in the State of New Mexico, the factors that are showing the problem that we are facing because of capacity issues, and the solutions that are already implemented as well as solutions

suggested for being implemented. Within the Health Sciences Center we have the clinical enterprise – The UNM Health System (HS). The UNM Health System includes all of the clinical programs in the Health Sciences Center (HSC), *i.e.*, UNM Hospitals (encompasses Adult Psychiatric Hospital, the Children’s Psychiatric Hospital, Children’s Hospital, Carrie Tingley Hospital, and the Cancer Center), Sandoval Regional Medical Center, Inc., and the UNM Medical Group, Inc. Through fiscal year 2015, the HSC has seen 171,000 inpatient days (inclusive of all hospitals), provided over 760,000 clinic visits, 24,000 urgent care visits, over 100,000 Emergency Room visits by end of the year, conducted over 23,000 surgeries, and 3,000 births. The UNM Hospital is the only quaternary hospital in New Mexico. UNM Hospitals (UNMH) is the only hospital in the state (and in some instances in a large region of the United States) that provides certain specialized services. One of the challenges that contribute to the HS capacity issues is that approximately 90% of all patient admissions are unplanned. Since the UNMH is a Level One Trauma Center, there are number of very specific types of roles that we play for New Mexico. UNMH tends to care of very high acuity urgent or emergent types of patients that require inpatient services. For a routine hospital, emergency visits would be way below 50%. This is an example of the very unique portion of business that, amongst all the other differentiating features, that characterizes the HS differently than most. Another characteristic that is steeped in tradition and our history at UNMH, stems from the contract agreement between Bernalillo County and the Indian Health Services, in 1952. UNM Hospital, the building, the program, etc. began as the Bernalillo County Indian Hospital and was built on Native American land. The Agreement in 1952 allowed for the conversion of the Bernalillo County Indian Hospital to a Bernalillo County facility. There was a transfer of Native American land to Bernalillo County and the contract, among other things, also stipulated that, in perpetuity, whoever operated that facility would carry with that operation a special priority to address Native American health care needs, particularly inpatient needs. In 1968, a Joint Powers Agreement was entered into to share operation of the UNMH and it was officially leased to the University of New Mexico (UNM), in total, with full authority of the UNM Board of Regents in 1978. In 1978, Bernalillo County approached UNM and UNM, very positively, had conversations with the County. By that time, a School of Medicine was established, had residency programs, and there was a need to establish a closer relationship with the medical school as a place for training. Bernalillo County recognized that it needed to identify an entity to actually operate the facility and it leased the facility from UNM for \$1 per year with the promise that UNM would address the Bernalillo County health needs and agree to assume all obligations in the 1952 contract, and also agree to assume all the liability associated with running a hospital (financially, patient care, quality, etc.). If there is a problem at our hospital, the entity that is accountable is UNM. In exchange for UNM to assume those obligations and the liability for Bernalillo County, the County agreed that a mill levy tax would be passed to help underwrite the operations and maintenance costs associated with running a county hospital. At this point, Dr. Roth recognized that Commissioner Maggie Hart-Stebbins was in attendance. There is a close relationship not only with the County but through the County for Native American populations, particularly the pueblos, since many of the discussions we have relative to providing access to Native Americans is conducted through the All Pueblo Council of Governors. To answer the question, “What is the problem at our hospital?” UNM

Hospital has 527 beds. Sandoval Regional Medical Center, Inc. has 72 beds. Dr. Roth's presentation included graphs. The major problem: we have 308 adult beds at UNMH. There is some ability to have access in OB/GYN, some reasonable access in Pediatrics most of the year, some capacity in Psychiatric beds. This lack of capacity issue focuses on our concern on patient safety and quality of care. To explain, and looking now at only UNMH and its 308 adult beds, for teaching hospitals comparable to UNMH throughout the United States, the average occupancy of beds is about 72%. Out of the 308 adult beds, our number is 222 beds. Dr. Roth said, "If hospitals have occupancies over 85%, you start running into efficiency problems, difficulties with maximum delivery of quality of care and potentially patient safety problems." Going back to July 2012, at that time we knew we were getting into a problem with occupancy and with capacity. It was at that time that we presented to HSC Board of Directors, the UNM Board of Regents, and HED and gained approval for the construction of a 96-bed hospital. At that time, that was the conservative approach. Dr. Roth added details on why. Dr. Roth stated that, unfortunately, we were unable to get final approval for construction. Since then, we adopted a number of approaches to attempt to mitigate against what we knew, at that time, would be only escalating demand and pressures on our capacity to meet patient needs. Subsequently, since 2012 but especially since fall of 2014, the trend is well above the maximum patient safety line of 85%. Dr. Roth specified that this does not include true crises from a hospital and patient care viewpoint. He highlighted a graph that showed during each month what the peak number of beds for patients that have been admitted to the hospital. It showed that even though UNMH has only 308 beds, there are months when the hospital was close to 400 patients admitted. How is this possible? There were 44 seriously ill patients admitted that were waiting in the Emergency Department, in the Post-Acute Care Unit (or Recovery room) there were patients kept there because there was no bed, etc. Dr. Roth noted that this is the reason he has been sending our 'heads up' alerts to the Board and pressing the point that from the nursing and medical staff, they are telling us that they are worried about the numbers of patients that we are currently required to manage where the patients are not in the right place at the right time and not in the right setting for maximum delivery of high quality patient care. He added, "Another representation of this capacity problem is that, if all the beds are filled in the hospital, and there are still emergency patients continuing to flow into the Emergency Department, one of those holding areas is, itself, the Emergency Department." He showed a graph and highlighted July 2013 through March 2015, the numbers of patients in a situation where the doctor has already decided the patient needs to be admitted, the orders to admit the patient have been completed, and there is no bed available. Similarly, he showed a graph that indicated the number of hours that those admitted patients are waiting in the Emergency Department for a bed. A benchmark: on average, a similar institution in the U.S., the amount of time between when a doctor writes an order to admit the patient until they are physically in a bed is approximately 6-8 hours. In March 2015, on average, the number of hours that seriously ill patients waited in the UNMH Emergency Department, waiting for a bed at UNMH, was approximately 15-16 hours. Dr. Roth noted that there were exceptional things done in March, for example, by sending patients to Lovelace, a number of exceptional operational decisions made to deal with those numbers of patients that were sitting in our Emergency Department. We tried to move these patients anywhere

