

**UCHC Board of Directors  
Clinical Affairs Subcommittee  
Minutes  
November 11, 2003**

**Attendance**

**Voting Members:** Mr. Chudwick (Chair), Dr. Kozol, Mr. Lawrence, Ms. Leonardi, Dr. Palmisano, Mr. Samuels, Dr. Garibaldi, Dr. Shafer

**Staff:** Mr. Borda, Dr. Deckers, Mr. Kelly, Ms. Lattanzio, Ms. McManus, Dr. Sanford, Dr. Simon, Dr. Strongwater, Mr. Walter, Mr. Upton, Ms. M. Whalen, Mrs. E. Whalen (recorder)

**Other Attendees:** Mr. B. Carlson, Dr. Scott Wetstone, Ms. Susan Whetstone

**Guests:** T. Trutter, S. Armstrong, John Meyer

- The meeting was called to order by Chairman, Bruce Chudwick at 8:37 a.m.

**I. Clinical Plan  
Clinical Space Plan**

- Dr. Strongwater reported that the UConn Health Center was designed in the 1960's. Since that time, the health care delivery system has changed considerably. The development of the proposed renovations to John Dempsey Hospital (JDH) were created in a very thoughtful manner, taking into consideration planning for both space and the long term needs associated with developing technologies. John Dempsey Hospital is the only hospital in the greater Hartford region that has not undergone significant renovations within the past 10 years.
- The space proposal will allow us to keep pace with Signature Program clinical needs.
  - We have fallen behind in developing patient rooms in the Neonatal ICU.
  - We need greater facilities to accommodate new technologies, to meet new code requirements, ensure patient satisfaction, and to accommodate growth.
- We have been working with the Kurt Salmon Associates, Fladd and the Mitchell Architectural Group, as well as various internal sub-committees and key stakeholders in the development of the proposed renovations.
- There are four principal areas presented today: Operating Rooms, Neonatal Intensive Care Unit (NICU), Hospital Tower and Ambulatory Facilities.
- No final decisions have yet been made regarding the acquisition of a facility for the Department of Public Health Lab. Land on UCHC property is one option, but DPH is exploring alternatives. If land at UCHC is purchased, it would not interfere with the proposed Clinical Space plan.
- **Operating Room Plan**  
The renovations are designed to accommodate future growth projections for inpatient surgery cases and minutes related to both the Signature Programs and other surgical specialties. Renovations will include a minimum of seven operating rooms and one room for ambulatory cases that can not be accommodated in the Farmington Surgery Center, for a total of 8 rooms. It was noted that we have space to accommodate our own robotic technology into the space plan.

- **Clinical Affairs Discussion**

- Currently, we have 10 operating rooms, all within the 400/500 s.f. range. They are crowded and difficult to fit needed equipment in.
- The proposal is for operating rooms with 700 s.f. of space, sized for equipment and efficient work space, and consistent with industry benchmarks.
- Plan to ensure that we don't underestimate our growth needs. The data presented suggests a need for 8 operating rooms plus one ambulatory room. Numbers need to be validated to be sure we size the suite correctly.
- Consider utilizing our operating room more fully. Increase evening elective surgeries. However, we don't want to ramp up staff for evening hours if we don't have the patient volume to support the additional FTE expenses.
- Long term growth depends upon partnerships with faculty and community physicians.
- Future construction will need to be internal; there will be no room to expand outside of the proposed footprint for the Operating Room.
- After looking at renovating existing space and creating new space

**Option 4 was recommended:**

- Existing rooms 3, 4, 5 and 6 will be new construction. These 4 rooms will each have 700 s.f. of space and will be completed within the first phase of construction.
- In addition, it is proposed that we renovate existing space, rooms 7 and 8.

- **Neonatal Intensive Care Unit (NICU)**

- Recommendations were developed by a multidisciplinary committee following site visits to children's hospitals across the country.
- There were eight options within 4 concepts evaluated. The resulting proposed NICU renovation will provide leading edge patient facilities with "family centered care" environment.
- Single rooms to accommodate 50 bassinets which include 5 double rooms to accommodate twins.
- There will be 150 s.f. of space around each bassinet and 60 s.f. of space for parents for a 24 hour stay in the patient room.
- Glass walls will allow nursing stations to visibly monitor patients.
- Shared bath accommodations will be required due to space constraints. A missing component is the provision of private bathrooms.
- We will be the only hospital between Maine and Philadelphia to offer single patient rooms with family space in each room.
- We currently have a high patient to staff ratio and existing nursing staff will be able to handle patient volume. We will not need to hire new nursing staff.

