✓Included in the PDF posted March 30, 2012 (F)

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, April 2, 2012

6:00 p.m. (Closed) | 7:30 p.m. (Open)

Location: Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue, Alameda, CA 94501
Office of the Clerk: (510) 814-4001

Members of the public who wish to comment on agenda items will be given an opportunity before or during the consideration of each agenda item. Those wishing to comment must complete a speaker card indicating the agenda item that they wish to address and present to the District Clerk. This will ensure your opportunity to speak. Please make your comments clear and concise, limiting your remarks to no more than three (3) minutes.

I. Call to Order (6:00 p.m. – 2 East Board Room) — Jordan Battani

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes

1. March 5, 2012 (Regular)

C. Medical Executive Committee Report and Approval of Credentialing Recommendations — H & S Code Sec. 32155

D. Board Quality Committee Report (BQC) — H & S Code Sec. 32155

E. Discussion of Pooled Insurance Claims — Gov't Code Sec. 54956.95

F. Consultation with Legal Counsel Regarding Pending and Threatened Litigation — Gov't Code Sec. 54956.9(a)

G. Instructions to Bargaining Representatives Regarding Salaries, Fringe Benefits and Working Conditions — Gov't Code Sec. 54957.6

H. Discussion of Report Involving Trade Secrets — H & S Code Sec. 32106

1. Discussion of Hospital Trade Secrets applicable to long-term care expansion.

   No action will be taken.

   Estimated Date of Public Disclosure: April 2012

2. Discussion of Hospital Trade Secrets applicable to healthcare organization affiliations.

   No action will be taken.

   Estimated Date of Public Disclosure: Not known at this time.

I. Adjourn into Open Session

V. Reconvene to Public Session (Expected to start at 7:30 p.m. – Dal Cielo Conference Room)

A. Announcements from Closed Session — Jordan Battani

VI. General Public Comment

VII. Regular Agenda

A. Special Presentation

✔ 1) Annual Auxiliary Report to the Board — Linda Lingelser, Auxiliary President

[enclosure] (PAGES 4-8)

B. Consent Agenda — **ACTION ITEMS**

✔ 1) Approval of March 5, 2012 Regular Meeting Minutes

[enclosure] (PAGES 9-16)

✔ 2) Approval of Annual Appointment of Committee Membership to the Community Relations and Outreach Committee

[enclosure] (PAGES 17-19)

✔ 3) Approval of Amendments to the Medical Staff Rules and Regulations, Article I-A, Section B.1 and Article 16, Section H

[enclosure] (PAGES 20-21)

✔ 4) Ratification of Appointment of District Board Member Elliott Gorelick to ACHD 2012-2013 Education Committee

[enclosure] (PAGES 22-29)

C. Action Items

✔ 1) Acceptance of February 2012 Unaudited Financial Statements and March 28, 2012 Finance and Management Committee Report — J. Michael McCormick

[enclosure] (PAGES 30-50)

✔ 2) Approval to Establish of a Comprehensive Orthopedic Program at Alameda Hospital and Approval to Enter into Professional Services Agreements with Two Orthopedic Surgeons — Deborah Stebbins, Mary Bond, RN, Tony Corica

[enclosure] (PAGES 51-63)

✔ 3) Approval of Proposed FY 2012 Executive Performance Metrics and Incentive Compensation Plan — Deborah E. Stebbins

[enclosure] (PAGES 64-67)

C. District Board President Report INFORMATIONAL — Jordan Battani

✓Included in the PDF posted March 30 2012 (F)

D. Chief Executive Officer Report **INFORMATIONAL** — Deborah E. Stebbins

✔ 1) FY 2012 Goals and Objectives 2nd Quarter Update

[enclosure] (PAGES 68-77)

✔ 2) Update on Management of Rehabilitation Services

[enclosure] (PAGES 78-80)

✔ 3) Monthly CEO Report

[enclosure] (PAGES 81-92)

- Reports and Updates on Subacute Expansion, Wound Care, Waters Edge, BLS & Alameda Fire Department, IGT, Workers Compensation Rebate, AB97 Injunction, FY2013 Budget

4) Monthly Quality Metrics

a) Stroke Program Data (Michaele Baxter, RN) [to be distributed]

G. Medical Staff President Report **INFORMATIONAL** — James Yeh, DO

F. Community Relations and Outreach Committee Report **INFORMATIONAL** — Stewart Chen, DC

1) March 27, 2012 Committee Meeting

VIII. General Public Comments

IX. Board Comments

X. Adjournment

ALAMEDA HOSPITAL AUXILIARY REPORT TO:

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD

JULY 1, 2011 TO JUNE 30, 2012
(As of April 2, 2012)

PREPARED BY:

LINDA LINGELSER
ALAMEDA HOSPITAL AUXILIARY PRESIDENT

It was an honor to serve as Alameda Hospital Auxiliary President again this year, as well as serving as Chair of the Floor Hostess Service. Although I will be moving out of the area in June, I hope I have made a difference and helped to move the Auxiliary in a positive direction. The following report details the Auxiliary's activities and accomplishments for the 2011-12 term through March of 2012 (actual end of term 6/30/12).

Membership

Currently for 2011-2012 the Auxiliary has 85 Active Members, which includes 16 Life Members, and 2 Honorary Members. Thus far this year, Tommie Anderson, Vice-President, has received 64 applications. Interviews were conducted with 33 candidates; 27 have been placed and 6 are pending. The remaining 31 individuals either had scheduling issues, found jobs or decided not to pursue the opportunity.

I have placed several articles regarding the Auxiliary and its' events in the Alameda Sun, Journal, and Patch (on-line), as well as meeting announcements, for purposes of promoting the volunteer opportunity and recognition of the Hospital.

Currently, we are conducting an Auxiliary Membership Drive to increase the number of volunteers. Additional membership is needed to provide coverage for existing services, as well as the new TeleChat and future coverage at Waters Edge and a Junior Volunteer Program. A generous "guardian angel" has offered to pay this year's membership dues for any new volunteer recruited by a current volunteer through June of this year.

Services

The Auxiliary is made up of twelve services:	Chair:
Continuous Improvement	Betty Sanderson
Continuum of Care	Alice Martin RN
Emergency Care	Pam Ferrero
Floor Hostess/Host	Linda Lingelser
Gift Shop	Lily Eucker
Lap Robes/Pinkies	Jovita Herrera
Hospital Services	Barbara Rosenberg
Lobby Hostess/Host	Terry Veasy

(Continuation)

Office Services	Marlene Sahr
Physical Therapy	Kathleen Jensen
South Shore Skilled Nursing	Barbara Rosenberg
TeleChat*	Barbara Rosenberg

*New Services added this year:

- TeleChat - Volunteer of the day makes calls to seniors or individuals with health issues that live alone to determine that they are ok. If the individual is not reached, one of their alternative contacts will be alerted.
- Services for the Wounds Care Center, Water's Edge and Junior Volunteer Service are pending.

For the first three quarters of our year (July 1, 2011 through March 2012), Alameda Hospital Auxiliary Members collectively donated over 12,000 hours of service to Alameda Hospital.

During the year, the Pinkies, other Active Auxiliary members, and Retired Auxiliary members delivered: 82 lap robes (regular and Veteran), which were not only donated to patients in the hospital but to South Shore Convalescent as well as to the Gift shop to sell. In addition, 235 Stuffies (handmade stuffed animals and pillows, the majority to children) were delivered to ER, lab, lobby, and x-ray. Halloween bags and Christmas stockings were presented to ER. Also, the Infusion Center was presented with 14 shawls and chemo-caps for patients.

Financial

A donation of $40,000 is being made by the Auxiliary to the hospital which will purchase an EMG Testing Machine for Neurology, as well as additional equipment TBD.

Subsequent to the donation shown above, we have a total of $14, 495.77 in the General Auxiliary Account and $11,657.12 in the Gift Shop Account. Money in the General Account is comprised of dues, refundable uniform deposits, earnings from fundraising events, vending machines, etc. and funds transferred from the Gift Shop account. Money in the Gift Shop Account is comprised of sales. The annual dues for the Auxiliary have remained the

same: a one time fee of $100 for Life Members; $6/year for Active Members; and $10/year for Associate Members.
The Gift Shop organized 2 coupon book sales and 2 fine jewelry sales. This past year, I arranged for three fundraisers: Carewear Scrubs (1 day) – September 2011, Masquerade (1 day) – December 2011, and AJ Floral Farms (2 days) – March 12 and 13, 2012. A future fundraising event has been scheduled for December 2012, which will be a two day Masquerade $5 Sale.

Fundraising Events:	Earnings
Masquerade $5 Sale	$1,600.00
AJ Floral Farms Orchid Sale	937.80
Carewear Scrubs	176.00
Coupon Book Sales	417.67
Dazzle Jewelry Sales	108.00
	$3,239.47

Other Income:	
Uniform Deposits	725.00
Uniform Deposit Refunds	(290.00)
Donations/Gifts/EBC Win	300.00
Vending Machines	894.90
Remembrance	520.00
Dues	278.00
Other/Misc./Investment	1,282.20
Bridge/Dominoes	420.00
Interest (Gift Shop)	16.83
Interest	24.53
	$4,171.46

Total	$7,410.93

In addition to the previous uniform options, a royal blue polo shirt option has been added, which includes the Alameda Hospital logo and VOLUNTEER. This option provides a more modern uniform alternative and is less expensive than the current smocks. We continue to have a $50.00 refundable uniform deposit for members less than 50 years of age. The uniform deposit is refunded upon resignation with the return of the uniform and ID badge.

Additional Activities

The Auxiliary gave 8 boxes of donated items to Operation Mom for individual gift boxes sent to active duty troops, provided $500 to cover mailing costs; and collected product coupons for families of troops.

Additional special projects that the Auxiliary participated in were:

- Alameda Hospital Foundation mailings
- Annual Health Faire
- Fourth of July Parade
- Speaking and tour requests

Scheduled General Meetings:

- Hours Award Luncheon - October
- Installation Luncheon – June

Thank You

I would like to thank our liaisons: Tony Corica - 2011 and Dennis Eloe - 2012 for their on-going counsel and assistance to the Auxiliary. Thank you also to the members of my Executive Council and Board for their service over the past two years. Special appreciation is extended to Tommie Anderson, Vice-President, Floor Hostess and Uniform Chair for her friendship, support, on-going interviews and orientation of new volunteers.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Monday, March 5, 2012 Regular Meeting

Board Members Present	Management Present	Legal Counsel Present	Guests
Jordan Battani Stewart Chen, DC Robert Deutsch, MD Elliott Gorelick J. Michael McCormick	Deborah E. Stebbins Kerry J. Easthope Bob Anderson	Thomas Driscoll, Esq.	N/A
		Medical Staff Present	Excused
		Jim Yeh, DO	N/A
Submitted by: Erica Ponce, Administrative Secretary			

Topic		Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:05 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present.	
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 6:06 p.m. Director Gorelick made an objection to the Closed Session Agenda, Public Performance Evaluation Title: Chief Executive Officer and Senior Executives, indicating that discussion regarding compensation should occur in open session and not in Closed Session. Objection was noted.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 7:35 p.m.	

A. Announcements From Closed Session

Director Battani stated that the Minutes were reviewed and approved from the February 6, 2012 meeting. The Board Quality Committee Report for December 2011 was reviewed and accepted as presented. The Board approved the Credentialing Recommendations of the Medical Staff as outlined below. No other action was taken.

Initial Appointments – Medical Staff

Topic	Discussion		Action / Follow-Up	
	Name	Specialty	Affiliation	
	• Richard Brenner, MD	Radiology	Bay Imaging	
	• Stephen Cady, MD	Emergency Medicine	CEP	
	• Leslie Graham, MD	Emergency Medicine	CEP	
	• Hana Oswari-Burke, MD	Family Practice	Alliance Medical Group	
	• Lee Shratter, MD	Radiology	Bay Imaging	
Reappointments – Medical Staff				
	Name	Specialty	Staff Status	Appointment Period
	• David Chang, MD	Orthopedic Surgery	Courtesy	04/01/12 – 03/31/14
	• Lawrence Gettler, MD	Emergency Medicine	Courtesy	04/01/12 – 03/31/14
	• Mehra Hosseini, MD	Gastroenterology	Courtesy	04/01/12 – 03/31/14
	• Alka Sharma, MD	Internal Medicine /Nephrology	Active	04/01/12 – 03/31/14
	• Jeffrey Stern, MD	Gynecologic Oncology	Courtesy	04/01/12 – 03/31/14
	• Mark Tu, MD	Teleradiology	Courtesy	04/01/12 – 03/31/14
	• Allen Verne, MD	Ophthalmology	Courtesy	04/01/12 – 03/31/14
	• Vivian Wing, MD	Teleradiology	Courtesy	04/01/12 – 03/31/14
	• Kam Y. Wong, DPM	Podiatry	Courtesy	04/01/12 – 03/31/14
	• David Woo, MD	Teleradiology	Courtesy	04/01/12 – 03/31/14
	• Robyn Young, MD	Neurology	Active	04/01/12 – 03/31/14

Topic	Discussion	Action / Follow-Up
Reappointment - Allied Health Professional		
There were no applications submitted for reappointment to Allied Professional status.		
Staff Status Change		
• Karen Herzog, MD Advanced to the Honorary Staff		
Resignations		

	Name	Specialty		
	• Premjit Chahal, MD	Gastroenterology		
	• Lindsay Clark, MD	Internal Medicine / Hospitalist		
	• Darlene Fields, CRNA	Nurse Anesthetist		
	• Suzanne Johnson, DO	Emergency Medicine		
	• Jean Kusz, CRNA	Nurse Anesthetist		

VI.	Regular Agenda	
	A. Consent Agenda	
	1) Acceptance of February 6, 2012 Regular Meeting Minutes	Director Deutsch made a motion to approve the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried.
	2) Approval of Administrative Policy No. 45 – Smoke Free Environment	
	B. Action Items	
	1) Acceptance of January 2012 Unaudited Financial Statements and February 29, 2012 Finance and Management Committee Report Director McCormick reviewed his notes from the February 29th committee meeting	Director Deutsch made a motion to accept the January 2012 Unaudited Financial Statements and Finance and management Committee Report as

Topic	Discussion	Action / Follow-Up
	noting the following: The January 2012 Unaudited Financial Statements were reviewed for discussion and analysis at the Finance and Management committee meeting of February 29, 2012. Higher activity, coupled with items making a positive impact made it possible for the District to exceed budget by $631,000. A negative $206,000 was budgeted and a positive $425,000 was realized. Gross revenues were above budget for the first time this year with inpatient revenue up 1.6% and outpatient revenue up 1.4%. Inpatient admissions were above budget by 10.5%. Emergency revenues were above budget due to a change back to a former charge methodology. Case Mix Index rose (due to higher surgical volumes and more acute care cases) to 1.41% from last month's 1.28%. Collection ratio also rose over two points (24.7 to 22.3) due largely to adjustments made to reverse the AB97 accrual. With increased activity come increased expenses, which were .8% over budget. The Current Ratio (current assets divided by short term liabilities) is due to improve but is currently at .99. At the end of January 2012 the District's YTD loss was $886,000. Director McCormick noted that though always risky to make overly-simplified projections, this time next year with the addition of both Water's Edge and the Wound Care Center in a maturing operational mode, it is reasonable that the revenue generation of these two new initiatives will offset today's YTD budget loss to a financial position closer to January 2011's almost breakeven point. Director Gorelick had questions relating to the AB97 reversal. He inquired as to whether additional communication from the State had been received. Ms. Stebbins stated that Management has received communication from a couple of agencies that the State may not collect the monies retroactively. The Hospital has also been notified of a retroactive rate-increase in our cost-based reimbursement for DP SNF was raised to $416.95 per day, up from $385.74. Director Gorelick commented on the 2011 repayment to Medi-cal of $600,000 Ms. Stebbins replied that the case he referred to was part of the budget process and was a different situation than AB97. Director Gorelick added that the appeal still stands. President Battani said that she read the same information which Ms. Stebbins referred to and said that it is being reported in such a way in multiple sources. In regards to the other case which Director Gorelick referred to, President Battani stated that the retroactive billing was not a surprise to the Hospital. The fact that the State has gone back and put an increase in place with DP SNF reimbursement is a signal. She stated that she is in agreement with Management that it is a positive signal.	presented. Director Chen seconded the motion. The motion carried.