possible that there was an appropriate kind of bed available but it is important to remember that, for example, a trauma patient, UNMH is the only Level 1 Trauma Center. For many patients, there were no alternatives but when there were we sought out transferring patients to Lovelace, etc. to manage these patients in the best way possible under the circumstances. Dr. Roth acknowledged Lovelace for their significant work to help receive many of these patients. Dr. Roth highlighted a graph that showed the number of peaks – in March there were admitted patients that waited in our Emergency Department over three days for a bed to open up. Dr. Roth’s presentation continued with other examples. Hospitals around New Mexico routinely transfer patients that require specialized care to UNMH. For the CY14, almost 530 patients that were referred to us were forced to go out of state or to other facilities or they stayed where they were which, Dr. Roth added, submitted was not good patient care. If the patient’s doctor decided that the patient needed to be transferred to UNMH, it became apparent that this was not possible, and it was decided that the patient would remain where they were, this is a problem. This is not good patient care. Another example, when UNMH is at a point where we are completely filled, we call that Code Purple. We send out alerts to the entire medical staff asking that if they have any patients that you think that you could discharge, immediately go to the record and discharge them, even if it means that there might be a need for follow-up earlier than we normally would have done, arrange for home health, or other types of services so that the patient is not at undue risk for being discharged, we issue an institution-wide Code Purple. For the year 2014, 90% of the time we were in a Code Purple situation. Regent Hosmer asked, “What had been happening to the average Length of Stay (LOS) under this pressure?” Dr. Roth responded that, in looking at adults, Kurt Salmon & Associates (“KSA” - outside consultants studying the HSC Strategic Plan, updating demographics, etc.; KSA will present to HSC Board again in near future), recently data showed that LOS had actually increased. This is being driven by, for the most part, that the fact that we cannot discharge patients. For example, when a trauma patient comes in with orthopaedic injuries, we could discharge that patient from this acute care setting inpatient but there are no openings in a rehab facility or in a long-term acute care facility – and often the facility would not accept patients that could not pay – Dr. Roth added that Mr. McKernan has gone out of his way to contract with these types of organizations and offered that even though the patient could not pay, that UNM would pay them to accept these patients, just in order that this patient could be discharged from UNMH and get into a reasonable setting and open a bed. Regent Hosmer commented, “So, downstream congestion.” Dr. Roth corroborated. President Frank asked, “Have we calculated, if we had a [new] regional hospital as part of our system, how much relief it would mean?” Dr. Roth noted “yes” and that all details will be presented with KSA in the future. This would immediately translate to one of the solutions to this problem and that would be a new facility. Director Eaves added, “Earlier, you finessed a point that I think really needs to be made. What you are telling us is not new information. Much of this is information we have heard before because the Regents approved the new 96-bed hospital. The HSC Board of Directors approved it. The financing was available. We were not asking for state funds to build it. HED approved it and when it got to State Board of Finance. And when you said ‘we could not get final approval,’ you did elaborate on why we could not get final approval. Obviously, we did not convince the State Board of Finance of the need for

