

**MINUTES  
JOINT MEETING  
DURHAM COUNTY HOSPITAL CORPORATION  
BOARD OF TRUSTEES  
and  
DURHAM COUNTY BOARD OF COMMISSIONERS  
FEBRUARY 13, 2006**

**TRUSTEES PRESENT:**

MaryAnn E. Black  
Robert A. Buchanan, Jr.  
Mary T. Champagne, Ph.D.  
Lewis A. Cheek  
Eugene F. Dauchert, Jr., Chair  
Exter G. Gilmore, Jr.  
Kenneth R. Hammond  
Joseph S. Harvard, III  
Penelope A. Keadey  
Evelyn D. Schmidt, M.D.  
Ira Q. Smith, M.D.

**TRUSTEES ABSENT:**

March Branch, III, M.D.  
Cedric M. Bright, M.D..  
Robert E. Price, Jr., M.D.

**DCHC ADVISORY BOARD MEMBER PRESENT**

William J. Fulkerson, Jr., M.D., Vice President – Acute Care Division, DUHS  
Diana R. Voorhees, M.D., Medical Staff President, DRH

**DCHC ADVISORY BOARD MEMBER ABSENT**

None

**COMMISSIONERS PRESENT**

Lewis A. Cheek  
Becky M. Heron  
Michael D. Page  
Ellen W. Reckhow, Chairman

**COMMISSIONERS ABSENT**

Philip R. Cousin, Jr.

**OTHERS PRESENT:**

Ernest J. Baptiste, Chief Operating Officer, DRH  
John L. Crill, Attorney, Wyrick-Robbins-Yates-Ponton, LLP and DCHC Counsel  
G. Gregory Damron, Chief Financial Officer, DRH  
Carolyn P. Titus, Deputy Durham County Manager  
Victor J. Dzau, Chief Executive Officer, DUHS  
Kathleen B. Galbraith, Director, Marketing and Corporate Communications, DRH  
Debra T. Hernandez, CNO, DRH  
Ellen Holliman, Director, The Durham Center  
S. C. Kitchen, Durham County Attorney  
Mary E. Kritsch, Administrative Assistant to the CEO, DRH and Assistant Secretary, DCHC  
Brian Letourneau, Director, Durham County Public Health  
Ann Lore, Government Relations Representative, DUHS  
David P. McQuaid, Chief Executive Officer, DRH  
Gregory Phillips, Reporter, *Herald-Sun*  
Michael M. Ruffin, Durham County Manager

Vonda C. Sessoms, Clerk to the Board of Durham County Commissioners  
Pamela M. Sutton-Wallace, Chief of Staff for the Chancellor for Health Affairs, DUHS  
Gwynn T. Swinson, Vice President-Government & Community Affairs & External Relations,  
DUMC/DUHS  
Paul Vick, Associate Vice President-Government Affairs, DUHS  
Richard J. Walsh, Ph.D., CHRO, DRH  
J. Brian Williams, Post Graduate Administrative Fellow, DRH

### **CALL TO ORDER**

Mr. Dauchert and Mrs. Reckhow respectively called to order a joint luncheon meeting of the Durham County Hospital Corporation (DCHC) Board of Trustees and the Board of Durham County Commissioners at 12:16 p.m. on Monday, February 13, 2006, in the 1<sup>st</sup> Level Classroom of Durham Regional Hospital (DRH).

### **WELCOME & INTRODUCTIONS**

Mr. Dauchert welcomed those in attendance. On behalf of the County, Mrs. Reckhow thanked DCHC for the invitation to get together. Everyone around the table then introduced themselves. Dr. Dzau took the opportunity to also make a special introduction of Ms. Swinson whose first day with the Duke University Health System (DUHS) is this date. Ms. Swinson is a former cabinet secretary of N.C. Governor Mike Easley and the state's chief administrative officer.