Topic	Discussion	Action / Follow-Up
	2) Approval of Resolution No. 2012-2J – *"Amending Resolution No. 2002-10X of the Board of Directors of the City of Alameda Health Care District Relating to Employee Relations for the City of Alameda Health Care District"* relating to the addition of Waters Edge Employee Association Bargaining Unit	Director Chen made a motion to approve Resolution No. 2012-2J as presented. Director McCormick seconded the motion. The motion carried.
	3) Approval of the Waters Edge Employee Association Memorandum of Understanding / Handbook	Director Deutsch made a motion to approve the Waters Edge Employee Association Memorandum of Understanding / Handbook as presented. Director McCormick seconded the motion. The motion carried.
	In reference to above Action Items B2 and B3, there was a combined presentation and discussion. Phyllis Weiss, Director of Human Resources, summarized the information included in the Board Packet (refer to pages 43-64). Director Chen inquired as to whether or not the information therein is consistent with the associations we currently work with. Ms. Weiss replied that it is generally the same with minor differences in implementation. After a brief discussion, both Action Items were individually voted on and approved.	
C.	Board President Report 1) Special Board Meeting Scheduling for March – April 2012 President Battani discussed the scheduling of a Special Board Meeting. The date of March 31, 2012 was agreed upon by all Board Members. Management will provide details as they become available. President Battani briefly spoke about Alameda Hospital's Annual Tenure event which took place on February 28, 2012. She praised the Human Resource Department for putting together a wonderful event.	
D.	Chief Executive Officer Report 1) Monthly CEO Report Alameda Hospital received a gift from the Alameda Hospital Auxiliary in the amount of $40,000. $16,000 of the donation was used to purchase an electromyography machine (EMG) to be used for diagnostics. Ms. Stebbins called attention to her written report included in the Board Packet and asked if there were any questions regarding the materials. Director McCormick asked for an update regarding the South Shore facility. Ms. Stebbins stated that	No action taken.

Topic	Discussion	Action / Follow-Up
	Richard Espinoza has been working diligently emphasizing the monitoring of referrals and maximizing discharges from the hospital. 2) Bank of Alameda Line of Credit and Wound Care Loan Update Management has worked with the Bank of Alameda to finalize the Wound Care Project Loan for approximately $1 million. 3) Monthly Quality Metrics A report on Medication Errors was presented by Lee Headley, PharmD, Pharmacy Director. Information was handed out and is included in the Board Packet.	
E.	Operations and Facilities Report 1) SB90 Seismic Extension Application and Presentation Kerry Easthope, Associate Administrator, gave a presentation regarding SB90, the notes for which are included in the Board Packet. There were questions regarding the details of which building(s) will be affected and what the budgeted cost will be for the application, architects, and repairs needed. Mr. Easthope reported that each application has a $250 fee with an additional cost of the architects' time to review the applications. He estimates the cost of necessary repairs to be $11-$12 million, and added that until the workers have actually gained access to the interior of the walls, the cost can be somewhat unpredictable. 2) Approach to Assessing Management Options and Opportunities of Rehab Services at Alameda Hospital There were two speaker cards presented and both requested to speak regarding the Rehab Services portion of the meeting. President Battani introduced the first speaker, Denise Bartalini. Ms. Bartalini is a Physical Therapy Assistant in the Alameda Hospital Rehab Department. She spoke on her concern regarding the cost of outsourcing for the management of this department. President Battani called the second speaker, Karen Moerwald, to speak She spoke regarding her concern about funding and that the department would like to be involved in decisions. Mr. Easthope began by stating he held a meeting with the Rehab Staff and there was a consensus for the need for a better management structure. Rehab is the only department of Alameda Hospital without a dedicated manager. The Hospital has a unique demand on rehab care due to patient needs within the subacute and acute units, skilled nursing facility, and outpatient care. A manager is needed who understands each area, can train accordingly, and can guide the department with	No action taken.

Topic	Discussion	Action / Follow-Up
	laws, reimbursements, and administration. Director Chen added that while visiting the Rehab Department about a year ago he realized that the equipment was outdated and the space needs an upgrade. Mr. Easthope emphasized the need to utilize the time, space and appointments efficiently in order to maximize current resources. Director Gorelick inquired as to whether there is structure being considered which will increase revenue without investing additional finances. President Battani shared a concern that if a new position is being created at Alameda Hospital, she is interested in learning how it will be paid for. She asked for a financial analysis concerning such a position. Dr. Deutsch asked if there has been consideration to outsource the set-up of the Rehab Department and then have it managed in-house. Director McCormick suggested that the financial information for the cost be brought to the Finance and Management Committee on March 28, 2012. President Battani added that the decision will be based on the business case; determining cost versus upside potential.	
F.	Medical Staff President Report James Yeh, DO, Medical Staff President, stated that the CME programs for March are slated for March 13 and March 27 with the following speakers presenting: • Edie Zusman, MD – Heads up: Evaluating and Treating Concussions • Jeffrey West, MD – Living Well with Cardiovascular Disease – Hype, Hope, or Here? The Medical Staff is in the process of updating their rules and regulations to reflect current practice for acute care patients as well as for long-term care patients. The proposed revisions will be submitted to the Board over the next few months. The bylaws are also being reviewed	No action taken.
G.	Community Relations and Outreach Committee Report	
	Director Chen reported on the Community Relations and Outreach Committee noting the following: The Community Relations Committee did not meet in February but is scheduled to meet on March 27, 2012. Alameda Hospital offered the “3B’s Assessment” (blood pressure, blood glucose, body mass index) at the Islamic Center of Alameda on March 2, 2012. The “Let’s Move Alameda” taskforce is developing a summer program that will focus not only on exercise, but will include a nutrition component. Alameda Hospital’s Asian Health Outreach program will participate in the Harbor Bay Isle Spring Festival on Saturday, March 10, 2012.	No action taken.

Topic	Discussion	Action / Follow-Up
	The “Free Stroke Risk Assessment” program is being offered on Friday, March 30, 2012 from 8:30 – 11:30 a.m. at the Hospital. Alameda Hospital will be launching its FaceBook social media presence this week.	
VII.	**General Public Comments** There were no additional comments.	
VIII.	**Board Comments** There were no comments.	
IX.	**Adjournment**	Being no further business, the meeting was adjourned at 9:13 p.m.

Attest:

Jordan Battani President	Elliott Gorelick Secretary

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: March 28, 2012

For: April 2, 2012 District Board Meeting

To: Community Relations and Outreach Committee

From: Stewart Chen, DO, Chair - Community Relations and Outreach Committee
Terrie Kurrasch, Co-Chair - Community Relations and Outreach Committee

Subject: Approval of Membership to the Community Relations and Outreach Committee for CY 2012

RECOMMENDATION:

The Community Relations and Outreach Committee recommends the following slate of committee members be reappointed for calendar year 2012.

	Voting Member
Medical Staff	
Jim Yeh, DO	✔
James Kong, MD	✔
Community at Large	
Terrie Kurrasch, Co-Chair	✔
Jeptha Boone, MD	✔
Hien Doan	✔
Shubha Fanse	✔
Jim Franz	✔
Mike McMahon	✔
Monica Valerio	✔
Bill Withrow	✔
Tracy Zollinger, LaC	✔

BACKGROUND:

The Board of Directors, on January 9, 2012, reappointed Stewart Chen, DO as Chair of this committee and Jordan Battani as the second voting member from the Board of Directors. Per the approved committee structure, committee membership shall be appointed annually.

The following structure has been approved by this committee as well as the District Board of Directors. Similar committee structures have been developed for other two board designated committees (Finance and Management Committee and Board Quality Committee).

1. Community Relations Committee:

    a. Primary Purpose: The primary purpose of the Community Relations Committee is to develop a community engagement and outreach plan that supports the hospital's strategic plan and annual goals. The Committee advises the board on strategies and programs to enhance health care services to the community, increase the district's (hospital's) market share, effectively position the hospital for success based on information flow with the community and elected officials and support the fund-raising objectives of the Alameda Hospital Foundation.

    b. Committee Composition and Voting Rights: The committee shall be comprised of the following members:

        i. At least two members of the City of Alameda Health Care District Board of Directors all of whom shall be voting members of the committee. One of these members also shall be appointed to serve as the committee co-chair. The other co-chair will be an at large member from the community who will be elected each year.

        ii. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-noting member, unless the President is serving as a voting member of the committee.

        iii. Up to three members of the Alameda Hospital Medical Staff all of whom shall be voting members of the committee.

        iv. Up to eleven at large members chosen for expertise needed by the district all of whom shall be voting members of the committee. At least one member at large shall also be a member of the Alameda Hospital Foundation Board.

        v. The City of Alameda Health Care District Chief Executive Officer, and other hospital management as delegated, who shall not be voting members of the committee.

The Executive Director of the Alameda Hospital Foundation and the Director of Community Relations shall serve as staff to the Committee and collaborate with the Committee co-chairs on the preparation of agenda.

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: Committee shall meet monthly.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: March 28, 2012

For: April 2, 2012 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: James Yeh, DO
Chairman, Medical Executive Committee

Subject: Proposed Revisions to Medical Staff Rules and Regulations

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The Medical Executive Committee respectfully requests your consideration in approving the following proposed amendment to the Medical Staff Rules and Regulations:

1. Article I-A, Section B.1: This revision adds nurse practitioner to the approved categories of allied health practitioners who will be eligible to apply for privileges at Alameda Hospital.

2. Article 16, Section H: This proposed revision addresses the requirements for completing medical record entries for long-term care patients, e.g., patients in the SNF, Water's Edge, etc. There are different requirements for long-term care vs acute care patients.

A copy of the above proposed rules is attached.

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ALAMEDA HOSPITAL
MEDICAL STAFF RULES & REGULATIONS

PROPOSED REVISIONS

Article 1-A: ALLIED HEALTH PROFESSIONAL STATUS

Section B.1. – The proposed revision adds nurse practitioner to the approved categories of allied health practitioners who shall be eligible to exercise privileges at Alameda Hospital.

Section B: Categories of Allied Health Professionals

1. Approved Categories

   a. Physician Assistant
   b. RN First Assistant
   c. Clinical Psychologist
   d. Certified Registered Nurse Anesthetist
   e. Nurse Practitioner

Article 16: MEDICAL RECORDS

Section H – New: Addresses requirements for completing medical record entries for long-term care patients, e.g., patients in the SNF, Waters Edge, etc.

Section H. Completion of Medical Record Entries for Long-Term Care Patients.

All medical record entries for patients in long term and SNF care shall be subject to and comply with the regulations set forth in Title 22.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: March 28, 2012

For: April 2, 2012 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: Kristen Thorson, District Clerk

Subject: Ratification of Appointment of District Board Member Elliott Gorelick to ACHD 2012-2013 Education Committee

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ACTION:

Ratification of Appointment of District Board Member Elliott Gorelick to the Association of California Health Care Districts (ACHD) 2012-2013 Education Committee.

BACKGROUND:

At the January 9, 2012, District Board Meeting, the Board of Directors approved that District Board Members, if interested, could represent the City of Alameda Health Care District and participate on a standing committee of the Association of California Health Care Districts (ACHD). If selected and appointed by ACHD, the District Board would ratify the appointment at a future Board meeting.

Director Gorelick submitted a Committee and Volunteer Interest Form and has such been appointed to ACHD's Education Committee.

A·C·H·D
ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Alameda Hospital
ADMINISTRATION
MAR 19 2012

March 16, 2012

Elliott Gorelick
City of Alameda Health Care District
2070 Clinton Avenue
Alameda, CA 94501

RE: Appointment to ACHD 2012-2013 Education Committee

Dear Elliott,

We are pleased to confirm your appointment to the Education Committee by the Board of Directors for the 2012-2013 term. We believe that by your involvement in our organization you make ACHD more effective for all our members. We greatly appreciate your willingness to assume Committee responsibilities and we look forward to working with you.

As a result of our Board of Directors Retreat in 2011, we changed our Committee structure and expanded the Committees sphere of influence. We are confident that our new orientation will improve our organization and expand its' impact for both Hospital and Community Based Districts.

Enclosed are Board and Committee Rosters, a Board and Committee Meeting Calendar, and a Committee Commitment Form. Also enclosed is a copy of Policy No. 3 of the ACHD Board of Directors Policies and Procedures; this policy addresses the compensation of committee members for attending committee meetings.

On behalf of the Board we welcome you and look forward to getting to know you. We hope you can join us at Legislative Day, March 26th and 27th as well at the Annual Meeting on May 9th through May 11th.

Please contact Leyla Taber at leylat@achd.org or (800) 424-2243, or any Board member, if you have any questions or need additional information.

Sincerely,

Kathleen M. Kane

Kathleen M. Kane
Board Chair

Sincerely,

David McGhee
Chief Executive Officer

KK:DM/lt

Enclosures

2012 - 2013 Education Committee

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2012 - 2013 Education Committee

EX-OFFICIO

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ACHD/ALPHA FUND
2012 BOARD & COMMITTEE MEETING CALENDAR

MEETING	DAY	DATE	START	END	LOCATION	TYPE
ALPHA Participants' Meeting ALPHA Council Meeting	Thursday Friday	2/23/12 2/24/12	1:30 pm 8:00 am	4:30 pm 1:00 pm	Newport Beach	Meeting
Board of Directors	Friday	3/2/12	10:00 am	12:00 pm		Call
Finance Committee	Tuesday	3/6/12	2:00 pm	3:00 pm		Call
Governance Committee	Wednesday	3/14/12	10:00 am	12:00 pm		Call
Education Committee	Friday	3/16/12	10:00 am	12:00 pm		Call
Advocacy Committee	Monday	3/26/12	8:00 am	10:00 am	Sacramento	Meeting
Legislative Day Legislative Reception & Dinner	Monday	3/26/12	10:00 am 5:30 pm	5:00 pm 9:00 pm	Sacramento	Meeting
Legislative Day Capitol Visits	Tuesday	3/27/12	9:00 am	3:00 pm	Sacramento	Meeting
Board of Directors Reception & Dinner	Tuesday	3/27/12	6:00 pm	9:00 pm	Sacramento	Event
Board of Directors Meeting	Wednesday	3/28/12	8:00 am	12:00 pm	Sacramento	Meeting
Board of Directors - Tentative (Approval of Any Action from Governance Committee)	Wednesday	4/4/12	10:00 am	12:00 pm		Call
Education Committee	Friday	4/6/12	10:00 am	12:00 pm		Call
ALPHA Council	Thursday	4/12/12	11:00 am	2:00 pm	Granite Bay	Meeting
Board of Directors	Wednesday	5/9/12	8:00 am	10:00 am	Incline Village	Meeting
Advocacy Committee	Thursday	5/10/12	8:00 am	9:00 am	Incline Village	Meeting
Annual Meeting	Wed-Fri	5/9-11/12	All Day	All Day	Incline Village	Meeting

* Dates, time and location subject to change

Updated 3/16/2012

ACHD/ALPHA FUND
2012 BOARD & COMMITTEE MEETING CALENDAR

MEETING	DAY	DATE	START	END	LOCATION	TYPE
ALPHA University	Tuesday Wednesday	6/12-13/12	All Day	All Day	Sacramento	Meeting
ALPHA Council (Tentative)	Wednesday	6/19/12	10:00 am	11:00 am		Call
Finance Committee	Thursday	6/28/12	2:00 pm	5:00 pm	Burbank	Meeting
Board of Directors	Friday	6/29/12	8:00 am	12:00 pm	Burbank	Meeting
Education Committee	Friday	7/13/12	10:00 am	12:00 pm		Call
Advocacy Committee	Friday	7/20/12	10:00 am	12:00 pm		Call
Advocacy Committee	Wednesday	9/19/12	10:00 am	12:00 pm		Call
ALPHA Council	Friday	11/16/12	8:00 am	12:00 pm	Granite Bay	Meeting
Board and Committee Retreat ▪ Advocacy Committee ▪ Education Committee ▪ Finance Committee ▪ Board Day 1 ▪ Board Day 2	Wed-Fri Wed Wed Thu Thu Fri	12/12-14/12	 9:00 am 1:30 pm 9:00 am 2:00 pm 9:00 am	 11:30 am 4:30 pm 12:00 pm 5:00 pm 1:00 pm	TBD	Meeting

* Dates, time and location subject to change

Updated 3/16/2012

ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS, INC.