the hospital.... I was told that a very detailed presents were made by Steve and others and, as I understand it, it was in more than one meeting ... but the crisis we are having now and a couple of years ago, when we tried to get approval of the 96-bed hospital, that's the final approval we could not get. The situation is now worse than it was then. The current facility is really old. It is not modern. Frankly, a lot of people would not want to have surgery there because it is not as modern.... We cannot sugar-coat this. We have got to figure out a way to get State Board of Finance approval.... Probably, the most important job these Board members have is to work with you and try to work with State Board of Finance, the Governor, whoever it takes, to convince people that this community, the people in this state, need this hospital to do what it was designed to do.... [In a letter I wrote] I was frustrated that [Dr. Roth] was sending out these "heads-up" notices and the meeting in which we were going to hear about this was deferred. I am concerned that not only have we let about two years slip by without getting final approval but we're starting this process again and, as I understand it, we're going to on the State Board of Finance agenda in September.... We've got to be very realistic about the problem here. We have a serious problem because we failed in convincing the State Board of Finance and we have to figure out a way to do it." Regent Doughty added, "Where does Sandoval Regional Medical Center come in. I thought ... when was that built... How many beds are at Sandoval Regional Medical Center.... and timeline?" Dr. Roth responded, "At that time, one of the questions raised was that we had Sandoval Regional Medical Center – a brand new facility and there was lots of vacancies and occupancy capabilities in that hospital at that time. So, it was a legitimate observation. We were at maximum capacity at [UNMH], why not use Sandoval Regional Medical Center (SRMC)? We tried to respond that UNMH is a quaternary care referral center. It is for specialized services. SRMC is a community hospital. To some extent, in some routine cases admissions could go to SRMC but a lot of the patients that required admission to UNMH required a level of care that SRMC was not designed for. Nevertheless, the concern was that we did not maximally utilize some of the resources available in the Health System. This is a legitimate observation and that was one of the main concerns. Director Eaves commented, "That hospital was never designed to fill the gaps that we are discussing here.... What we did out there was an effort to expand the reach out into Rio Rancho.... It was never intended to solve the problem of our aging main hospital here or to provide a hospital for patients that we are unable to accept from other hospitals around the state. The plan [at SRMC] is to expand not only the Health Sciences Center out there but academically the main campus and the State Land Commissioner worked with us to help make that happen. What [Dr. Roth] says is correct but it was never designed for that purpose to begin with." Dr. Roth commented that it was never designed to duplicate and be a Level 1 Trauma Center, to be a transplant center, stroke and sepsis center, etc. Director Eaves said, "To add to your basic description here, the one thing that is missing is that we weren't just looking to do a 96-bed hospital. That was only the first phase because the subsequent phase was to take the place of the old, main hospital." Discussion. Dr. Roth noted, "At this point, we just need to try to do the responsible thing, given where we are today, but the point remains that the first step is that my job is to make sure that this Board is comfortable with what I will be recommending and then that the Regents are fully informed and feel comfortable with it and approve moving forward. And, if so, our job is to convince

HED and then the State Board of Finance that this is a reasonable use of public funds to help deal with this capacity problem. Regent Quillen commented, "From the southern part of the state...that we rarely admit a patient into UNMH... no matter what their acuity. El Paso has become our referral center for the southern part of the state which is too bad because it is out of state. There are a lot of New Mexico Medicaid so it is a real burden for patients and their families and providers to get that taken care of. And then we've started using Arizona when El Paso is full. So, El Paso is now building a hospital closer to our border because they see a great opportunity. We cannot get patients here... rarely...." Regent Hosmer added, "What this says is that the saturation graphs under represent." Dr. Roth answered, "Absolutely. This is only from the perspective of a receiver of demand, as a provider. What we also know is that the phenomenon that Suzanne just described is present in many of the hospitals around the state of New Mexico. That they are so frustrated with the fact that they cannot get patients into our facility, they are routinely sending patients out of state and not even trying to transfer patients here." Regent Hosmer asked if there was a way to get a handle of the number of exports. Discussion on where diverted patients were sent, etc. Mr. McKernan added, "At multiple levels, it is hard to understand how much out migration is going on but we believe it to be substantial." Dr. Roth added, "To give you a comparison.... In 2012, when we did make the presentation to the State Board of Finance, I think the number of patients within that previous 12 months that we had to divert from UNMH was over 760 patients. There clearly has been a phenomenon that is very representative of what Regent Quillen just said." Regarding solutions, Dr. Roth presented that, at all levels, our health care workers and leadership are pondering what can be done to simply deal with the current circumstances today and then what can be done in the future. The four factors that impact capacity are demand for service, managing patient load, effectiveness in discharging patients, and bed capacity. He said, "Hospitals like ours, even when we are going through health reform, and a shift in the way we manage patients, will continue to see increases in demand. Community hospitals will most likely see a drop in demand because there will be regionalization of some of the highly specialized services.... It will become more of a referral center." He asked the question, "How well do we manage the patients that we have once they are admitted?" This has to do not so much with the medical care directly but rather case management or discharge planning. This is defined as, in an ideal situation, the minute someone is admitted, a team is called on to begin planning for the discharge of that patient, whether they will need to be discharged to a rehab facility or home, etc. At the HSC we call this "Care Management." As we get more into issues around health reform the idea of Care Management stretches across as a continuum of care. Dr. Roth presented on what the HSC has been doing to address issues of capacity. The HSC has gone through a number of programs and operations to maximize the efficiencies in which we manage patients but can always strive to improve. He gave "skilled Nursing staff" as an example as a specialty in nursing in specific areas where we would want those types of patients to be in units with those skilled nurses. Due to the bed shortage, we are not able to do this because the patient will go to whatever bed is available. The bed, however, may not be in the unit that specializes in that patient's illness. Such examples as this, is why the 85% number is so important because a hospital needs the flexibility to be able to place a certain patient in the right bed, at the right time. Dr. Roth said, "What we knew in 2012 is no different