### **DURHAM COUNTY HOSPITAL CORPORATION BOARD CHAIR UPDATE**

It was noted that an earlier report was presented last July to the DCHC Board by the then outgoing Board Chair, and a copy of that report was then mailed shortly thereafter to the Commissioners. Mr. Dauchert then proceeded to provide an update to previous report. A lot of activity has transpired in the intervening months from the end of the fiscal year to this meeting. Under the Operating Agreement, the DCHC Board has certain retained responsibilities, and Mr. Dauchert's interim update report covered activities in the same format as presented in previous reports. A copy of this updated report dated February 10, 2006, was placed at the seat of each attendee. A copy is also attached to the original set of these minutes.

Mr. Dauchert provided a brief overview of the document, and noted that the DCHC has a hard working board which has been very involved with DRH and its many accomplishments over the past years.

### **DURHAM REGIONAL HOSPITAL OVERVIEW**

Mr. McQuaid was called upon and provided a DRH specific overview. He first recognized the individual members of senior management and commented upon their commitment to teamwork. He also acknowledged the diligent and effective work of physician leadership at the hospital.

Mr. McQuaid began by explaining and focusing upon the balanced scorecard results. Data and statistics involving the quadrants—clinical quality, service, people and finance were reviewed in detail. Under quality national measures were described, and DRH performance reported. In terms of service, targets and survey figures for inpatient services, the emergency department, ambulatory surgery, and outpatient services. Information related to the 2005 work culture survey and employee turnover statistics were shared. The top drivers of motivation and overall satisfaction were noted. In addition, an synopsis of the 2005 physician satisfaction survey was presented. This included information with regard to overall satisfaction by specialty and category.

Another priority for the hospital is finance. Financial results through Period 6 of FY '06 were summarized, and reasons behind variances were explained. Six month statistics as to actual, budget and prior year involving discharges, surgical procedures , outpatient radiology procedures (MRI and CT) were noted. The following community benefit figures (in millions) were provided:

	<u>FY 2005</u>	<u>FY 2006 YTD</u>	<u>FY2006 Projected</u>
LCHC Cash	2,100	2,100	2,100
LCHC In-Kind	3,066	1,568	3,136
EMS Cash	<u>1,500</u>	<u>1,500</u>	<u>1,500</u>
	<u>6,666</u>	<u>5,168</u>	<u>6,736</u>
Charity Care (at Foregone Charges)	24,260	13,867	27,734

Mr. McQuaid spoke to growth for the hospital and programs for optimizing capacity utilization. In conclusion, time was spend addressing FY2006 capital investment, facility and infrastructure investment, clinical equipment investment, and information system investment. This segment of the agenda then ended with Mr. McQuaid responding to questions. Chairman Reckhow asked that copies of the presentation slides be provided to the Commissioners. Mr. McQuaid stated that copies will be mailed. A copy is also attached to the original set of these minutes.

## **LEGISLATIVE ISSUES AFFECTING HEALTHCARE INSTITUTIONS**

### **Federal**

Mr. Vick then took the floor to speak to federal issues and reviewed 2005 highlights. As for appropriations it is a tight budget year due to the federal deficit, war in Iraq, and disaster recovery costs. Other than for defense and homeland security, there are cuts in most federal FY 2006 appropriations for discretionary programs. The same fiscal environment can be expected for FY 2007.

As for the Budget Agreement there is protection for Medicare hospital and physician payments and the details were reviewed. It also lays the foundation for Pay for Performance in 2007. Such expands the number of quality measures hospitals must report. Hospital that do not report will receive a 2% cut in market basket. Physician P\$P is under consideration. In addition, cuts affect Medicare/Medicaid beneficiaries, and there is increased flexibility for states regarding cost-sharing and benefit packages.

In looking forward to the President's budget proposal for FY 2007 there are: \$36-billion in cuts to Medicare over five years, implementation of a Medicare spending cap, which, if exceeded, would trigger automatic across-the-board cuts to all provider payments, and with it being an election year, most proposals will gain no traction. Finally, MedPAC's recommendations for FY 2007 were noted.