BOARD OF DIRECTORS POLICIES AND PROCEDURES

Effective March 2002

POLICY NO. 3

COMPENSATION OF DIRECTORS

For purposes of this Policy No. 3, the term "member" shall mean any member of the ACHD Board of Directors and/or a member of any ACHD Committee; the term "meeting" shall mean meetings of the ACHD Board of Directors and of any ACHD Committees.

I. Attendance at ACHD Board and Committee Meetings:

A. Stipends. Each member shall be eligible for a stipend of Two Hundred Dollars ($200) for personal attendance at a meeting, or One Hundred Dollars ($100) for participation at a meeting by conference call. Each member shall be eligible for a stipend of no more than Two Hundred Dollars ($200) when participating – by personal appearance or by conference call – at more than one (1) meeting during any one (1) calendar day.

B. Expenses. Each member shall be entitled to reimbursement of all reasonable out-of-pocket expenses in connection with attendance at a meeting as set forth herein, except expenses for meetings held in conjunction with the Annual Meeting shall be reimbursed as set forth in the subsection on attendance at the Annual Meeting. "Out-of-pocket" expenses shall be defined as, and include the following:

i. Transportation expenses based on the most practical transportation available, portal-to-portal, including

   a. Airfare plus necessary ground transportation; and/or

   b. Personal vehicle mileage based on the current per mile reimbursement rate allowed by the Internal Revenue Service.

ii. Lodging reimbursement when travel time one way requires more than two (2) hours or on an occasion when the meeting lasts more than eight (8) hours or lasts beyond 6:00 p.m. Should lodging be desired at a facility other than where the meeting is held, or if a member desires upgraded or special accommodations or other individual arrangements, the reimbursable rate shall be the actual cost of the lodging, but not greater than the regular ACHD room rate charged by the facility where the meeting is being held.

iii. Meals up to a maximum of Sixty Dollars ($60) per day.

iv. Parking, bridge tolls and tips.

II. Attendance at the ACHD Annual Meeting.

A. Registration Fee. The Annual Meeting registration fees for each member shall be borne by that member's Health Care District.

B. Stipend. Each member shall be eligible for a meeting stipend for attendance at the ACHD Board of Directors meeting held during the ACHD Annual Meeting, in the amount stated in section 1 (a) of this Policy.

C. Expenses. Each member shall be eligible for reimbursement for those out-of-pocket expenses, including travel expenses, associated with attending a meeting scheduled in conjunction with the ACHD Annual Meeting, as provided in Section 1, above. However, reimbursement for lodging shall be limited to only one (1) night's stay (the evening of the scheduled meeting) at the facility where the Annual Meeting is held. All meals, parking, tips and other expensed individually incurred while attending the Annual Meeting shall be borne by each member's Health Care District, unless otherwise approved by the Board.

III. Governance Education Workshops. Unless the Board approves a different reimbursement policy for attendance of members at a particular workshop, the out-of-pocket expenses of each member who attends the Association's governance education workshops shall be borne by the member's Health Care District.

IV. Other Committee Fees and Expenses. Members of the Board of Directors shall be eligible for reimbursement of out-of-pocket expenses and registration fees for attendance at board meetings, committee meetings and workshops of related or affiliate organizations when the member is attending such meetings or workshops as a representative of ACHD at the request of the Association's Board Chair or CEO.

V. Requests for Reimbursement. All requests for reimbursement by a member must be submitted in writing to the Association, supported by original receipts and approved by the Association's CEO or designee.

VI. Member District Personnel. Directors, administrators or other personnel representing Member Districts who appear before the Board or Executive Committee in any capacity other than as a member of the ACHD Board or Committees, shall pay their own expenses.

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING FEBRUARY 29, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
FEBRUARY 29, 2012

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
FEBRUARY, 2012

The management of Alameda Hospital (the "Hospital") has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending February 29, 2012 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Highlights

Activity in the month of February made it possible for the hospital to exceed its budget. A negative bottom line of $5,000 was budgeted and a positive $175,000 was realized. Year to date (YTD) the hospital has a loss of ($711,000) versus a budgeted loss of ($6,000).

Activity was strong in February with discharges above budget and patient days just under budget. Discharges were above budget 5.8% and patient days were just 1.9% under budget. For the first time this year the length of stay was above budget. Therefore the hospital had more patients that stayed a longer length of time.

Inpatient surgery cases were 49 which was above the budgeted volume of 44 by 11.4%. As you may recall, inpatient surgery cases had been running below budget for most of the year. Therefore YTD surgery cases are below budget 8.6%. This month's positive surgical volume contributed to higher inpatient revenues. The current months inpatient revenues were above budget $629,000 or 4.2%. This is in contrast to the YTD values where inpatient revenues are down $3.0 million or 2.5%.

Overall outpatient activity was also higher than previous months. This month outpatient volumes were only 1% below budget. This is a significant improvement over prior months as YTD outpatient volumes are about 6% below budget.

Contributing to the positive outpatient volumes, Emergency activity was above budget this month. As well, YTD emergency visits are very close to budget.

Outpatient surgeries were above budget for the month by 4.2%, and, continue above budget YTD by 7.0%.

Gross revenue in February is generally in line with activity. Overall gross revenues were 3.1% above budget, with the inpatient component up 4.2% and outpatient up 0.8%.

The Case Mix Index (CMI) ran above the YTD average. The overall CMI in February was 1.3572; down from last month's high of 1.4123, but still strong compared to earlier months this fiscal year.

The net result of these revenue related influences caused net revenues to be $143,000 or 2.9% above budget. YTD net revenues however are down ($846,000) or 2.1% below budget.

The hospital recently conducted a review of the hospitals charge description master. The purpose of the study was to identify changes in charges and coding which would more appropriately price our services and improve reimbursement. Several of these recommendations have been incorporated into the hospital's charge structure which should improve charges and reimbursement in future months.

Expenses ran slightly under budget this month. Overall expenses were $30,000 or 0.6% below budget. Labor costs continue to track very closely to budget. Increased professional fee costs were offset by savings in supply costs. These trends have continued throughout the year. Our expenses continue to outperform budget as YTD expenses are down $98,000.

Actual cash is up slightly from the prior month. It increased from $2.0M to almost $2.3M. However expressed in days-cash-on-hand, the hospital went from 13.8 days in January to 12.4 days in February. Through the first three weeks in March, daily cash collections have improved significantly. Average daily cash for the year has averaged about $140,000/day. Through the first 21 days of March, collections averaged $158,000. This is a much needed improvement in cash collections.
Net accounts receivable (AR) grew by $678,000 in February. This is due to the higher revenues experienced in February. AR days remained at basically the same level as the previous month. Note that net accounts receivable are only calculated at month

end therefore March's figures are not yet available. It is expected that AR will decrease in March for the first time this year.

Accounts payable grew slightly from $8.7M to $8.9M. AP days were 142. This is down slightly from the previous month. Improved collections in March should reduce this further and then the April tax monies will allow for a significant decrease.

Lastly, the current ratio is now 1.03. This is an improvement over the previous month of .99 and now above the 1.0 threshold necessary to meet Bank of Alameda's criteria for funding the Wound Care project and extending the hospitals line of credit. We expect to see this ratio continue to rise above the 1.0 threshold so long as the hospital continues to experience positive operating performance.

ACTIVITY

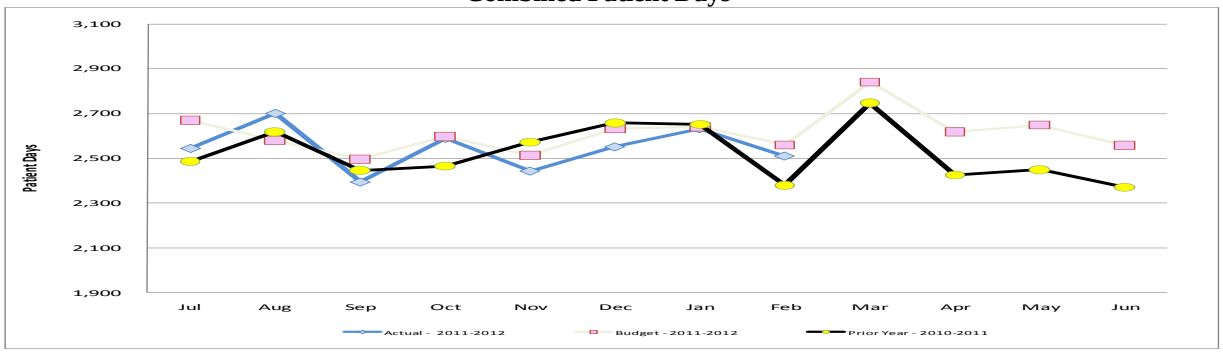
ACUTE, SUBACUTE AND SNF SERVICES

Patient days were slightly below budget for the month but above February of last year. This month's Acute days were up 8.9%, Sub-Acute down .6% and Skilled Nursing down 18.8%. YTD days are now (1.6%) under budget.

February's acute care patient days were 83 days more than budget for the month and 30.7% above the prior year's average daily census of 26.83. The acute care program is comprised of the Critical Care Unit (4.9 ADC, above budget 11.9%), Definitive Observation Unit (12.7 ADC, 5.2% above budget) and Med/Surg Units (17.5 ADC, 10.9% above budget).

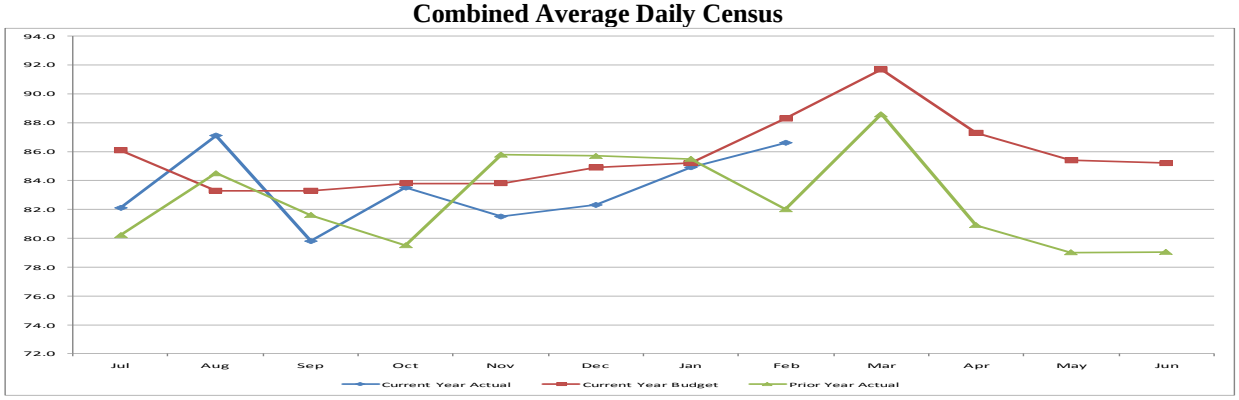
The graph, below, shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

Combined Patient Days



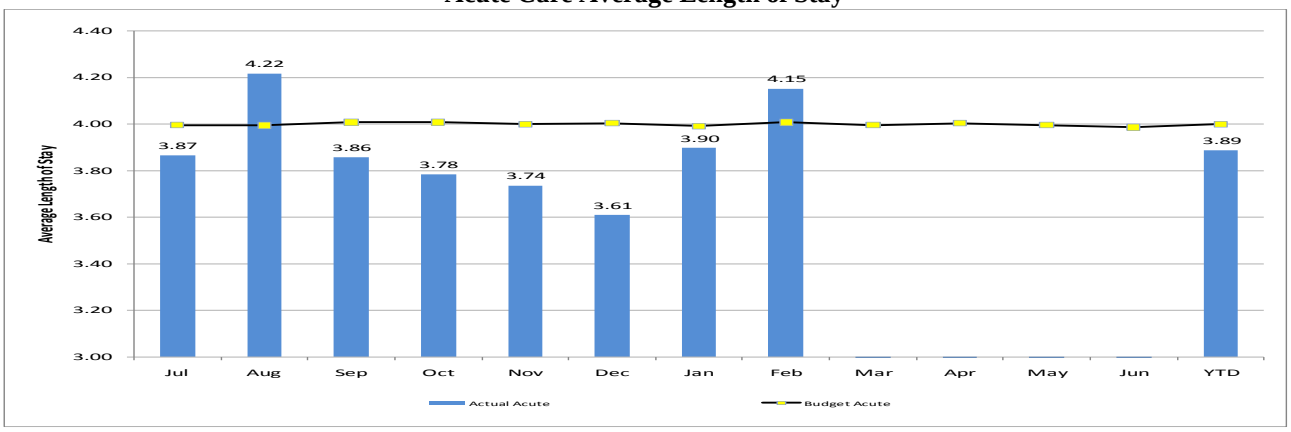
The graph below shows the average daily census for all inpatient services. The actual ADC was 86.59 versus budget of 88.28 an unfavorable variance of 1.9%.

Combined Average Daily Census



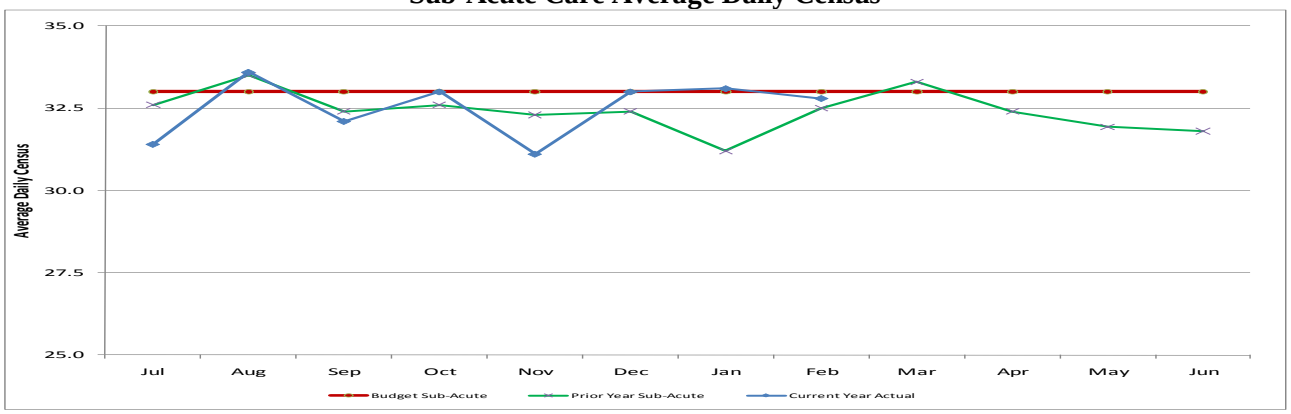
The acute average length of stay (ALOS) increased from the January value of 3.90 to 4.15 in February, just the second time this year it has been above 4.0. Budgeted acute ALOS is 4.0, and YTD is still under that target. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month compared to the budget.