from what we know today. We still need different kinds of beds than we currently have and we need more of them.” Dr. Roth’s presentation addressed maximizing efficiencies beyond what has already been discussed – discharge planning, SRMC, etc. -- certain clinical service lines have been moved completely to SRMC, expanded outpatient programs (social determinants), collaboration with Bernalillo County, behavioral health expansion, and Emergency Department process improvement. Dr. Mike Richards added that there are 60 adult emergency cubicles/beds. Dr. Roth then noted that if 44 of those beds are filled with patients that are having to be admitted that leaves only 16 beds for routine emergency care. The implications of UNMH in fulfilling its role in the state of New Mexico, in the County of Bernalillo, in the City of Albuquerque is dramatically being compromised because of our inability to process patients who need emergent and urgent hospitalization. Regent Quillen asked, “When we hear that people spend three days in the ER, it does cross one’s mind, if they’ve made it three days in the ER, and they haven’t required specialty services ... how sick are they and could they be taken care of elsewhere?” Dr. Roth responded, “That is a good question. The fact is that we have the admitting team coming down to the Emergency Department and they are implementing treatments, whether it is IV Therapy, or other forms of treatment, in the Emergency Department. The patients are getting treated but in the ER and, for example, these patients are being treated with ER nurses rather than by the nurses in whatever area the patient needs to actually be in the best case scenario, *i.e.*, Orthopaedics. We do not believe this could be considered high quality patient care. Dr. Richards added that the ER is not designed to deliver inpatient care and so not set up to provide ongoing medication administration, feed patients, bathe patients, etc. Dr. Roth noted that on the continuum of care, this has been an ongoing problem. Mr. McKernan has been able to negotiate with a number of facilities here in town that we will pay them to accept our patients. That has cost, on average, \$5 million per year out of UNMH operating budget so that these facilities will accept our patients. We have close ties with First Choice and other federally qualified health centers. We do the best we can in trying to arrange for appropriate placement of patients. We are currently exploring a closer relationship with other entities where we can develop a public-private partnership. We have an option: do we want to build our own nursing home or should we contract or have a close affiliation with an existing company that has experience in this area and one in which we will have these built-in arrangements to accept our patients at the appropriate time? We are currently having conversations with many other health care organizations in an effort to determine whether these kinds of public-private partnerships would be an option to our having to build our own. This would be our preferred approach. The third option would be for expansion of beds. When we looked at maximizing efficiencies, maximizing the post-acute piece, our consultants have clearly shown that if we are highly successful in maximizing our efficiencies, if we are successful in achieving solutions to the post-acute care problem, based on the demographics that they have updated from the previous plan in 2012, we will need a different kind of bed and we need more beds. “Different type of bed” was defined. Currently, in the older part of UNMH, it has semi-private beds (rooms with two beds). One of the efficiency problems that we cannot solve unless we build a different kind of bed is that, if there is male patient in one semi-private room beds we can’t have a female patient into the same semi-private room. This limits 50% of the patients that need to be

admitted. If the patient in a semi-private room bed has an infectious disease, it is not appropriate to admit a cancer patient who has immune issues to the other bed in that room. We can no longer have semi-private room beds. Regent Quillen asked, "How many semi-private beds do we have?" Mr. McKernan answered that UNMH has 60 rooms with semi-private beds...." The rooms are too small for modern health care and the same problem exists in the operating rooms – the floor-to-ceiling height in those rooms may have been appropriate for the building code in the 1950s and 1960s, but the new equipment that is necessary for modern care, is designed for a different floor-to-ceiling height. Often we cannot accommodate new equipment in the operating rooms because they are too small, the height does not easily accommodate the types of instruments and equipment that is necessary in the operating rooms. There are other restrictive issues related to the old facility (60 years old). Dr. Roth added that SRMC represents a quality facility designed to meet modern needs and the Pavilion – the new part of UNMH – is well designed and can accommodate modern equipment and technology. The older part of UNMH, in which all of our main adult Operating rooms exist, that makes this a problem. Regent Quillen stated, "I don't think we would ever want to but I do not think we can build semi-private rooms any longer." Mr. McKernan said, "Not by national codes, no. National building codes will not allow a hospital built with semi-private rooms." Dr. Roth added that Presbyterian recently went through major renovation in Albuquerque to convert their semi-private rooms to private and, as a result, netted fewer beds in their facility. In discussions with Mr. Jim Hinton, one of the advantages to building onto Rusk was to make up for the lost beds at their Albuquerque facility, etc. Presbyterian is doing extraordinarily well, very busy, and needed the additional beds due to patient care demands. Dr. Roth reviewed a letter from the HSC facilities planning consultant, DPS, and the takeaway points were that the "current infrastructure is aged and undersized (except for the BBRP), the buildings have gone well beyond their expected lifespans, and the existing patient rooms, other than those in BBRP, do not comply with modern codes and standards of hospitals. Director Eaves said, "It would not be economical or feasible to remodel UNMH." Dr. Roth responded that, "If we renovated it, we would lose 60 beds." Mr. McKernan added that we could not renovate part of the hospital to code now because the floor-to-ceiling height, etc. would not permit renovations to meet code requirements. Director Eaves said, "That is not a viable option to renovate. This is the reason we were trying to build a new hospital." This was all part of the conversation two years ago. Next steps: strategic plan is being updated with new demographics data, consideration of concepts in health reform and need to have more outpatient and subsequent reduction for the need for hospitalization for populations, consideration of kinds of acuity of care that our patients will require, etc. KSA is refining the strategic plan and will be completed in a few weeks. That information will then feed to DPS and they will use this data to draft an HSC Master Facility Plan. We know we need a replacement hospital because we can't continue working much longer in such old facilities. In addition to replacing the existing beds with modern beds, how many more beds do we really need if health reform and all other concepts associated with health reform was fully implemented in the state of New Mexico. Regent Hosmer asked questions regarding the consultant's analyses. Dr. Roth responded that the consultants will be meeting with the consultants preliminarily in order to inform the Board and for the Board to engage in the iterative process but the consultant analyzes the