- **Hospital Tower Plan**

- There is a high demand for private, single rooms. Patient satisfaction, privacy and safety are issues.
- There is also increased demand for beds resulting from Signature Program needs.
- **41 beds are needed to accommodate expected growth in signature and other programs based** upon planning assumptions developed with PWC and internally updated:
  - Cancer **17.2** non-ICU beds
  - Cardiovascular **31.0** non-ICU beds
  - Musculoskeletal **28.2** non-ICU beds

- We are now exceeding projected growth rates for the Ambulatory Cardiac and Cancer Signature Program.
- There were two different options evaluated for Zone A and three different options evaluated for Zone B.

**Recommended Option: Zone B, 24 Bed Floor** – 3 floors of new construction and renovation of existing space by converting existing rooms to single patient rooms. This will take us from a 224(204 beds and 20 additional bassinets) to a 229 bed facility. Any construction would require a Certificate of Need (CON).

- **Emergency Department**

- Create a Holding Unit.
- Create Isolation Rooms.
- Create a new Waiting Room.
- Complete the expansion already in process.

- **Conceptual Total Estimated Costs**

- Operating Room      \$22,000,000
- Hospital Tower      \$52,600,000
- NICU                    \$16,900,000
- Emergency Dept.    \$ 1,500,000
- **Total Estimated      \$93,000,000**

- **Clinical Affairs Committee Discussion**

- The renovations are necessary for us to be competitive over the next 25 years of providing health care.
- The first phase of construction would be for our Operating Room and the NICU. The Hospital Tower project is more elective.
- Each project takes approximately two years to completion after we receive the Certificate of Need (CON).
- In order to fund renovations, Connecticut hospitals have had continuous capital campaigns, and they also had to borrow funds, and indeed have high mortgages.
- We need to focus on public relations and appeal to our stakeholders to assist with project funding.
- Our focus should be to garner local community support in submitting our CON.
- Discussion ensued regarding developing financing strategies (a capital campaign dedicated to this construction) and clinical planning at the same point in time. There are also legislative considerations to consider regarding this construction.

- **Ambulatory Planning**

- KSA noted that we are in the expected range for exam room volume. If we become more efficient, the space plan will accommodate growth.
- Current ambulatory facilities are undersized with respect to contemporary planning standards.
- Overall visit volume is projected to grow 5% annually, or a 36% increase (from 147, 000 to 200,000 visits) by 2010.
- Cardiology and Cancer Signature programs have been projected to grow by 10% and 12% annually.
- Other high-growth services are projected to grow at > 8% annually.

- Based on revised volume projections, it is estimated that UCHC will require 67,000 additional s.f. by the year 2010; most of this growth is driven by Cardiology and Cancer as well as “right sizing” current space (it does not include taking down the “Dowlings”). Shortfall manifests itself in smaller rooms, compromised circulation, and reduced support space (e.g. waiting, staff workspace, storage). The square footage shortfall for Ambulatory is projected to be 54,300 by 2010.
- November 2002 Master Plan, the Dowling buildings will require replacement or significant investment to continue long-term use.
- **Three renovation options were evaluated. Option 3 is being recommended.**
- Option 3 allows for interim growth and provides for a convenient facility on the lower campus.
- The timeframe to begin renovating is the end of this fiscal year (July 2004).

## 2. Clinical IT Strategy

- A suite of new clinical systems, anchored by the Siemens Patient Safety System, will be implemented throughout our clinical operations over the next four years. Additionally, several other state-of-the-art clinical systems will be implemented in UCHC Clinical Operations over the next four years, placing UCHC at or ahead of the curve relative to other healthcare organizations. Funding will primarily come from operations and is contingent on financial performance. A 22.3% return on investment is expected in total for the new systems.
- It was noted that only 10% of hospitals have implemented an order entry system and there are only two facilities in Connecticut who have a Radiology PACS system.

### *There are 5 IT Strategy Goals for Clinical Operations:*

1. Continuous improvement in clinical outcomes and patient safety through leading edge automation and standardization of clinical care.
2. Clinical point of care, secure single sign-on anywhere, anytime access to all necessary information.
3. Revenue enhancement through value-added patient services, including patient portals and on-line self-service.
4. Electronic capture and storage of patient data in an integrated electronic medical record and in data repositories supporting outcome reporting and timely decision support.
5. Facilitation of efficient low cost administration and revenue maximization through billing enhancements, automated medical records, streamlined/reduced transcription, and use of digitized, on-line images.