Acute Care Average Length of Stay



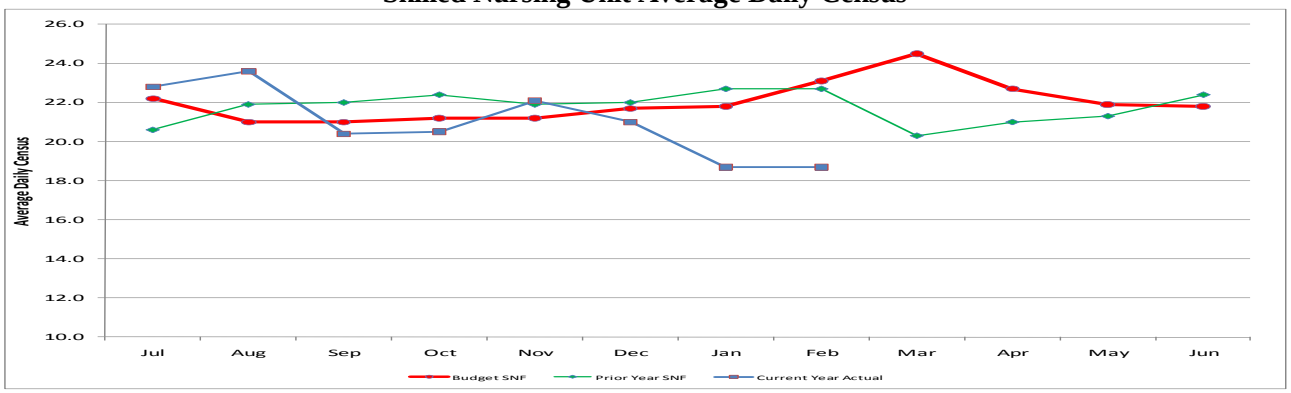
The Sub-Acute programs average daily census of 33.13 in February was just above budgeted projections by 0.4%. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



The Skilled Nursing Unit (South Shore) patient days were 18.8% or 126 patient days lower than budgeted for the month of February. YTD days are also down compared to both budget and the prior year. However, efforts to improve census have been fruitful as the March ADC is approximately 22.0. The graph, below, shows the Skilled Nursing Units monthly average daily census as compared to budget and the prior year.

Skilled Nursing Unit Average Daily Census

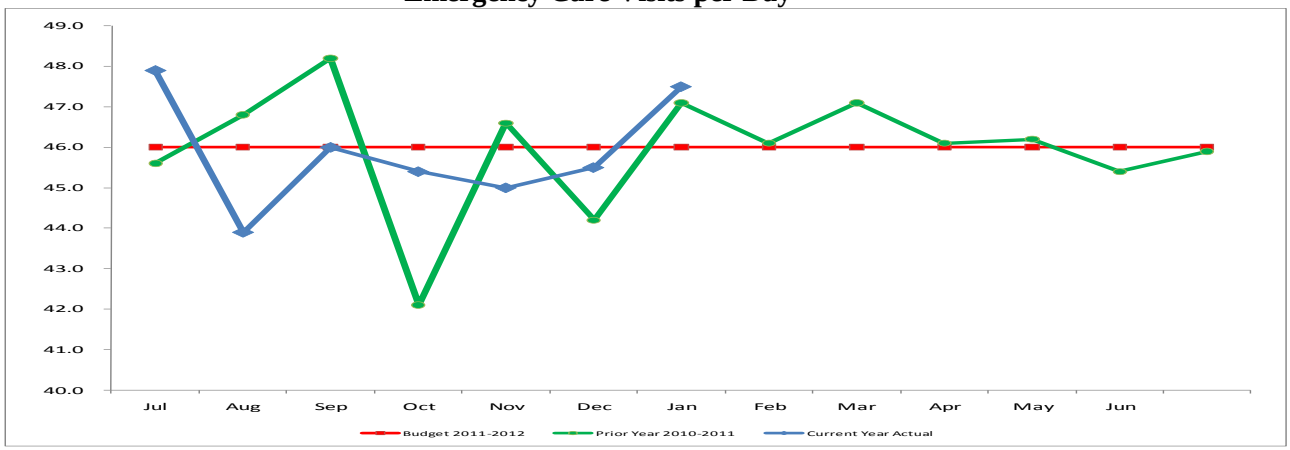


ANCILLARY SERVICES

Outpatient Services

Emergency Care Center visits in February were 1,384. This is 50 visits (3.7%) over the budget of 1,334. 19.2% of ECC visits resulted in inpatient admissions versus 17.9% in January. On a per day basis, the total visits represent an increase of 4.4% from the prior month daily average. In February, there were 267 ambulance arrivals versus 338 in the prior month. Of the 267 ambulance arrivals in the current month, 188 or 70.4% were from Alameda Fire Department (AFD) ambulances.

Emergency Care Visits per Day



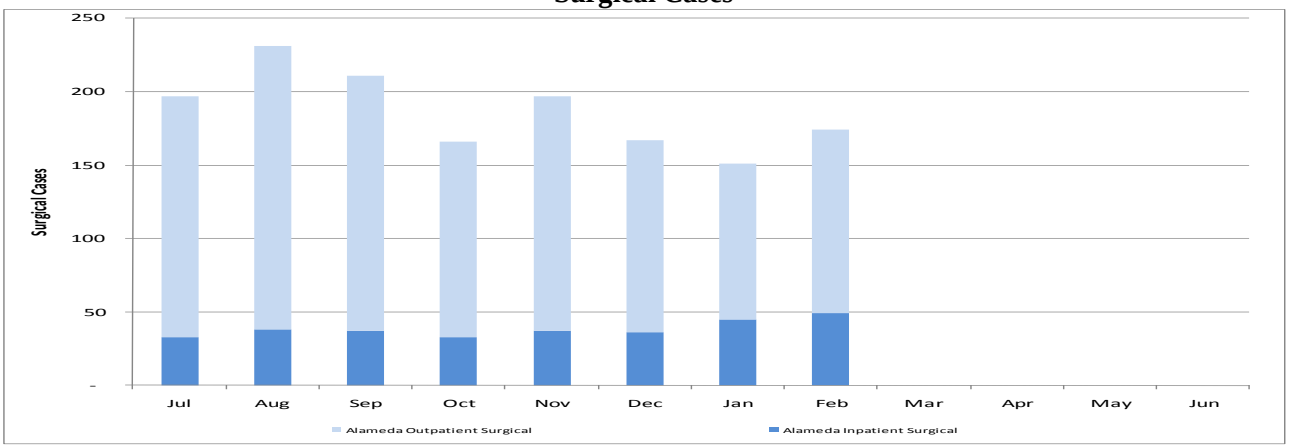
Outpatient registrations were 1,854, or 3.3% below budget. This is less than the prior month primarily due to fewer days in February. February's average daily registrations were 63.9 which was 2.4% higher than the prior month. This is in contrast to YTD outpatient registrations which are below budget by 7.4%. This month IV Therapy was down by 3 patients which equated to 47 visits. Additionally, Laboratory and Occupational Therapy were down 106 and 19 visits respectively. On the other hand visits were up in Radiology (65 visits) and Physical Therapy (28 visits). There were no Wound Care visits but visits were budgeted as the program was expected to start in February.

Surgery

The year-to-date surgery cases were 1,504 or 3.3% above the budget of 1,456 and also above last year. For the month, total surgery cases were above budgeted expectations by 6.1% at 174 cases versus the budget of 164 cases. Inpatient cases were above budget 5 (11.4%) while outpatient cases also 5 (4.2%) above budget. Inpatient and outpatient cases totaled 49 and 125 in February versus 45 and 106 during the prior month. It was a busy inpatient surgery month in February.

The graph below shows the number of inpatient and outpatient surgical cases by month for fiscal year 2012.

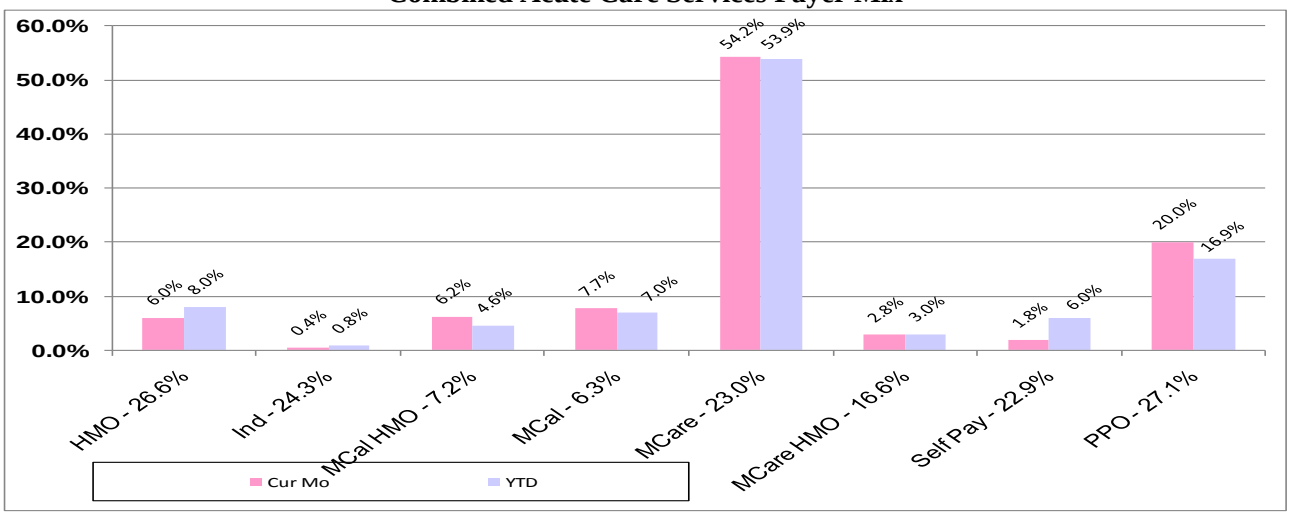
Surgical Cases



Payer Mix

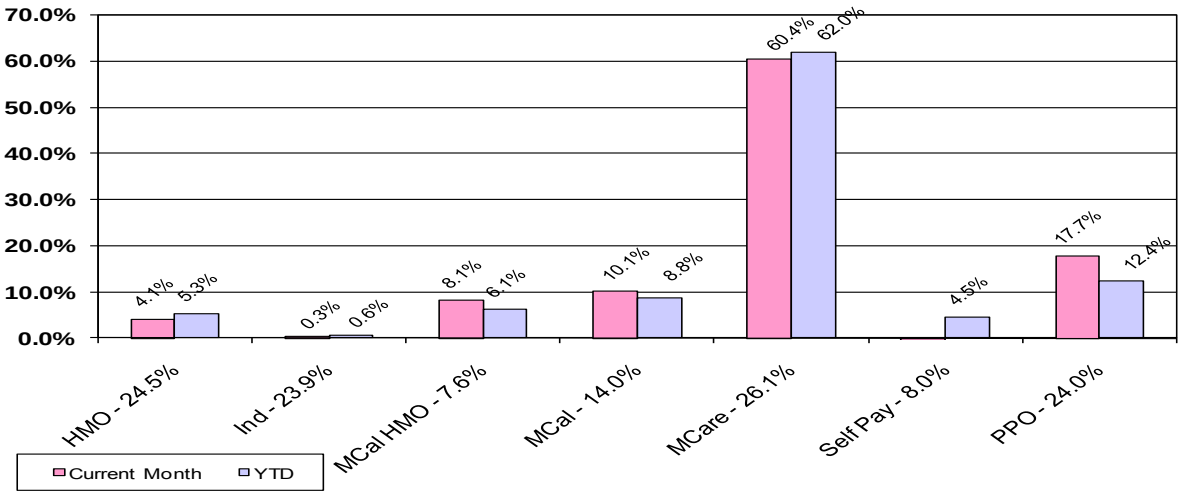
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in February made up 57.1% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 26.0%, Medi-Cal Traditional and Medi-Cal HMO utilization at 13.9% and self pay at 6.0%. The graph below shows the percentage of gross revenues generated by each of the major payers for the current month and fiscal year to date as well as the current month's estimated reimbursement for each payer for the combined inpatient and outpatient acute care services.

Combined Acute Care Services Payer Mix



The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 60.4% of our total inpatient acute care gross revenues followed by HMO/PPO at 21.8%, Medi-Cal and Medi-Cal HMO at 18.2% and Self Pay at 8.0% of the inpatient acute care revenue. The graph below shows inpatient acute care current month and year to date payer mix and current month estimated net revenue percentages for fiscal year 2012.

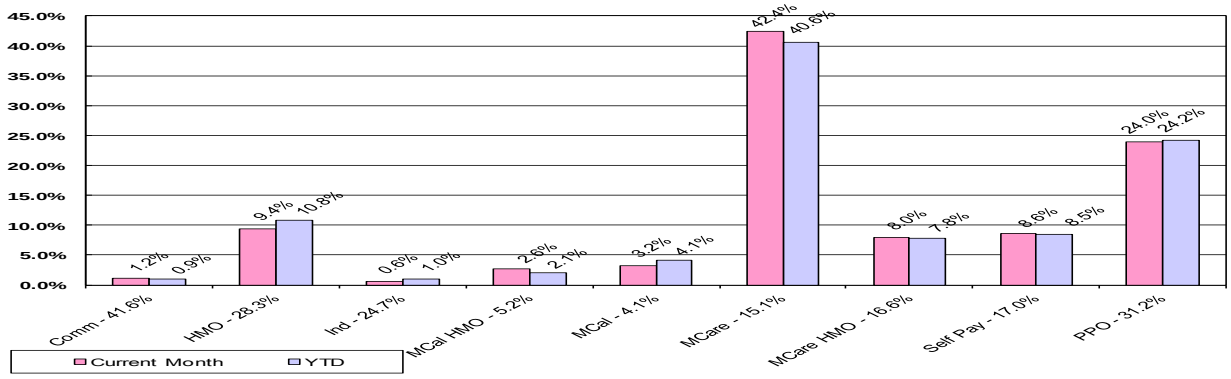
Inpatient Acute Care Payer



The outpatient gross revenue payer mix for February was comprised of 50.4% Medicare and Medicare Advantage, 34.5%

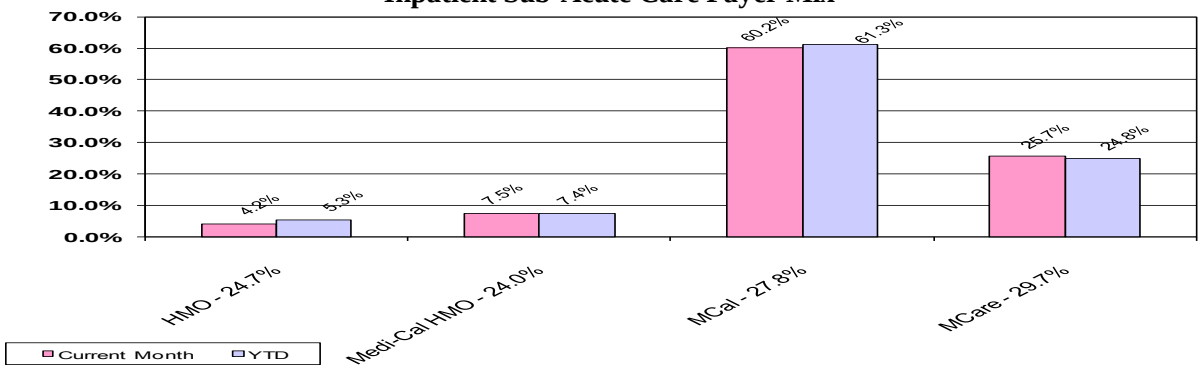
HMO/PPO, 5.9% Medi-Cal and Medi-Cal HMO, and 8.6% self pay. The graph below shows the current month and fiscal year to date outpatient payer mix and the current months estimated level of reimbursement for each payer.