general population, health care needs of that population, comparison of New Mexico actuals, factor in Health Reform and the changes in which we manage patients, etc. Discussion on timeline – projecting to 2024. Director Eaves commented, “I think the next step is one that we went through two or three years ago. The Governor appointed Suzanne, Brad, and Conrad.... This project was in the planning stage even before then. I think the folks at the Health Sciences Center work very hard and I know that other members of this Board work very hard ... to try to educate Conrad, Suzanne and Brad on this issue because the inability to get approval from the State Board of Finance was already a problem. I think that educational process really paid off because Conrad James and Suzanne and Brad all supported the need for this. They understood. The other Regents understood. This Board approved; the Regents approved it and because we were not successful in convincing the State Board of Finance we are now having to do this again. If we had been successful with the first effort ... the hospital would probably be in operation right now and we would not have this crisis. Now the crisis is worse than it was then and if this institution is going to continue we have to have that new hospital facility.... We need to do whatever is necessary to convince the new appointees to the Board of Regents about the urgency and the critical nature of this. At the same time, we need to take the message to the community because I do not think the people in Albuquerque ... understand what a crisis this is. This University and Health Sciences Center have a duty and an obligation to serve the patients and the community state wide and we are at a point where we cannot do that. We should not be falling behind any of the other hospitals. We have the money to get this done. We need to convince ... that this is a project that must be approved soon. Frankly, I’m disappointed that it is going to take until September to go back to the State Board of Finance but we should use that time for educational purposes. We can’t fail to do this. As a board member, I have an obligation to pursue and press this and do whatever I can to make sure people understand the problem. Hopefully, we will be successful this time.” Discussion. Dr. Roth noted that the HSC is motivated purely driven on values and purpose and that has to do with assuring quality care, maximum patient safety, and that the role the HSC plays in the state of New Mexico is to improve the general health care of all New Mexicans. Regent Quillen commented, “Conrad and I came onto the Board right after the State Board of Finance meeting and the hurdles we have overcome looking forward is that the messaging was a little confusing. What problem were we trying to solve. The message in the community [at that time] was that it was a ‘cosmetic center,’ it was a ‘boutique hospital,’ and so it was confusing. At the same time, Sandoval Regional came on board and had some capacity The serious thing to me that I’ve heard since I’ve been on this Board is when the [UNMH] engineer came to speak with us last year and told us about the power surge issues in the ORs and that we have some risk issues because of that. To me, the patient safety issues trump everything. We have such dated facilities.... We have to have a very clear message that people can articulate ... what problem are we trying to solve. Capacity for sure but patient safety is huge. [The engineer’s] message about what we will be facing and the risk issues with power in the ORs alone, etc. was frightening.... We need to make sure we highlight patient safety. We can all relate to that. [A patient] assumes when a physician takes you to an operating room that it is state of the art and ours are not....” Discussion on electrical system, age of facility, risk, etc. Dr. Roth concluded his presentation with plans to go to the October State Board of

Finance. He stated, "In order for governance to do your job, you have to have all the data, you need to have all your questions answered. We have a series of preliminary meetings that are set up with you and the consultants, ask questions, and make sure you are comfortable to subsequently finalize the plan and then come before the Board for final approval...." Director Olguin commended all UNMH faculty and staff and Mr. McKernan for managing this crisis as well as possible and that patient care has always been their number one priority. He added "I was at the State Board of Finance meetings in Santa Fe. They were extremely disappointing.... The institution has stepped back and rethink the entire Master Plan and I think the direction you wish to pursue is one that needs to be done very aggressively and deliberately...." Director Eaves agreed and reiterated that the current crisis is not the fault of faculty and staff. Director Rhoades commented on the retention of faculty and staff successes even in this crisis. Regent Quillen agreed and noted that it is frustrating and it is a crisis but we really haven't heard it bubble up to the crisis in the community because of the excellent efforts at managing it by the faculty and staff at UNMH. Regent Hosmer added that this is an "illustration of exceptional leadership within the Hospital and circumstances which could be just frustrating at the working level have been turned into a source of motivation...."