### **The key components supporting IT strategy include:**

- Invision suite of clinical management and results reporting systems.
- Clinical Manager (UMG) suite of ambulatory healthcare management systems.
- Softmed Case Management
- Pharmacy
- Radiology

### **Projects to be Implemented and Projected Timelines and Benefits:**

- The Camtronics Cardiac Cath Lab system was completed in September 2003. Benefits include a 5 year annual average ROI of \$70,000.
- Upgrade of the current Anatomic Pathology system. Timeframe: July 2004. Benefits include a 5 year annual average ROI of \$79,000.

- Siemens Medical Records document scanning, routing, archiving and retrieval system, fully integrating with the Patient Safety System. Timeframe: April 2005. Anticipated benefits include a 5 year annual average ROI of \$490,000.
  - Siemens Radiology Picture Archiving System (PACS). Timeframe: July 2005. Benefits include elimination of lost films and need to transport films; decreasing turnaround time for image review and greater efficiency.
  - Physician Portal and Knowledge Repository – secure e-mail with patients, single sign-on to all clinical systems, etc. Timeframe: April 2005 and October 2007. Benefits improved quality of care through online access to robust databases of evidence-based clinical information; on-line collaboration; greater efficiencies.
  - Emergency Department information system. Timeframe: April 2005. Benefits include improved patient care and patient documentation; increased profitability through increased productivity; support of JCAHO compliance requirements and enhanced patient satisfaction.
  - Patient Portal enabling secure e-mail transactions. Timeframe: January 2006. Benefits include increased patient satisfaction and physician office staff productivity.
  - Wireless connectivity, including wireless laptops affixed to carts. Timeframe: March 2004 in hospital and January 2006 in physician offices. Benefits: Improved quality of care; improved efficiency of physicians, etc.
  - Critical Care Information System enabling continuous online monitoring of patients’ vital signs while in the ICU, the OR and throughout the hospital. Timeframe: July 2007. Benefits include: 5 year annual average ROI of \$718,000.
  - Laboratory Information system. Timeframe: December 2007. Benefits include increased productivity of Lab staff.
- The question was raised as to whether community physicians will be able to tie into our computer system to keep their patient records. Referrals to UConn would then be seamless. We would need to address secure firewalls and security systems.
  - Dr. Deckers noted that he would like to see an accelerated timeline for technology implementation to keep us competitive with other hospitals. We are behind our competitors in the area of hospital technology.
  - Dr. Kozol noted that advances in technology such as PACS will create “quantum leaps” in the quality of our patient care.
  - Dr. Garibaldi noted that in his opinion, advances in technology are more critical to the hospital than construction.

## II. Public Comment

There was no public comment.

## III. Minutes of the Clinical Affairs Subcommittee Meetings

The motion was made and seconded (Palmissano/Samuels) to recommend **that the Clinical Affairs Subcommittee approve the minutes of the Clinical Affairs Subcommittee meetings held on August 4, 2003, August 19, 2003, September 16, 2003, and October 21, 2003. The motion was unanimously adopted.**

#### IV. John Dempsey Hospital Bylaws

The motion was made and seconded (Leonardi/Lawrence) to adopt the proposed changes to the **John Dempsey Hospital Bylaws**.

The motion was made and seconded (Leonardi/Lawrence) to amend the main motion to the **John Dempsey Hospital Bylaws** and to adopt the proposed amendments as follows. The motion was unanimously adopted.

##### Proposed changes:

- Article III, Section 2, Number 7, should read: *Maintaining confidentiality regarding board deliberations and decisions, as allowable and applicable by State law.*
- Article III, Section 6, (c) should read: *Board members shall disclose any business relationship that may exist between Board members and the Hospital. The business relationship shall be evidenced by contract or written agreement drawn up in accordance with existing State statutes.*
- Article IV, Section 2, d, should read: *Submitting a final operating budget for review by the Executive Vice President for Health Affairs, the President of the University, the Board of Directors and the Board of Trustees prior to the beginning of the John Dempsey Hospital fiscal year on July 1.*

The main motion, as amended, was unanimously adopted.