Outpatient Services Payer Mix



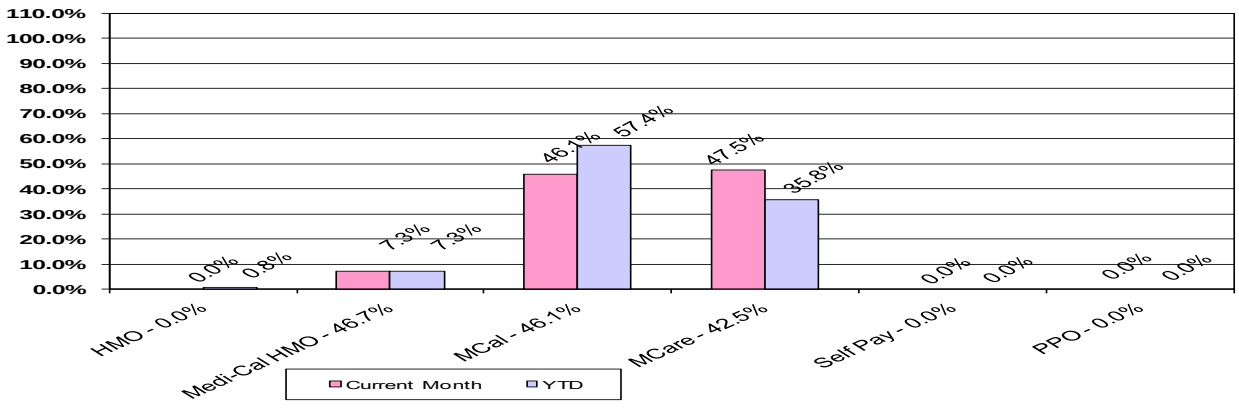
In February, the Sub-Acute care program again was dominated by Medi-Cal utilization of 67.7%, down from a high of 70% in January. Medicare was 25.7% and HMO/PPO rounds out the unit at 4.2%. The graph below shows the payer mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payer.

Inpatient Sub-Acute Care Payer Mix



The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. Note the change in volumes between Medicare and Medi-Cal. This reflects the successful placement of an increasing volume of post-acute skilled patients (Medicare).

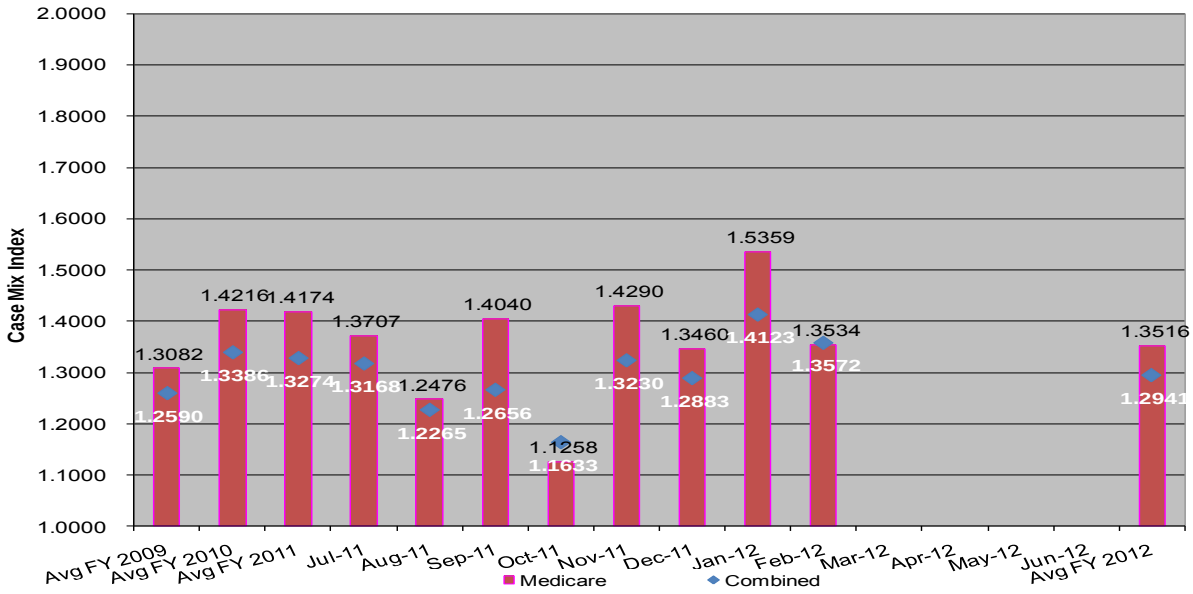
Inpatient Skilled Nursing Payer Mix



Case Mix Index

The hospital's overall Case Mix Index (CMI) for February was 1.3572, down from the prior months high of 1.4123, and above the February 2011 of 1.3331. The Medicare CMI decreased from 1.5359 in January to 1.3534 in February. The graph below shows the Medicare CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

Case Mix Index Trend



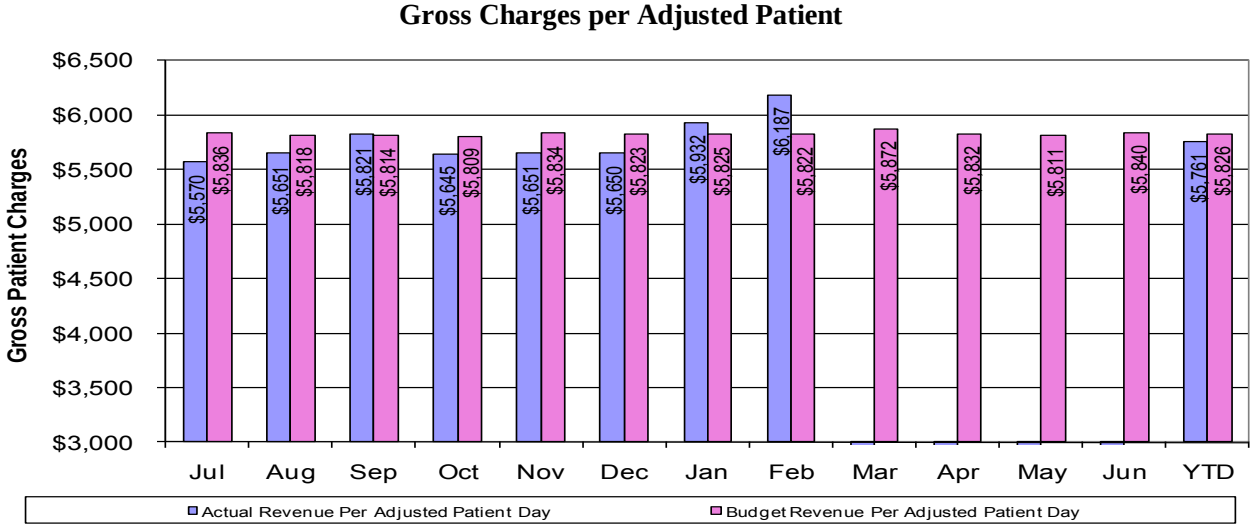
The CMI at the time of forecasting this year's budget was 1.3758. Year-to-date February 2012 the CMI was 1.2998. This represents a 5.3% decline compared to the same time frame last year. However, the month of February 2012 continues the year-to-date average climb. Note that payers with lower volume can have substantial swings in CMI from one period to another. See the table below that compares the CMI by payer for the three periods.

Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Feb 11 YTD	Feb 12 YTD	Feb 12 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.1878	1.0394	6
HMO	1.2522	1.1781	1.3278	79
Industrial	1.8373	1.4212	1.3856	8
Kaiser	1.8412	1.7929	1.9376	9
Medi-Cal HMO	1.0008	1.0026	1.0469	104
Medi-Cal	1.2724	1.2701	1.3066	106
Medicare	1.4724	1.4751	1.3570	997
Medicare HMO	1.3568	1.3580	1.3964	172
Personal Pay	1.0105	1.0247	1.0964	126
Medi-Cal Pending	1.8334	1.8123	2.0751	4
PPO	1.2613	1.3211	1.1187	207
VA	1.4051	1.3213	1.4262	39
Combined	**1.3758**	**1.3719**	**1.2998**	1,857

Revenue

Gross patient charges in February were above budget by $614,000, or 2.8%. Inpatient revenues were up $629,000 over budget and outpatients were down just $15,000. Most inpatient volumes, surgeries and emergency visits were above or close to budget. Outpatient registrations were just 3.3% under budget. Outpatient revenues were slightly lower than budget as a result of the lower volume. On an adjusted patient day basis, total patient revenue was $6,187, above the budget of $5,822 for the month of February and higher than January gross revenue per APD of $5,932. The following table shows the hospital's monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2012 compared to budget.



Contractual Allowances

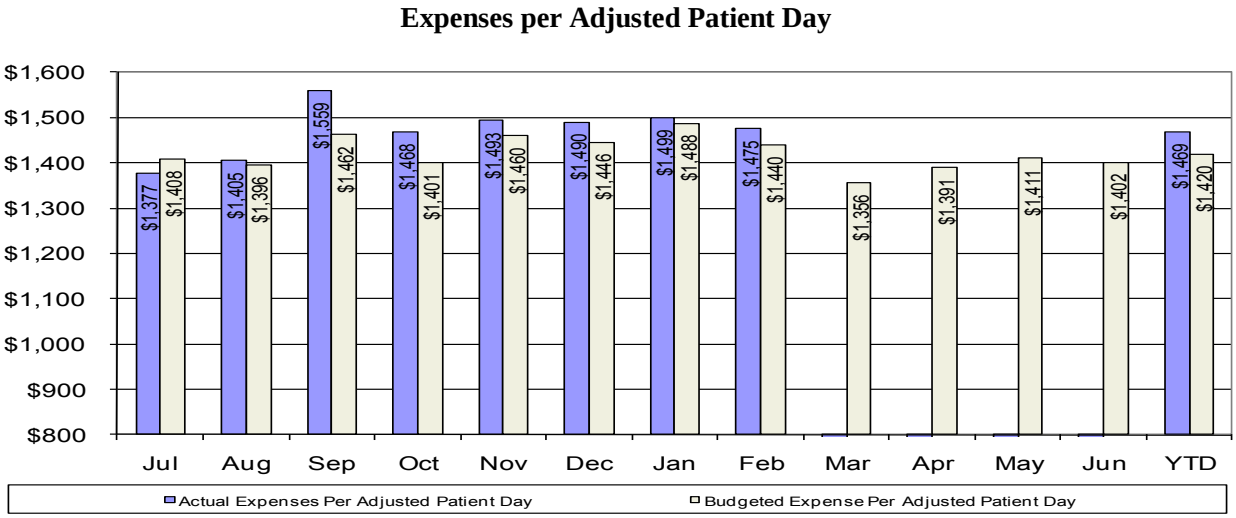
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payers such as Blue Cross. As such net revenues as a percentage of gross revenues were very close to budget. A collection ratio of 22.3% was budgeted and 22.2% was realized.

Expenses

Total Operating Expenses

Total operating expenses were lower than the fixed budget by $30,000 or 0.6%. This compares to a gross revenue variance of 5.8%. As such, overall expenses were favorable. Salaries, benefits were up due to high activity in the acute hospital. Non-medical professional fees were up due to consulting fees along with expenses related to Water's Edge.

The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2012 fiscal year by month as compared to budget. Note that expenses per patient day were over budget this month. This is a bit of an anomaly because even though revenues were over budget, patient days were below budget. The reason patient days were low was because of patient day activity in the SNF unit. Occasionally some statistics give a false impression of performance. That is the case with expenses per adjusted patient days this month.



Following are explanations of the significant areas of variance that were experienced in the current month.

Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were unfavorable to the fixed budget by $43,000 and were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $35 or 4.6%. Year to date salaries and agency expenses are running just above budget by 1.9% PAPD.

Benefits

Benefits were favorable to the fixed budget by $64,000 or 17.7%, and right on budget per adjusted patient day. Group Health Insurance – Non Alameda Hospital contributed to this positive variance.

Professional Fees

Professional fees were unfavorable to budget by $67,000 in February due to $11,000 from Medical Professional Fees (ER and Clinic physician expenses) and $30,000 from Non-Medical Professional Fees related to HFS fees for Accounting $13,000, Revenue Cycle $30,000, Pharmacy $15,000 and Administration $11,000.

Supplies

Supplies were favorable to budget by $123,000 (16.8%) or $28 or 14.3% per adjusted patient day in February. As in prior months, this favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies associated with the IVT program (low IVT program volumes), and prosthetics.

Purchased Services

Purchased services were at the fixed budget and $3 unfavorable PAPD.

Rents and Leases

Rents and leases were above the fixed budget by only $4,000, and above budget $2 PAPD in February at $33 per adjusted patient day versus a budget of $31.

Other Operating Expense

Other operating expenses were $11,000 under the fixed budget and $3 under the budget on a per adjusted patient day basis.

Balance Sheet

Total assets increased almost $400,000 from the prior month, partly because of the increase in accounts receivable as well as the increase in cash. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for February increased by $272,000 and days cash on hand including restricted use funds decreased to 12.4 days on hand in February from 14.6 days on hand in January.

- Net patient accounts receivable increased in February by $678,000 compared to an increase of $304,000 in January. Days in outstanding receivables were 66.5 at February month end, just above the 62.9 days in January. Collections in February were $4.4 million compared to $4.9 million in January. February had 2 less business days than January.

- Other Receivables, Third Party Settlements, Inventories and Prepaids remained fairly constant from one month to the next.

Total liabilities decreased by only $42,000 compared to a decrease of $997,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses increased $147,000. This small increase is an improvement over prior month's accrued expenses.