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

Mr. Steve McKernan noted that the full report has been made available and stated that "we are maintaining and improving our quality, improving patient satisfaction, we're increasing the number of patients that we are serving, and the finances are stable."

Public Comment

There was no public comment.

Action Items

Review of HSC FY2015 Preliminary Budget and FY2015 Revised Projections

Dr. Roth commented his review of the Division of the Health Sciences Center, how the Health Sciences Center functions, and the relationship with the President. He said, "One thing we are proud of is the fact that we have a presence throughout New Mexico. We have 430 very specific programs and activities spread out over 152 communities throughout the state and he highlighted the slides that show the HSC goals and the Health System goals.... For the Health Sciences Center, if you add up Medicaid, Medicare, commercial insurance, other patient revenues and the mill levy, we are looking at about 80% of our operating revenues comes through clinical revenue, driven by our clinical enterprise. The takeaway message is that the reason we are viewed often as being very different from the rest of the University is because our business and business model is dramatically different that the rest of the

University. We drive our enterprise based on our business – the business of health care and we are far less dependent on our tuition and our I&G.... What drives our strategy is very often the marketplace, our competitive position within the marketplace, and those types of strategic initiatives that relate to assuring the stability of the business enterprise.” Director Eaves added, “This is the reason – because we have to be able to compete in this marketplace with hospitals such as Presbyterian, that is the reason we have to have the flexibility to build new facilities to allow us to do that. When you look and see that only 5.4% comes from I&G and the state, and less than 1% from tuition, this is a self-supporting institution. It is not like the rest of the University... the University does not have the ability to generate this income but when this income is generated, if you look at the employment here, the jobs that would be created by building a new hospital, the impact on the local economy is enormous. That is the reason we cannot let this institution be denied the ability to build a new hospital. This is the reason it is a crisis and the argument is overwhelming. We must do a good job in educating the people in Santa Fe whose approval is necessary.” Ms. Ava Lovell’s presentation included a review the Total Budget and Revenues for 2016 is almost \$2 billion (\$1.9 billion) or about a 4.2% increase over our projected 2015. Ms. Lovell said, “The way we present the Health Sciences Center finances is by breaking it down into two major operations – the Health System and Academic.” On the Health System, one of the financial assumptions that were built into this budget: an overall approximate 5% growth in Revenue and the expansion of outpatient services. Expense growth was in compensation and supplies. Medical malpractice insurance continues will rise by almost 20% this year (last year it was up almost 30%). She said, “We cannot go very far into the UNM HS without talking about Uncompensated Care. It is changing. In 2011 we were at about \$230 million but beginning in 2015 we saw an expansion in Medicaid. We still think that as the ACA is fully implemented ... we will still see about 12% of our total cost in Uncompensated Care at about \$126 million...” She provided detail on what groups of patients will be seeking uncompensated care. Regent Quillen added that it is important to clarify because many people think that once ACA is fully implemented there will be no uncompensated care. This is not true. Dr. Roth added that the government projected 8% of American public will still be without insurance and in New Mexico that will be a higher number due to state demographics. Ms. Lovell introduced Ms. Ella Watt who provided additional details on Uncompensated Care, patient care revenue at UNMH, and what the change was from Uncompensated Care into Medicaid. Regent Hosmer asked, “On Uncompensated Care, the numbers suggest that we think that has bottomed out and so it is now migrating back up?” Answer: yes. More detail was provided regarding “Federally Authorized Others” or Supplemental Medicaid funding, definition of Disproportionate Share and ACA’s elimination of Disproportionate Share, cost of care, drop in pass-through, Triwest monies, greater volume of patients and associated costs, contractual allowances, operating loss, charity care write-offs, classifications within Medicaid, historical information on the mill levy versus operating costs the mill levy provides today (9.3% of the total operating cost of the hospital) and the importance of the mill levy. Ms. Lovell reviewed the Budget for the Health System (includes UNM Hospitals, SRMC, and UNM Medical Group) that included 2014 Actuals, review of 2015 projections, 2016 Operating Budget (no capital expenditures are included), patient care, source of increases, Contract & Grant revenue, I&G, Other Revenue, \$1.3 billion HS Revenues (~ 4.6% increase),

etc. HS Expenses review included prioritization for salary increases, facilities costs, maintenance of aging building, etc. Dr. Roth added asked that where the reduction in debt service (by over \$1 million per year) will be reflected if the State Board of Finance approves the refinancing of the Bonds. It is reflected in Interest Expense. The 4.2% possible reduction was not included in the Budget because consideration and potential approval of the State Board of Finance has not yet occurred. Director Eaves asked, "What is the remaining term of the debt obligation?" Answer: The final Bond expires 2030. Mr. Eaves continued, "A million a year savings but this is multiplied times the remaining term of the indebtedness. That is the way in which we should think about it, not on an annual basis. What would that number be?" A big gain – approximately \$20 million.... Ms. Lovell added that there is no risk to refinancing and that a huge savings is available, much like when a person refinances their home mortgage. Discussion. Regent Quillen noted that Other Expenses are, by far, the largest category and asked for detail. Ms. Watt answered that it is items such as software maintenance (approximately \$1 million), SRMC's warranties ending, equipment, etc. Dr. Roth asked, "Since that is almost 20%, are there categories within that we should breakout separately?" Answer: yes. Discussion. This category will be expanded.