### State

Ms. Lore presented a State level update. In terms of 2005 highlights, CMS accepted North Carolina Medicaid State Plan Amendment for one year (October 2005 through September 2006). This preserves the supplemental Disproportionate Share Hospital (DSH) program. The payment methodology and timing are yet to be determined.

Looking ahead to 2006 issues, Ms. Lore listed as priorities protecting reimbursement (Medicaid, State Employees Health Plan, and other state government contracts); protecting/increasing the safety net for uninsured (Medicaid eligibility, undocumented immigrants, and small group health insurance reform); supporting spending of available discretionary funds (Medicaid county share, prisoner care, mental health reform, and gang violence prevention); and continuing support for tort reform—medical malpractice liability, Certificate of Need (CON), and workforce training and development.

### Local

Ms. Black, a DCHC Trustee as well as Associate Vice-President-Community Relations for the DUHS, then provided brief initial remarks related to the economic impact of healthcare as represented by DRH and DUHS upon Durham County during 2005. The interest and efforts toward moving the City of Medicine to the Community of Health was emphasized. There are many challenges including understanding the unmet needs in our community such as health care access (e.g. emergency room utilization), hypertension projects at both DRH and Duke, mental health and substance abuse contracting as well as private-public collaboration were noted. The purpose of the annual Health Summits is to review key health issues identified by the community and develop strategies to address them collaboratively through partnerships. The dates and focus of this year's NC Health Summit in April were highlighted.

In summary, Ms. Black cited significant collaborative efforts such as the City and County governments' establishment of the "Partnership for a Health Durham" with results based accountability. Also, Dr. Dzau has established a Chancellor's Community Advisory Board. In closing Ms. Black encouraged those present to cultivate already good working relationships by together continuing to identify and built ways to address the healthcare needs of Durham citizens.

## **THE DURHAM CENTER—A SUBSTANCE ABUSE TREATMENT SERVICES BRIEFING**

Chairman Reckhow called upon Ms. Holliman for remarks about The Durham Center and substance abuse treatment services in Durham County. Historically, substance abuse program issues in Durham County have presented numerous challenges to creating an effective and efficient continuum of addiction treatment services. Previously, there were underdeveloped and fragmented core services and residential programs (particularly for adolescents), the inability to track service

delivery, underdeveloped relationships with the self-help community, inadequate numbers of qualified substance abuse professionals and insufficient training opportunities for people who work with individuals with addictions.

One of the priorities for North Carolina State “Mental Health” system reform has been to enhance service delivery to people with all disabilities but particularly to address many of the unmet needs of people who suffer from an addiction illness. As the agency primarily responsible for carrying out the intent of system reform in Durham County, The Durham Center (TDC) has aggressively taken the lead in addressing many of the deficiencies that have previously existed in the area of substance abuse treatment services.

While there have been numerous obstacles, TDC has set the pace for other areas in North Carolina through a continuum of care that has emphasized the expansion of services, increasing the number of substance abuse treatment providers and by creating as many local programs as possible so that people can access treatment without having to leave their own communities. The Durham Center has adopted a best practices approach to service delivery and is already seeing results. There has been a 25% increase in outpatient treatment services this year compared to last year. Also, more citizens are receiving services nearer to their home as admissions to the State-operated addictions treatment facility have consistently declined by 59% during the past year. Innovative programs like the Integrated Dual Disorder Treatment program (treatment for people with both mental illness and substance abuse) are reducing barriers to treatment, accurately identifying people who need services and aligning them with the most appropriate types of services. Substance abuse treatment providers have increased and are working together to provide the most efficient, appropriate and cost effective services that the community has to offer. In addition, local substance abuse professionals are becoming better trained through the variety of training programs offered through TDC.

The Durham Center Access (DCA) emergency crisis program is an example of another new service that has significantly reduced State hospital admissions. Approximately 70% of the people served at DCA have a substance abuse problem. The cost of the DCA is \$2.5 million dollars, of which Durham County Government contributes approximately \$1 million dollars. During the first year of operation, DCA averaged approximately 140 admissions each month with an average utilization of approximately 80% during the last quarter of Fiscal Year 2005.