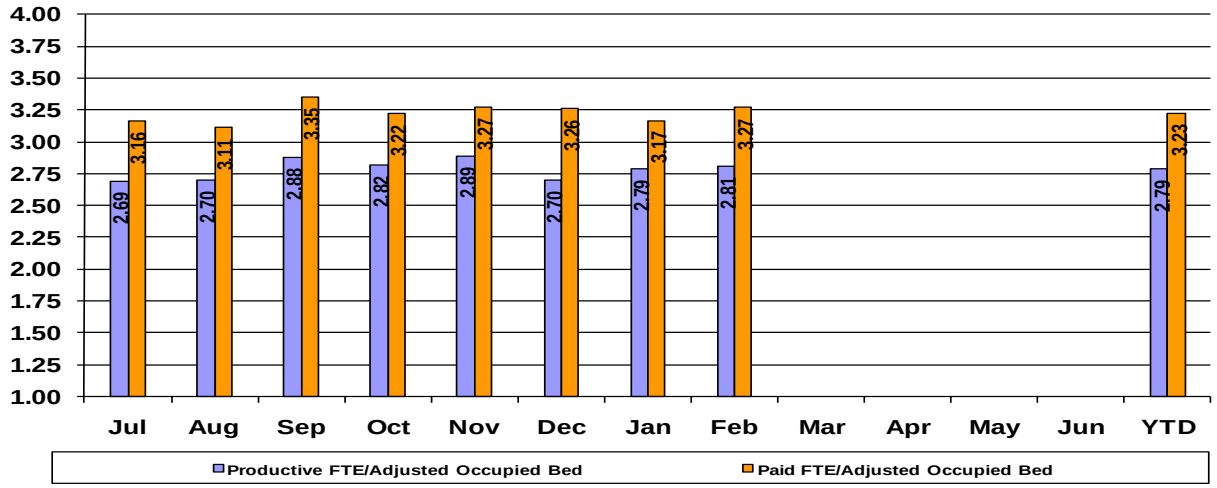
- Payroll related accruals increased by $211,600 as a result of the timing of pay period end in relation to the month end.

- Deferred revenues decreased again by $477,000 due to the recognition of one-twelfth of the 2011/2012 parcel tax revenues of $5.7 million.

Key Statistics

FTE's per Adjusted Occupied Bed

On an adjusted occupied bed basis, productive FTE's were 2.81, above the budget of 2.66 FTE's by 5.3%, and paid FTE's were 3.27 or 5.1% above budget. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2012 by month.



Current Ratio

The current ratio for February is 1.03. This has increased above our threshold of 1.0 with the reclassification of the Jabor cash.

A/R days

Net days in Accounts Receivable are currently at 66.5. This is up from prior month. We are working hard to bring this number down to 51, which will help our cash position and current ratio.

Days Cash on Hand

Days cash on hand for February was 12.4. This has decreased slightly from prior month of 13.8 because of increased expenses associated with February activity. We would like this ratio to be closer to the FY 2010 number of 20+ days.

The following pages include the detailed financial statements for the seven (8) months ended February 29, 2012, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
FEBRUARY 2012

	ACTUAL FEBRUARY 2012	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	FEBRUARY 2011	YTD FEBRUARY 2012	YTD FIXED BUDGET	VARIANCE	%	YTD FEBRUARY 2011
Discharges:										
Total Acute	245	233	12	5.2%	197	1,880	1,840	40	2.2%	1,649
Total Sub-Acute	3	1	2	200.0%	1	15	12	3	25.0%	16
Total Skilled Nursing	9	9	-	0.0%	10	69	70	(1)	-1.4%	60
	257	243	14	5.8%	208	1,964	1,922	42	2.2%	1,725
Patient Days:										
Total Acute	1,017	934	83	8.9%	778	7,310	7,363	(53)	-0.7%	6,989
Total Sub-Acute	951	957	(6)	-0.6%	943	7,936	8,052	(116)	-1.4%	7,914
Total Skilled Nursing	543	669	(126)	-18.8%	659	5,125	5,278	(153)	-2.9%	5,375
	2,511	2,560	(49)	-1.9%	2,380	20,371	20,693	(322)	-1.6%	20,278
Average Length of Stay										
Total Acute	4.15	4.01	0.14	3.6%	3.95	3.89	4.00	(0.11)	-2.8%	4.24
Average Daily Census										
Total Acute	35.07	32.21	2.77	8.6%	26.83	29.96	30.18	(0.22)	-0.7%	28.64
Total Sub-Acute	32.79	33.00	(0.20)	-0.6%	32.52	32.52	33.00	(0.48)	-1.4%	32.43
Total Skilled Nursing	18.72	23.07	(4.20)	-18.2%	22.72	21.00	21.63	(0.63)	-2.9%	22.03
	86.59	88.28	(1.63)	-1.9%	82.07	83.49	84.81	(0.69)	-0.8%	83.11
Emergency Room Visits	1,384	1,334	50	3.7%	1,337	11,248	11,224	24	0.2%	11,179
Outpatient Registrations	1,854	1,918	(64)	-3.3%	1,866	14,720	15,897	(1,177)	-7.4%	15,684
Surgery Cases:										
Inpatient	49	44	5	11.4%	48	318	348	(30)	-8.6%	354
Outpatient	125	120	5	4.2%	118	1,186	1,108	78	7.0%	1,105
	174	164	10	6.1%	166	1,504	1,456	48	3.3%	1,459
Adjusted Occupied Bed (AOB)	125.47	129.69	(4.22)	-3.3%	127.30	246.19	125.71	120.48	95.8%	124.08
Productive FTE	352.18	345.53	6.65	1.9%	378.12	341.57	342.55	(0.98)	-0.3%	366.36
Total FTE	410.63	403.84	6.79	1.7%	436.32	395.85	404.98	(9.13)	-2.3%	423.81
Productive FTE/Adj. Occ. Bed	2.81	2.66	0.14	5.3%	2.97	1.39	2.72	(1.34)	-49.1%	2.95
Total FTE/ Adj. Occ. Bed	3.27	3.11	0.16	5.1%	3.43	1.61	3.22	(1.61)	-50.1%	3.42

City of Alameda Health Care District
Statements of Financial Position
February 29, 2012

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 2,253,861	$ 1,981,838	$ 1,784,141
Patient Accounts Receivable, net	10,563,953	9,885,867	7,249,185
Other Receivables	3,674,460	3,616,054	8,090,457
Third-Party Payer Settlement Receivables	661,578	661,578	150,000
Inventories	1,152,120	1,182,028	1,183,358
Prepaids and Other	300,951	324,645	262,359
Total Current Assets	18,606,923	17,652,009	18,719,500
Assets Limited as to Use, net	24,337	558,983	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,397,622	43,397,622	43,383,571
Construction in progress	3,515,044	3,476,290	2,921,048
Depreciation	(39,404,854)	(39,336,772)	(38,862,494)
Property, Plant and Equipment, net	8,385,757	8,415,085	8,320,070
Total Assets	**$ 27,017,018**	**$ 26,626,077**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,583,545	$ 1,606,237	$ 746,074
Accounts Payable and Accrued Expenses	8,881,340	8,734,064	6,987,765
Payroll Related Accruals	4,732,459	4,520,785	3,991,254
Deferred Revenue	1,909,641	2,386,689	5,725,900
Employee Health Related Accruals	629,895	617,641	343,382
Third-Party Payer Settlement Payable	368,344	35,075	(3,930)
Total Current Liabilities	18,105,224	17,900,491	17,790,445
Long Term Debt, net	845,575	845,722	1,142,109
Total Liabilities	18,950,799	18,746,213	18,932,554
Net Assets:			
Unrestricted	7,871,881	7,150,875	8,037,015
Temporarily Restricted	194,337	728,988	553,716
Total Net Assets	8,066,218	7,879,863	8,590,731
Total Liabilities and Net Assets	**$ 27,017,018**	**$ 26,626,077**	**$ 27,523,286**

City of Alameda Health Care District

Statements of Operations

February 29, 2012

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,511	2,560	(49)	-1.9%	2,380	20,371	20,693	(322)	-1.6%	20,278
Discharges	257	243	14	5.8%	208	1,964	1,922	42	2.2%	1,725
ALOS (Average Length of Stay)	9.77	10.53	(0.76)	-7.3%	11.44	10.37	10.77	(0.39)	-3.7%	11.76
ADC (Average Daily Census)	89.7	91.4	(1.75)	-1.9%	85.0	84	85.2	(1.33)	-1.6%	83.4
CMI (Case Mix Index)	1.3543				1.3331	1.2936				1.3632
Revenues										
Gross Inpatient Revenues	$ 15,535	$ 14,905	$ 629	4.2%	$ 12,579	$ 117,383	$ 120,378	$ (2,995)	-2.5%	$ 110,161
Gross Outpatient Revenues	6,977	6,922	55	0.8%	6,260	54,755	57,694	(2,939)	-5.1%	53,877
Total Gross Revenues	22,512	21,827	684	3.1%	18,839	172,139	178,073	(5,934)	-3.3%	164,037
Contractual Deductions	17,031	16,095	(936)	-5.8%	13,389	128,639	131,169	2,530	1.9%	116,997
Bad Debts	361	695	333	48.0%	690	3,382	5,663	2,281	40.3%	4,954
Charity and Other Adjustments	113	169	56	33.2%	188	1,369	1,365	(4)	-0.3%	1,257
Net Patient Revenues	5,006	4,869	137	2.8%	4,572	38,749	39,876	(1,127)	-2.8%	40,830
Net Patient Revenue %	22.2%	22.3%			24.3%	22.5%	22.4%			24.9%
Net Clinic Revenue	36	28	8	29.4%	50	285	146	138	94.4%	258
Other Operating Revenue	8	10	(2)	-24.7%	12	224	81	143	177.6%	81
Total Revenues	**5,050**	**4,907**	**143**	2.9%	**4,635**	**39,257**	**40,103**	**(846)**	-2.1%	**41,169**
Expenses										
Salaries	2,723	2,713	(10)	-0.4%	2,825	22,745	22,597	(148)	-0.7%	23,708
Temporary Agency	173	140	(33)	-23.3%	216	924	1,179	256	21.7%	1,605
Benefits	765	787	23	2.9%	768	6,770	6,365	(405)	-6.4%	6,306
Professional Fees	379	313	(67)	-21.3%	255	3,051	2,349	(702)	-29.9%	2,373
Supplies	611	734	123	16.8%	731	4,779	6,004	1,225	20.4%	5,845
Purchased Services	366	364	(2)	-0.5%	328	2,883	2,946	63	2.1%	2,961
Rents and Leases	120	116	(4)	-3.7%	68	699	717	18	2.5%	544
Utilities and Telephone	73	65	(8)	-12.6%	70	535	519	(16)	-3.1%	502
Insurance	29	17	(12)	-73.0%	34	221	135	(87)	-64.3%	254
Depreciation and amortization	68	77	9	11.9%	77	579	565	(14)	-2.5%	642
Other Opertaing Expenses	60	71	11	16.1%	68	712	621	(91)	-14.7%	705
Total Expenses	**5,368**	**5,398**	**30**	0.6%	**5,440**	**43,898**	**43,997**	**98**	0.2%	**45,446**
Operating gain (loss)	**(317)**	**(491)**	**174**	35.4%	**(805)**	**(4,641)**	**(3,894)**	**(747)**	19.2%	**(4,277)**
Non-Operating Income / (Expense)										
Parcel Taxes	477	478	(1)	-0.1%	479	3,846	3,824	22	0.6%	3,828
Investment Income	1	0	0	220.6%	0	4	(102)	107	-104.3%	8
Interest Expense	(13)	(15)	2	10.6%	(8)	(127)	(13)	(114)	893.5%	(71)
Other Income / (Expense)	28	23	5	20.5%	22	206	179	28	15.4%	175
Net Non-Operating Income / (Expense)	**492**	**486**	**6**	**1.3%**	**494**	**3,930**	**3,888**	**42**	**1.1%**	**3,941**
Excess of Revenues Over Expenses	**$ 175**	**$ (5)**	**$ 180**	**-3762.3%**	**$ (311)**	**$ (711)**	**$ (6)**	**$ (705)**	**11853.7%**	**$ (337)**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

February 29, 2012

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 4,269	$ 3,976	$ 293	7.4%	$ 3,529	$ 3,929	$ 3,933	$ (3)	-0.1%	$ 3,648
Gross Outpatient Revenues	1,917	1,846	71	3.8%	1,756	1,833	1,885	(52)	-2.8%	1,784
Total Gross Revenues	6,187	5,822	364	6.3%	5,285	5,762	5,817	(55)	-0.9%	5,433
Contractual Deductions	4,681	4,293	(387)	-9.0%	3,756	4,306	4,285	(21)	-0.5%	3,875
Bad Debts	99	185	86	46.4%	194	113	185	72	38.8%	164
Charity and Other Adjustments	31	45	14	31.1%	53	46	45	(1)	-2.8%	42
Net Patient Revenues	1,376	1,299	77	5.9%	1,283	1,297	1,303	(6)	-0.4%	1,352
Net Patient Revenue %	22.2%	22.3%			24.3%	22.5%	22.4%			24.9%
Net Clinic Revenue	10	7	2	33.3%	14	10	5	5	99.2%	9
Other Operating Revenue	2	3	(1)	-22.5%	3	8	3	5	184.4%	3
Total Revenues	**1,388**	**1,309**	**79**	6.0%	**1,300**	**1,314**	**1,310**	**4**	0.3%	**1,364**
Expenses										
Salaries	748	724	(25)	-3.4%	792	761	738	(23)	-3.1%	785
Temporary Agency	48	37	(10)	-27.0%	61	31	39	8	19.8%	53
Benefits	210	210	(0)	-0.1%	216	227	208	(19)	-9.0%	209
Professional Fees	104	83	(21)	-25.0%	71	102	77	(25)	-33.1%	79
Supplies	168	196	28	14.3%	205	160	196	36	18.4%	194
Purchased Services	101	97	(3)	-3.5%	92	97	96	(0)	-0.3%	98
Rents and Leases	33	31	(2)	-6.9%	19	23	23	0	0.1%	18
Utilities and Telephone	20	17	(3)	-16.0%	20	18	17	(1)	-5.7%	17
Insurance	8	5	(4)	-78.3%	9	7	4	(3)	-68.4%	8
Depreciation and Amortization	19	21	2	9.2%	22	19	18	(1)	-5.0%	21
Other Operating Expenses	16	19	3	13.6%	19	24	20	(4)	-17.6%	23
Total Expenses	**1,475**	**1,440**	**(35)**	-2.4%	**1,526**	**1,469**	**1,437**	**(32)**	-2.2%	**1,505**
Operating Gain / (Loss)	**(87)**	**(131)**	**44**	33.4%	**(226)**	**(155)**	**(127)**	**(28)**	22.2%	**(141)**
Non-Operating Income / (Expense)										
Parcel Taxes	131	127	4	2.9%	134	129	125	4	3.1%	127
Investment Income	0	0	0	230.4%	0	0	0	0	172.5%	0
Interest Expense	(4)	(4)	0	7.9%	(2)	(4)	(3)	(1)	27.1%	(2)
Other Income / (Expense)	8	6	1	24.2%	6	7	6	1	18.3%	6
Net Non-Operating Income / (Expense)	**135**	**130**	**6**	**4.3%**	**139**	**132**	**127**	**4**	**3.2%**	**131**
Excess of Revenues Over Expenses	**$ 48**	**$ (1)**	**$ 49**	-3873.2%	**$ (87)**	**$ (24)**	**$ 1**	**$ (24)**	-4807.5%	**$ (11)**

City of Alameda Health Care District
Statement of Cash Flows
For Eight Months Ended February 29, 2012