Regent Overton joined the meeting.

Ms. Lovell continued with a review of Total Expenses (7.7% increase), bottom line – Revenue minus Expenses, Net Margin, projections for this year, higher case mix index, etc. Director Eaves asked Ms. Lovell to distribute a summary of the projected cost savings and refinancing of Bond debt over the life to the Board. Ms. Lovell continued with a review of Return on Investment on Triwest, Capital Initiatives, Nonrecurring funds used to expand clinics, Total Nonrecurring Item, Net Margin (\$5.5 million), Bond refinancing, 2016 Budget reviewed by unit. She reviewed the Academic Enterprise (AE) (inclusive of School of Medicine, College of Nursing, College of Pharmacy, Research, Administration, and HSLIC) including Revenue. There will be a decrease in medical student tuition by 1%. Dr. Roth expounded that for the last five years medical student tuition has not increased. This was a result, in part, from the accreditation process where a comment was made that in spite of the fact that our total tuition is in the lowest quartile nationally, our student debt continued to climb and indebtedness tends to influence where a medical student chooses to practice. They are less likely to practice in rural communities. Dr. Roth added that the School of Medicine undertook a large campaign to drive up more scholarships and that helped somewhat but, in fact, we have still seen a rise in student indebtedness in spite of our tuition not being raised and the awarding of well over \$120,000 per year in free scholarships. As a result, he noted that his commitment to the student body was to reduce tuition 1% every year indefinitely. Director Hosmer asked if there is a significant amount of grant funding besides the University's funds. Dr. Roth answered, "We get, in financial aid, a number of endowments that are earmarked for certain populations.... We get some state and a fair amount of federal." Dr. Morrison added, "The formula and the processing have changed for students from more rural areas that were planning to go back. The last time we were funded, it was only for medical students and med lab

sciences.... The mix changed but we did receive the largest federal grant we had ever had for medical students.” The grant was based on the number of medical students who did go back to rural areas. Ms. Lovell reviewed the statewide formula funding program (except medical school) noting the generation of 1.4% increase in overall state funding; rely on Tobacco Settlement funding and funding level was sustained for 2016 with some uncertainty around those funds. Expenses, in this budget, have included a salary increase for HSC faculty of 1% average on their contract or we will adjust them to the 25th percentile; zero staff increases; utilities have increased. Dr. Roth commented on national benchmarks on salaries, the necessity to cross-subsidize Basic Science chair salaries with clinical funds, etc. Ms. Lovell recapped appropriations in House Bill 2. Senator Sue Wilson was recognized for donating her money as a senator for one year to go to I&G with hopes to convert this to recurring. Ms. Lovell discussed faculty compensation which is what Dr. Roth discussed regarding all HSC faculty to reach the 50th percentile in salary (\$3.2 million annually to get faculty to 25th percentile; \$13.6 million to get HSC faculty to 50th percentile). Regent Hosmer asked a question on delta and Dr. Roth responded “The \$13 million represents where the School of Medicine faculty are today, even those who are below the 25th percentile....” Discussion on reasonableness on targeting the 50th percentile and the decision to target the midpoint between the 25th and 50th percentile for School of Medicine faculty and staff as reasonable. Ms. Lovell presented that the College of Nursing and College of Pharmacy are not far from the 50th percentile for their faculty. Dr. Roth noted that the HSC follows whatever the decision of the Regents is for compensation increases for staff on Main campus for staff at the HSC. HSC Faculty compensation is always considered separately due to the difference in revenue stream. Ms. Lovell reviewed the HSC Academic Enterprise Budget including Revenues, Contracts & Grants, I&G and State, Facility and Administration, Tuition & Fees; Expenses, increase in FTEs, locum tenens, etc. Regent Hosmer asked a question regarding the bump in faculty salaries of 10%. Discussion that this is a result in the loss of faculty in Pediatrics, etc. Dr. Roth added that the fact that we lost almost the entire Division of Pediatric Gastroenterology is an example of the highly competitive salaries elsewhere that draws our faculty to leave for other states and that it costs a lot of money to bring in locum tenens to continue providing this service to patients. Other areas impacted were Pediatric Cardiology, Pulmonology, and Critical Care. It is difficult for the UNM School of Medicine to find the revenue streams to match what other academic centers can offer. Ms. Lovell continued her presentation stating that Total Expenses are up 5%; Net Margin; Projected End of Year, etc. Dr. Roth added that many startup packages for new chairs are beginning to wind down yet now we are now going through a search for a new chair of Family & Community Medicine, Internal Medicine, and Radiology. To hire quality people in those academic positions for a much smaller startup package will mean good negotiations. Dr. Roth said, “It would not be uncommon for a chair of Internal Medicine ... that a startup package would be \$20 million, as a standard.” He expounded on the details of what may be included in startup packages. Regent Hosmer commented that it is a national market not a New Mexico market and asked about where the faculty who are leaving are going to, whether in state or out of state; the reason for their leaving. Discussion. The outcome of investing in quality faculty is quality of care – an investment to the benefit of the state. Ms. Lovell continued her presentation on the FY16 Budget for the Academic Enterprise including Use of