While TDC has experienced important successes, there are many challenges ahead in developing the resources needed to continue to address the problem of substance abuse in Durham County. With the continued support of Durham City and County Governments, we can build on recent accomplishments and continue the development of new and innovative addiction treatment alternatives to institutionalization and incarceration.

At the Durham County Board of Commissioner’s retreat this past week, the board made addressing the issue of substance abuse a high priority. The goals presented and under consideration for Fiscal Year 2006-07 include the following:

- Initiate a community-wide planning effort – substance abuse is a community issue, not just a

Durham Center or Durham County Government issue. A system of care philosophy shall be used as a basic principle for tackling this problem as there is no one agency or one way to attack this dilemma because it cuts across the entire community.

- Instigate a community-wide media campaign to increase public awareness of existing substance abuse issues and reduce stigma.
- Continue working with the Durham City Police Department to develop a Crisis Intervention Team that will become active next year. In addition to providing officer training, this initiative will include the treatment resources provided by the DCA emergency crisis program that can accommodate individuals who require detoxification services. In order to provide this service, we are planning a new facility to expand this program from 12 to 16 beds.
- A substance abuse treatment facility is also needed that includes a minimum of 20 beds that would provide residential treatment to people from four to six weeks. It is hoped that this capacity could increase to 40 beds within ten years. The initial 20 bed facility could accommodate approximately 720 people each year.

With the continued support of Durham City and County governments, we can continue to build on recent successes and continue the development of new and innovative addiction treatment alternatives to institutionalization and incarceration. In closing, Ms. Holliman briefly reviewed The Durham Centers accomplishments for FY '05.

This segment of the agenda concluded with open dialogue as to the serious challenges faced by all involved and particularly the impacts upon local hospitals.

### **ACCESS TO HEALTHCARE IN DURHAM COUNTY**

Next, Mr. Letourneau was introduced and called upon to speak to the access to healthcare issues in Durham County. First, elements of the problem were presented and sobering statistics were provided. These included the percentage of uninsured and the affect of lack of insurance on access were outlined.

As for existing resources, Lincoln Community Health Center (LCHC) is the site where more than half of the total uninsured is seen. Numbers of patients seen continue to increase while funding from major sources remains flat. Patients have limited access to specialty medical care services and certain diagnostic and treatment procedures. Other resources include LCHC's satellite clinics—Walltown and Lyon Park. In addition there are the Duke outpatient clinics and the Durham County Health Department.

One of the major diseases in our community is diabetes. Mr. Letourneau spoke to the impact of diabetes upon people – both within the diagnosed and undiagnosed individuals. Statistics were reviewed related to individuals at risk due to lifestyle or socioeconomic factors, estimated numbers of people at risk of or with cardiovascular disease, estimated diabetes hospitalizations, and diabetes-related deaths.

Mr. Letourneau then noted strategies in place to address the problem. One is Durham Health Partners' "Specialty Access Project. Another is the Partnership for a Healthy Durham—Access to Care Committee.

In closing, Mr. Letourneau stressed that the community needs a shared vision that will ensure continuity of care for uninsured persons. As a result of this vision, a system should be developed that provides a sustainable cost-effective continuum of care that includes some level of reimbursement to providers to mitigate the financial losses associated with providing care for the uninsured.

Brief discussion ensued.

### **ADJOURNMENT**

Due to time constraints, dialogue had to be brought to a halt. In bringing the meeting to closure, Mr. Dauchert and Commissioner Reckhow again thanked everyone for their time, interest and participation. It was suggested that consideration be given to planning a longer session next year for the two boards' annual joint meeting. It was also suggested that it may now be time to together initiate serious community conversation about the hard healthcare issues now facing Durham and the increasingly tough concerns which are ahead.

There being no further business to come before the joint meeting at this moment, the meeting was adjourned at 12:43 p.m.

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Lewis A. Cheek, Secretary  
Durham County Hospital Corporation

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Vonda C. Sessoms, Clerk to the Board  
Durham County Commissioners