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ 175,005	$ (711,139)
Items not requiring the use of cash:		
Depreciation and amortization	68,082	$ 578,669
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(678,086)	(3,314,768)
Other Receivables	(58,406)	4,415,997
Third-Party Payer Settlements Receivable	333,269	(139,304)
Inventories	29,908	31,238
Prepaids and Other	23,693	(38,592)
Accounts payable and accrued liabilities	147,276	1,893,575
Payroll Related Accruals	211,674	741,205
Employee Health Plan Accruals	12,254	286,513
Deferred Revenues	(477,048)	(3,816,259)
Cash provided by (used in) operating activities	(212,378)	(72,865)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	534,646	459,379
Additions to Property, Plant and Equipment	(38,755)	(644,356)
Other	546,001	546,005
Cash provided by (used in) investing activities	1,041,891	361,027
Cash flows from financing activities		
Net Change in Long-Term Debt	(22,839)	540,937
Net Change in Restricted Funds	(534,651)	(359,379)
Cash provided by (used in) financing and fundraising activities	(557,490)	181,558
Net increase (decrease) in cash and cash equivalents	272,023	469,720
Cash and cash equivalents at beginning of period	1,981,838	1,784,141
Cash and cash equivalents at end of period	$ 2,253,861	$ 2,253,861

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	FY 2009	FY 2010	Unaudited Results FY 2011	YTD 2/29/2012
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.51%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-0.01%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-9.81%
Total Margin	-3.75%	1.03%	2.74%	-2.61%	-1.81%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	1.03
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	66.52
Days cash on hand (with restricted)	30.6	13.6	21.6	14.1	12.4
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	93.79%
Average pay period	58.93	58.03	57.11	62.68	79.99
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.00)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.23
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-8.82%
Debt to number of beds	20,932	13,481	10,482	11,515	15,088

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	FY 2009	FY 2010	Unaudited Results FY 2011	YTD 2/29/2012
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	20,371
Patient days (acute only)	11,276	11,787	10,579	10,443	7,310
Discharges(acute only)	2,885	2,812	2,802	2,527	1,964
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.72
Average daily patients (all sources)	61.99	83.46	83.85	82.93	83.49
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.86%
Average length of stay	3.91	4.19	3.78	4.13	3.72
Emergency Visits	17,922	17,337	17,624	16,816	11,248
Emergency visits per day	48.97	47.50	48.28	46.07	46.10
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	60.33
Surgeries per day - Total	14.78	16.12	13.46	6.12	6.16
Surgeries per day - excludes Kaiser	5.54	5.14	5.32	6.12	6.16

Notes:

1. Includes Kaiser Outpatient Sugercial volume in Fiscal Years 2008, 2009 and through March 31, 2010.
2. In addition to these general requirements a feasibility report will be required.
3. Based upon Moody's FY 2008 preliminary single-state provider medians.
4. EBIDA - Earnings before Interest, Depreciation and Amoritzation
5. EBIDAP - Earnings before Interest, Depreciation and Amortization and Parcel Tax Proceeds

Glossary of Financial Ratios

Term	What is it? Why is it Important?	How is it calculated?
EBIDA	A measure of the organization's cash flow	Earnings before interest, depreciation, and amortization (EBIDA)
Operating Margin	Income derived from patient care operations	Total operating revenue less total operating expense divided by total operating revenue
Current Ratio	The number of dollars held in current assets per dollar of liabilities. A widely used measure of liquidity. An increase in this ratio is a positive trend.	Current assets divided by current liabilities
Days cash on hand	Measures the number of days of average cash expenses that the hospital maintains in cash or marketable securities. It is a measure of total liquidity, both short-term and long-term. An increasing trend is positive.	Cash plus short-term investments plus unrestricted long-term investments over total expenses less depreciation divided by 365.
Cash to debt	Measures the amount of cash available to service debt.	Cash plus investments plus limited use investments divided by the current portion and long-term portion of the organization's debt insruments.
Debt service coverage	Measures total debt service coverage (interest plus principal) against annual funds available to pay debt service. Does not take into account positive or negative cash flow associated with balance sheet changes (e.g. work down of accounts receivable). Higher values indicate better debt repayment ability.	Excess of revenues over expenses plus depreciation plus interest expense over principal payments plus interest expense.
Long-term debt to fund balance	Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt. A declining trend is positive.	Long-term debt divided by long-term debt plus unrestricted net assets.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: March 30, 2012

FOR: April 2, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

THROUGH: City of Alameda Health Care District, Finance and Management Committee

FROM: Deborah E. Stebbins, Chief Executive Officer
Mary Bond, RN, Executive Director of Nursing Services
Tony Corica, Director of Physician Relations

SUBJECT: Approval to Establish a Comprehensive Orthopedic Program at Alameda Hospital and Approval to Enter into Professional Services Agreements with Two Orthopedic Surgeons

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The Finance and Management Committee and Hospital management recommend that the Board of Directors approve the following two (2) recommendations.

RECOMMENDATION #1:

Approve the establishment of a comprehensive Orthopedic Program at Alameda Hospital as described below in the Background and Discussion.

RECOMMENDATION #2:

Approve entering into three-year Professional Services Agreements with Nicholas Pirnia, M.D., and James DiStefano, M.D, two orthopedists wishing to establish medical office practices in Alameda.

BACKGROUND:

Orthopedics remains a highly profitable service line for hospitals across the country. A robust orthopedics portfolio can assist the hospital to support less profitable hospital services. The demand for orthopedic care covers the gamut of ages; the need for sports medicine can begin early in life, while spine surgeries peak in middle age and joint replacements occur predominately among the elderly population.

It is estimated that a full-time orthopedist generates combined net inpatient and outpatient revenues to the Hospital of approximately $2M annually. Our experience with our busiest orthopedic surgeon is in line with this estimate. Thus, the opportunity exists to replace some of the surgery volume lost by the April, 2010 departure of the Kaiser surgical volume from our Hospital. Additionally, physical therapy, diagnostic imaging, and laboratory services will increase.

We would like to develop a comprehensive orthopedic program that will focus on the addition of two orthopedic surgeons who would initially combine general orthopedics with their selected specialties in diseases of the spine and sports medicine, respectively. This program would be developed to enhance our existing services, be a resource for the existing medical community, and position us to become a destination hospital for orthopedics.

At a minimum this program would be developed to:

- Increase utilization in the Operating Room—we will offer block surgical time of ½ room (four hours) a minimum of 1 day per week to start with the potential of approximately 5 to 7 procedures beginning the first month. Surgical procedure ramp-up is generally fairly gradual, initially relying on referrals while the basic personal practice builds. This can be accomplished with minimal cost until volume increases are consistently established.
- Increase inpatient volume on the Nursing Units—our medical surgical unit would be reconfigured to include a specific unit dedicated to post-operative care for not only orthopedic but also vascular and some more intensive general surgical patients. We would like to use the wing off of 3-South, 5 rooms with 10 beds that can be initially used as private rooms. Nurses with experience specifically in post-operative orthopedic and vascular care would be hired to staff the unit.
- Provide a mechanism that will not only enhance our existing services but also allow us to plan for the retirement of orthopedic surgeons in the area.
- Provide increased community involvement through activities at the local schools, gyms, health facilities, and the Boys' and Girls' Club.
- Provide patients and the community with programs, events, and seminars on topics such as Sports Medicine, Total Joint Replacement, Minimally Invasive Orthopedic Surgery, and Post-operative Rehabilitation.
- Aggressively market the new orthopedic practice and program. Selecting a practice name larger than "Alameda" may assist in attracting patients from "off-island". Multiple forms of marketing will be used.
- Locate appropriate office space in Alameda and potentially additional office space within the extended service area for the surgeons. There is potential for financing tenant improvements of selected office location(s).

It should be emphasized that physical and rehabilitative therapy is vital and essential to an active, prosperous orthopedic program. Not only will orthopedic surgeons use physical therapy after surgical procedures, they will also recommend physical therapy on a conservative basis for those patients experiencing any kind of injury or chronic health problem, strength training, continued physical fitness, or pre-surgical treatment. Additionally, it is not infrequent that orthopedic surgeons are asked to recommend a physical therapy department either in social settings or in general conversation.

The development of a comprehensive orthopedic program backed by strong ancillary departments such as physical therapy, diagnostic imaging, and laboratory services addresses a key component of the Hospital's strategic plan to increase procedural/surgical services that will better serve the community and Hospital.

DISCUSSION:

As part of the Hospital strategic plan for growth, management has been investigating new program opportunities that are needed in our primary service area, that coincide with the mission and vision of the district, and that will provide a positive financial contribution to the hospital. One such program is the development of a multi-specialty orthopedic service line.

Recruitment of orthopedic surgeons has become one of the most difficult recruitment efforts among all specialties. The supply of physicians coming out of residency and fellowship programs is not keeping up with the rate of retirement for outgoing physicians. This shortage has driven the income averages for spine and sports medicine orthopedists to over $500,000 per year.

Alameda Hospital has entered into Professional Services Agreements with physicians since it established its 1206(b) clinic in 2009. We are currently negotiating Professional Services Agreements with two new orthopedists to work in our 1206(b) clinic. These Agreements would include a twelve month income guarantee in Year One. After the first year, the physicians would be eligible for production incentives based on work units, atop a smaller guaranteed base. The annual guaranteed incomes are within the Fair Market Values for the specialties of sports orthopedic medicine and spine orthopedic medicine. The development of the orthopedic program at Alameda Hospital is contingent upon the Hospital's successful negotiation of Professional Services Agreements with the two orthopedists.

Orthopedists Nicholas Pirnia, M.D. and James DiStefano, M.D. were contacted by Alameda Hospital in 2011 regarding their interest in establishing an orthopedic practice in Alameda. Over the past five months, management has engaged in discussions with these two orthopedists who will be completing their orthopedic fellowships in spine and sports medicine, respectively, at the end of July, 2012. They both worked at Alameda Hospital in 2010 as residents in the Kaiser Orthopedic Program. Both surgeons valued their time here and are considering establishing a multidisciplinary orthopedic practice that will include general orthopedic surgery, spine surgery, and sports medicine in Alameda. After numerous meeting/interview sessions with these two physicians, it was concluded that assisting them to establish their practices in Alameda would be an essential component of a comprehensive Orthopedic Program.

While their primary orientation will be to the Alameda community, we are excited about their potential to attract patients from off-island. Two new attending orthopedists recently recruited by Highland Hospital, Dr. Swapnil Shah (Chief of Orthopedics) and Dr. Michael Krosin, graduated two years prior to Drs. Pirnia and DiStefano from the same residency program. They are well-known and well-liked by Drs. Pirnia and DiStefano. This has potential to lead to a closer working relationship with the County. Opportunities for these Orthopedists to work with University Healthcare Alliance, Children's Hospital, Oakland and other healthcare network institutions will be facilitated by Alameda Hospital.

There are currently three orthopedists that have practices in Alameda. Two of those offices are part-time practices, and two of the orthopedists have been on the Alameda Hospital Medical Staff for over 30 years. The Hospital's busiest orthopedist performed 178 cases at Alameda Hospital in 2011, in contrast to the 5 and 6 cases done last year by his colleagues.

In calendar year 2010, approximately 104 Alameda residents (zip codes 94501 and 94502) had orthopedic surgeries at hospitals other than Alameda. Additionally, 494 Oakland residents and 230 San Leandro residents had orthopedic surgery at hospitals other than Alameda. These

numbers present additional volume that, with a comprehensive orthopedic program, could be attracted to the Hospital.

Additional statistical data was gathered from a 2010 study completed by the American Academy of Orthopedic Surgeons that supports the importance of recruiting new orthopedists to the community. The report chose to look at surgeon density in the 65 and older population because these are the people most likely to require orthopedic care and numbers and age of surgeons may be linked to access problems for this age group presently and in the future. This study looked at changes in numbers and ages of orthopedic surgeons from 2002 to 2010. From that report findings specific to the state of California include:

- There are approximately 5.25 orthopedic surgeons for every 100,000 patients
    - Alameda has 3 orthopedic surgeons for its population of 75,000 patients
- There are approximately 4.50 orthopedic surgeons for every 10,000 patients over the age of 65
- The mean age of orthopedic surgeons is 52.9 with a 5% increase between 2002 and 2010 in the number of surgeons over age 64.
    - Alameda's 3 orthopedists are 71, 65, and 58, respectively.
- California is one of 6 states with over 13% of orthopedic surgeons aged 65 and older
- California has experienced an increase of more than 675,000 people aged 65 and older between 2002 and 2010
    - The fastest growing segment of the Alameda population is that of people aged 65 and older. It is predicted to increase 23% between 2010 and 2015.

Given the prevalence of musculoskeletal injury, wear, and degeneration as the population grows and ages, the development of a multi specialty orthopedic program at Alameda Hospital will benefit the community and Hospital for decades to come.

Proposed Compensation

Recruitment of orthopedic surgeons has become one of the most difficult recruitment efforts among all specialties. The supply of physicians coming out of residency and fellowship programs is not keeping up with the rate of retirement for outgoing physicians. This shortage has driven the income averages for spine and sports medicine orthopedists to over $500,000 per year.

Alameda Hospital has entered into Professional Services Agreements with Physicians since it established its 1206 (b) clinic in 2009. The development of the orthopedic program at Alameda hospital is contingent upon the Hospital's successful negotiation of Professional Services Agreements with two orthopedists, a sports medicine orthopedist and a spine medicine orthopedist, who wish to join our clinic. In addition to the practice of multi-specialty orthopedics, these physicians will be actively involved in the development of the comprehensive orthopedic program. That program includes participation in the Hospital's community outreach and marketing efforts both inside and outside the City of Alameda.

An offer made to the physicians by the hospital must be deemed to be fair and reasonable. To ensure that the offer is within Fair Market Value, Alameda Hospital engaged the services of

Debra Phairas, President of Practice & Liability Consultants, Inc. Ms. Phairas was asked to make recommendations on Fair Market Value for determining Base Salary and Work Relative Value Unit incentive compensation to the sports medicine and spine medicine orthopedists interested in joining the Alameda Hospital Medical Staff and the Alameda Hospital Physicians 1206 (b) clinic. Ms. Phairas is a recognized practice management consultant with over 25 years experience working with over 1,600 practices.

The attached compensation packages (Attachment A) are within Fair Market Value for the specialties of Sports Medicine Orthopedic Surgeon and Spine Medicine Surgeon.

Financial Analysis

Attached is the three-year financial analysis for the program and the practice (Attachment B). The Clinic Direct Margin is the monies generated from professional fees earned for physician services performed in their offices and in surgery minus the physicians' salaries and practice expenses. The Hospital Direct Margin is the "spin-off" revenue generated by the physicians for laboratory testing, diagnostic imaging services, surgical services and rehabilitation services performed at the hospital minus the Hospital's cost to provide these services. **The Clinic Direct Margin and Hospital Direct Margin must be looked at together to identify the Total Program Direct Margin as summarized below.**

	Year 1	Year 2	Year 3	Total
Clinic Direct Margin	(413,421)	186,088	193,537	(33,796)
Hospital Direct Margin	1,206,924	2,438,568	3,241,716	6,887,208
Total Program Direct Margin	793,504	2,624,656	3,435,253	6,853,412

The financial analysis assumes a ramp up over the three (3) years. It is projected to yield Total Program Direct Margins of $793,504 in Year One, $2,624,656 in Year Two and $3,435,253 in Year Three. The Orthopedic Program will generate significant revenue for the Hospital, an estimated $6.85 M over the first three years. This margin provides the hospital a source of new revenue that is critical to the enhanced operation of essential services, such as the Emergency Care Center.

Marketing and Communications

The attached Marketing and Communications Outline (Attachment C) summarizes the objectives, strategy, target audiences and components that may be used to build the comprehensive orthopedic program as well as the physicians' office practices. It will serve to build awareness of the Alameda Hospital orthopedists and the comprehensive pre-operative, surgical and post operative services available to the Alameda Community and other nearby cities, including San Leandro, Oakland and Piedmont. The comprehensive orthopedic program will be prominently featured in Alameda Hospital's marketing efforts.