Reserves, Revenue Trends since 2012, Patient Revenue Trends, Expense Trends, Compensation Expense Trends, Medical Malpractice Premiums, etc. Roth added that the cost for the institution for medical malpractice continues to grow at a substantial rate and that main campus has also incurred commensurate increases to main campus as well by State Risk Management. Dr. Roth added that work is being performed on perhaps redefining what our role with State Risk Management might be in the future, such as many other academic health centers have done in other states. Discussion on assuming risk directly, infrastructure needed, establish appropriate systems for reserves and management, current capacity issue, quality of care. Ms. Lovell wrapped up the budget presentation with the Total All Components HSC Budget bottom line on approximately \$2 billion worth of Revenues and Expenses is \$536,000 Use of Balance. A motion was made to recommend approval of the Budget to the UNM Board of Regents. The motion was seconded. The motion passed with a vote of 5-0-0 in favor.

Approval of UNMH Contract with Precyse Solutions, Inc.

Mr. Steve McKernan presented background on this contract for services that will assist UNMH with ICD-10. Discussion. A motion was made to approve the UNMH Contract with Precyse Solutions, Inc. The motion was seconded. The motion passed with a vote of 5-0-0 in favor.

Information Items

Update on HSC Research Mission

This item was tabled and will be presented at the next regularly scheduled Board meeting. Dr. Larson commented that the HSC is on track this year to have another record Research year with about a 4% growth rate.

Review of Turnover of HSC Faculty and Staff

Dr. Leslie Morrison and Ms. Ava Lovell provided information on HSC faculty and staff turnover. Dr. Morrison discussed retention rates (the number of people who started at a certain point and are still at the institution five years later) providing data from the last AAMC report where UNM is compared with the national averages, broken down in five year intervals. The most recent compares senior faculty with the Associate and Full Professors to junior faculty or Assistant Professors. UNM is not far from national averages in terms of 2000-2002 data for senior faculty, however, junior faculty lower. The January 2015 data looked at three year retention rates. The 10 year retention rate is about 50%; the three year retention rate is substantially less; resignation rates. Regent Quillen asked if there are specific reasons for the separations. Dr. Morrison responded that exit interview data shows that reasons vary but it is often due to family/personal reasons and is rarely due to compensation although compensation is a critical factor for recruiting. She added that what drives our faculty, especially in Primary Care, is the

social mission; AAMC Faculty Forward data is expected soon on faculty satisfaction, mission area, intent to leave, etc. Director Rhoades asked Dr. Morrison to present more detail on “intent to leave” data from AAMC when it is received. Regent Quillen asked if there was any data on how many faculty, especially physicians, are reaching retirement age. Regent Quillen asked if we are planning to do anything to prepare for our aging physician population in New Mexico. Discussion was held on creative ways to retain faculty with a note that the most major impact is in rural areas.

Ms. Ava Lovell presented data on HSC staff turnover including voluntary separations (~ 10% per year), end of contract/term, involuntary separations, layoff status, discharge for cause, retirement, deceased, staff turnover by unit, and staff eligible for retirement.

Action Required Log

Regent Quillen led a review of the current Action Required Log. Mr. Scot Sauder confirmed that he will provide an annual review at the May 2015 regularly scheduled meeting. The item to review suggested changes to financial thresholds will be discussed at a future meeting.

General discussion was held on the May 1, 2015 Open House planned in conjunction with the regularly-scheduled Board meeting at 1650 University building. Director Eaves prompted a discussion on plans to potentially consolidate the FACC into the full Board meeting on a permanent basis; size of Board; recent transitions to Board and Regents, timing of meetings, etc. Upon Regent Quillen’s inquiry, Ms. Lovell confirmed that the current structure is working well for financial issues. The Board agreed to address this issue of integration at a future meeting. Mr. Sauder provided a legal perspective on the governing principals that were adopted by the Board in 2010 and 2011 and highlighted that there was a stipulation that the FACC would convene, however, the Board can amend governance principals. Mr. Sauder will draft proposed amendments.

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 5-0-0 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 5-0-0 in favor.

Adjournment

A motion was made to adjourn the meeting. The motion was seconded. No discussion; with a vote of 5-0-0 in favor. Motion passed.

Minutes were prepared by Patrice Martin and finalized on April 22, 2015.

Approval of Minutes:

Regent Robert Doughty, III, Chair

Date