#### V. Core Measures

- Dr. Sanford reported that relative to Quality Indicators, we have improved performance over the last 3 quarters. These include: Acute Myocardial Infarction, Heart Failure and Community Acquired Pneumonia (continuous and rate based measures).
- Multiple Performance Improvement Projects are underway and described in the handout.
- Dr. Deckers noted that our primary focus is to have the highest quality and the safest hospital in the region. In order to accomplish this, we need to change the culture of the institution. We need to be more proactive instead of reactive, which is critical to achieve this standard. We need to get beyond patient satisfaction and get to issues of the highest quality of care, which would include patient safety, no errors, and evidenced based medicine. Examples of where these things have already occurred include Dr. Giles work in regard to surgical site infections. The entire surgical staff is aware of their part in creating this positive change, and they are engaged in the improvement process.

#### VI. Key Performance Indicators

- Ms. McManus noted that the indicators have been reformatted and polished for the Committee based upon input from Ms. Leonardi and Mr. Chudwick.
- Results reported covered several key areas including, Agency RN FTEs, Overtime FTE's, Patient Satisfaction Results, Market Penetration and Volume and Financial Indicators. Brief discussion ensued and questions were addressed.
- Ms. Lattanzio noted that use of agency RN FTEs has decreased significantly in the past year. We are off budget due to hiring delays. We are now recruiting for and will increase the use of our internal CNAs for one-to-one "sitter" purposes.

#### VII. Announcements and Remarks

- An invitation was extended to attend the Safety Fair on November 13<sup>th</sup>.
- JDH has had a very busy October: there were 828 patient discharges; surgical cases were 136 over prior year.

- Gross billings are ahead of September and August.
- UMG volume increased 8.5% in October compared to September in the physician practices.
- There is an Annual Staff Meeting tomorrow.
- The Graduation Commencement date has been changed to May 16 at 1 PM.

**A) Clinical Incentive Plan**

- A revised Clinical Based Compensation Plan, approved by the Clinical Oversight Group which incorporates recommendations from CSC, went into effect in October 1, 2003.
  - The new plan leaves a pool of money for physicians who have a poor payor mix and increases the potential bonus to high earners.
  - There will be no financial impact to the physicians until May 2004, based upon performance from October 2003 through December 2003.
  - We continue to struggle with fringe benefit payouts. Malpractice costs continue to increase.
  - Medicare has proposed a 4.5% decrease in reimbursements to UMG which reduces Medicare payments in UMG by \$670,000 to the clinical practice.
  - Planning is underway to respond to these financial pressures.

**VIII. Hospital Director Performance Review**

- Hospital director evaluation is a requirement of JCAHO. Please complete and submit to the Executive Vice President by the end of November through Elizabeth Whalen.

**IX. Meeting Dates and Future Agenda Items**

- The scheduled Clinical Affairs Subcommittee meetings scheduled for 2004 will take place on February 3, 2004 and May 11, 2004.

**X. Adjournment**

There being no further business, a motion was made and seconded (Kozol/Leonardi) to adjourn the meeting. The motion was unanimously approved at 11:00 a.m.

Respectfully submitted:

Elizabeth Whalen  
Recorder

**UCHC Board of Directors  
Peer Review Subcommittee  
Minutes  
November 11, 2003**

**Attendance**

**Voting Members:** Mr. Chudwick (Chair), Ms. Leonardi, Mr. Samuels, Dr. Garibaldi, Dr. Shafer, Dr. Kozol, Dr. Palmisano

**Staff:** Dr. Deckers, Ms. Lattanzio, Dr. Sanford, Dr. Strongwater

The meeting was called to order by Chairman, Bruce Chudwick at 11:05 a.m.

A motion was made and seconded (Kozol/Leonardi) that the Peer Review Subcommittee go into Executive Session to discuss peer review material and adverse events reports. Adopted unanimously.

**Attendance:** Mr. Chudwick (Chair), Ms. Leonardi, Mr. Samuels, Dr. Garibaldi, Dr. Shafer, Dr. Kozol, Dr. Palmisano, Dr. Deckers, Ms. Lattanzio, Dr. Sanford, Dr. Strongwater

**Executive Session**

- Discussion ensued regarding the following subjects:
  - DPH Consent Agreement Patient Reports.
  - Cases reviewed which were submitted as Adverse Events Reports to DPH.

The Subcommittee returned to open session at 11:25 AM.

A motion was made and seconded (Palmisano/Leonardi) to adjourn at 11:25 AM. Adopted unanimously.

Respectfully submitted,

Elizabeth Whalen  
Recorder