ATTACHMENT A

COMPENSATION FOR SPORTS MEDICINE ORTHOPEDIST

1. **Base Compensation**. Physician's Base Compensation in Year One shall be Three Hundred Thousand Dollars ($300,000.00) per year. Physician Base Compensation in Years Two and Three shall be 70% of Year One Base, or Two Hundred Ten Thousand Dollars ($210,000) per year. Payment of Base Compensation shall be bi-weekly in the amount of 1/26 of Base Compensation, less applicable withholding.

2. **Physician Work RVU (WRVU) Threshold**. The WRVU Threshold shall be 7,000 per year.

3. **Incentive Bonus**. Once the Physician reaches the WRVU Threshold beginning in Year Two and years thereafter, Physician shall be paid an Incentive Bonus in the amount of forty-eight dollars ($48.00) for every WRVU over the WRVU Threshold as described in Section 2 above. WRVUs in excess of the WRVU Threshold shall be reviewed quarterly by Alameda Hospital Physicians (AHP) and interim Incentive Bonuses shall be paid to Physician based on progress during the quarter toward meeting the annual WRVU Threshold, reconciled for the full 12 months during the 4th quarter.

4. **Call Pay**. Physician's on-call pay for the days scheduled to provide general orthopedic coverage for patient care in the Emergency Room shall be at the rate established for general orthopedic coverage at Alameda Hospital. Physician's on-call pay for general orthopedic coverage at Alameda Hospital, or elsewhere as permitted hereunder, shall belong to, and be paid directly to, Physician and not to or through the Clinic. On-Call pay is not part of the Physician's Base Salary.

COMPENSATION FOR SPINE MEDICINE ORTHOPEDIST

1. **Base Compensation**. Physician's Base Compensation in Year One shall be Three Hundred Thousand Dollars ($300,000.00) per year. Physician Base Compensation in Years Two and Three shall be70% of Year One Base, or Two Hundred Ten Thousand Dollars ($210,000) per year. Payment of Base Compensation shall be bi-weekly in the amount of 1/26 of Base Compensation, less applicable withholding.

2. **Physician Work RVU (WRVU) Threshold**. The WRVU Threshold shall be 8,000 per year.

3. **Incentive Bonus**. Once the Physician reaches the WRVU Threshold beginning in Year Two and years thereafter, Physician shall be paid an Incentive Bonus in the amount of fifty dollars ($50.00) for every WRVU over the WRVU Threshold as described in Section 2 above. WRVUs in excess of the WRVU Threshold shall be reviewed quarterly by Alameda Hospital Physicians (AHP) and interim Incentive Bonuses shall be paid to Physician based on progress during the quarter toward meeting the annual WRVU Threshold, reconciled for the full 12 months during the 4th quarter.

4. **Call Pay**. Physician's on-call pay for the days scheduled to provide general orthopedic coverage for patient care in the Emergency Room shall be at the rate established for general orthopedic coverage at Alameda Hospital. Physician's on-call pay for general orthopedic coverage at Alameda Hospital, or elsewhere as permitted hereunder, shall belong to, and be paid directly to, Physician and not to or through the Clinic. On-Call pay is not part of the Physician's Base Salary.

ATTACHMENT B

Alameda Hospital
Orthopedic Program Pro Forma-First 12 Months
April 2, 2012

CLINIC													
Volume		**M-1**	**M-2**	**M-3**	**M-4**	**M-5**	**M-6**	**M-7**	**M-8**	**M-9**	**M-10**	**M-11**	**M-12**	**Total**
Sports - Office Visits		25	55	66	79	108	127	144	153	164	170	177	184	1,452
Spine - Office Visits		25	46	58	63	70	89	104	122	138	146	150	160	1,171
Total		50	101	124	142	178	216	248	275	302	316	327	344	2,623
Sports - Office Procedure/Hospital Surgery		3	5	7	8	10	9	11	10	12	12	13	13	113
Spine - Office Procedures/Hospital Surgery		4	6	7	8	9	10	9	10	10	9	11	11	104
Total		7	11	14	16	19	19	20	20	22	21	24	24	217
Physician Office Net Revenue														
Sports - Office Visit Professional Fee		3,050	6,710	8,052	9,638	13,176	15,494	17,568	18,666	20,008	20,740	21,594	22,448	177,144
Spine - Office Visit Professional Fee		3,050	5,612	7,076	7,686	8,540	10,858	12,688	14,884	16,836	17,812	18,300	19,520	142,862
Total		6,100	12,322	15,128	17,324	21,716	26,352	30,256	33,550	36,844	38,552	39,894	41,968	320,006
Sports - Hospital Surgery Professional Fee		3,396	5,660	7,924	9,056	11,320	10,188	12,452	11,320	13,584	13,584	14,716	14,716	127,916
Spine - Hospital Surgery Professional Fee		6,984	10,476	12,222	13,968	15,714	17,460	15,714	17,460	17,460	15,714	19,206	19,206	181,584
Total		10,380	16,136	20,146	23,024	27,034	27,648	28,166	28,780	31,044	29,298	33,922	33,922	309,500
Total Office Net Revenue		**16,480**	**28,458**	**35,274**	**40,348**	**48,750**	**54,000**	**58,422**	**62,330**	**67,888**	**67,850**	**73,816**	**75,890**	**629,506**
Clinic Expenses	FTE													
Staff Salaries	3	7,973	7,973	7,973	7,973	7,973	7,973	7,973	7,973	7,973	7,973	7,973	7,973	95,680
Physician Salaries	2	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000	600,000
Total Salaries		57,973	57,973	57,973	57,973	57,973	57,973	57,973	57,973	57,973	57,973	57,973	57,973	695,680
Benefits		15,653	15,653	15,653	15,653	15,653	15,653	15,653	15,653	15,653	15,653	15,653	15,653	187,834
Consulting & Legal - Practice Start up		17,000												17,000
Supplies		2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	2,083	25,000
Purchased Services-Billing Company		1,236	2,134	2,646	3,026	3,656	4,050	4,382	4,675	5,092	5,089	5,536	5,692	47,213
Rent		2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	2,600	31,200
Malpractice Insurance		1,583	1,583	1,583	1,583	1,583	1,583	1,583	1,583	1,583	1,583	1,583	1,583	19,000
Other		1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	1,667	20,000
Total Non-Wage		**41,822**	**25,720**	**26,232**	**26,612**	**27,242**	**27,636**	**27,968**	**28,261**	**28,678**	**28,675**	**29,122**	**29,278**	**347,247**
Total Clinic Expenses		**99,795**	**83,694**	**84,205**	**84,586**	**85,216**	**85,609**	**85,941**	**86,234**	**86,651**	**86,648**	**87,096**	**87,251**	**1,042,927**
Clinic Direct Margin		**(83,315)**	**(55,236)**	**(48,931)**	**(44,238)**	**(36,466)**	**(31,609)**	**(27,519)**	**(23,904)**	**(18,763)**	**(18,798)**	**(13,280)**	**(11,361)**	**(413,421)**

ATTACHMENT B

Alameda Hospital
Orthopedic Program Pro Forma-First 12 Months
April 2, 2012

HOSPITAL

Volume	M-1	M-2	M-3	M-4	M-5	M-6	M-7	M-8	M-9	M-10	M-11	M-12	Total
Sports - Inpatient Surgery Cases	4	4	4	4	4	4	4	4	4	4	4	4	48
Spine - Inpatient Surgery Cases	3	3	3	3	4	4	4	4	5	5	5	5	48
Sports - Outpatient Surgery Cases	1	2	2	2	2	2	2	3	3	3	3	3	28
Spine - Outpatient Surgery Cases	1	2	2	2	2	2	2	2	2	3	3	3	26
Total Hospital Cases	9	11	11	11	12	12	12	13	14	15	15	15	150
Total Cases Per Week	2	3	3	3	3	3	3	3	4	4	4	4	3
Hospital Surgery Case Net Revenue													
Sports - IP	55,600	55,600	55,600	55,600	55,600	55,600	55,600	55,600	55,600	55,600	55,600	55,600	667,200
Spine - IP	41,700	41,700	41,700	41,700	55,600	55,600	55,600	55,600	69,500	69,500	69,500	69,500	667,200
Sports - OP	3,992	7,984	7,984	7,984	7,984	7,984	7,984	11,976	11,976	11,976	11,976	11,976	111,776
Spine - OP	3,992	7,984	7,984	7,984	7,984	7,984	7,984	7,984	7,984	11,976	11,976	11,976	103,792
Total Hospital Surgery Case Net Revenue	**105,284**	**113,268**	**113,268**	**113,268**	**127,168**	**127,168**	**127,168**	**131,160**	**145,060**	**149,052**	**149,052**	**149,052**	**1,549,968**
Ancillary Outpatient Volume & Revenue													
Total Radiology Exams	44	89	109	125	156	189	217	241	265	277	287	302	2,300
Net Revenue	**8,507**	**17,184**	**21,097**	**24,160**	**30,285**	**36,750**	**42,194**	**46,788**	**51,382**	**53,764**	**55,635**	**58,527**	**446,272**
Physical Therapy Visits	99	178	222	254	311	349	388	415	456	463	495	512	4,142
Net Revenue	**2,673**	**4,806**	**5,994**	**6,858**	**8,397**	**9,423**	**10,476**	**11,205**	**12,312**	**12,501**	**13,365**	**13,824**	**111,834**
Total Hospital Net Revenue	**116,464**	**135,258**	**140,359**	**144,286**	**165,850**	**173,341**	**179,838**	**189,153**	**208,754**	**215,317**	**218,052**	**221,403**	**2,108,074**
Hospital Expenses													
Direct Hospital Expenses - IP	44,100	44,100	44,100	44,100	50,400	50,400	50,400	50,400	56,700	56,700	56,700	56,700	604,800
Direct Hospital Expenses - OP	3,358	6,716	6,716	6,716	6,716	6,716	6,716	8,395	8,395	10,074	10,074	10,074	90,666
Direct Variable Radiology Expenses	2,105	4,252	5,220	5,978	7,493	9,093	10,440	11,576	12,713	13,302	13,765	14,481	110,418
Direct Variable PT Expenses	2,277	4,094	5,106	5,842	7,153	8,027	8,924	9,545	10,488	10,649	11,385	11,776	95,266
Total Incremental Hospital Expenses	51,840	59,162	61,142	62,636	71,762	74,236	76,480	79,916	88,296	90,725	91,924	93,031	901,150
Hospital Direct Margin	64,624	76,096	79,217	81,650	94,087	99,105	103,358	109,237	120,458	124,591	126,128	128,372	1,206,924
Clinic Direct Margin	**(83,315)**	**(55,236)**	**(48,931)**	**(44,238)**	**(36,466)**	**(31,609)**	**(27,519)**	**(23,904)**	**(18,763)**	**(18,798)**	**(13,280)**	**(11,361)**	**(413,421)**
Hospital Direct Margin	**64,624**	**76,096**	**79,217**	**81,650**	**94,087**	**99,105**	**103,358**	**109,237**	**120,458**	**124,591**	**126,128**	**128,372**	**1,206,924**
Total Program Direct Margin	**(18,691)**	**20,860**	**30,286**	**37,412**	**57,622**	**67,496**	**75,839**	**85,332**	**101,695**	**105,793**	**112,848**	**117,011**	**793,504**

ATTACHMENT C

Marketing and Communications Outline for Comprehensive Orthopedic Program

Objectives

1. Establish a new comprehensive Orthopedic Program at Alameda Hospital.

2. Build awareness of new physicians and comprehensive rehab/post operative services available to the Alameda community and other nearby cities including San Leandro, Oakland, and Piedmont.

General Strategy

1. Position the new Orthopedic Surgeons as exceptional in their area of expertise.

2. Position Alameda Hospital's rehabilitation and post-operative services as exceptional in injury prevention/treatment and post-surgical care.

3. Positively influence the referring physician or other health care provider to refer patients for specialty orthopedic care.

4. Positively influence the consumer, both Alamedans and those from nearby communities, to choose Alameda Hospital's comprehensive Orthopedic Program when seeking care.

Target Audiences

1. Residents of Alameda and other nearby East Bay communities

2. Youth and adult sports community: health clubs, competitive sports leagues, schools, "active" adult clubs and organizations

3. Physicians and other health care providers (chiropractors, acupuncturists, massage therapists, physical therapists, etc.) including office personnel– both in Alameda and surrounding communities

4. Alameda Hospital Employees, Auxiliary and Foundation

5. Business community

6. Senior centers and organizations

7. New Homeowners

8. Community Leaders

Components

1. **Ad Development**

Determine program name and craft a message that will enhance perception as an exceptional, cutting-edge, orthopedic practice offering general orthopedic and specialty services. Program name and message will address the need to draw from beyond the city of Alameda. Develop an advertising campaign utilizing the following outlets:

1. Alameda Journal
2. Alameda Sun
3. SF Chronicle
4. Piedmonter
5. Montclarion
6. Piedmont Post
7. San Leandro Times
8. Alameda and Oakland Magazines
9. Harbor Bay Isle Homeowner's Association community newsletter
10. Alameda Patch online news site
11. E-blasts
12. Parent/student newsletters
13. Consider outdoor advertising including BART and AC Transit
14. Develop PSAs for local radio stations

2. **Direct Mail:**

a. Direct Mail Postcard featuring new surgeons and orthopedic program will be distributed to a targeted population in Alameda, Oakland, San Leandro, and Piedmont.

b. Fall 2012 Report to the Community – community newsletter distributed to Alameda residents and businesses. Newsletter will include a feature on Orthopedics.

c. Alameda Hospital will include information and announcement of new orthopedic service in "New Homeowner" programs.

3. **Web Site and Social Media:**

    a. Alameda Hospital will build separate Orthopedic page on Alameda Hospital web site. This will include health education and pre and post surgical information.

    b. Link from Alameda Hospital site to Physician practice site.

    c. Google analytics and paid search review will be completed to ensure keywords and adgroups include key orthopedic search words and phrases. This will increase traffic to the Hospital's web site.

    d. Facebook and Twitter posts will incorporate announcements of new surgeons and services, in addition to community events and presentations.

    e. Community presentations will be videotaped whenever appropriate and posted on the web site.

4. **Medical Staff Presentations and Mixers:**

    a. Attend and present at weekly Medical Staff meetings, and bi-weekly Grand Rounds

    b. Attend quarterly physician mixers

    c. Medical "Office Staff" presentations

5. **Community Outreach and Presentations:**

    a. Collaborate with community organizations and their existing programs. This includes presentations and tabling at events/venues.

        i. Chamber of Commerce – Alameda, Oakland, San Leandro

        ii. Mastick Senior Center

        iii. Health Clubs: Bladium, Harbor Bay Club, Mariner Square, etc.

        iv. College of Alameda

        v. Youth Organization meetings: Soccer, Baseball, Softball, Basketball, Lacrosse, Football, etc.

        vi. Golf Course

        vii. Alameda events and activities: Let's Move Alameda, FitCity Alameda

    b. Annual Community Health Fair – October 2012

    c. Community Presentations on sports medicine and orthopedic topics. There will be advertised in both print and electronic media.

d. Health and Wellness Articles - Regularly scheduled submissions in the Alameda Journal and Harbor Bay Isle Homeowners Association Newsletter will cover orthopedic/sports injury topics

6. **Monitor and Evaluate Effectiveness:**

    a. Monitor hospital census patterns for both inpatient and outpatient services

    b. Track physician patterns and utilization of hospital services

    c. Review patient demographics, including zip codes, age, ethnicity

    d. Monitor patient and visitor surveys, letters, comments

    e. Track overall website traffic and composition

    f. Monitor eblast open rates

    g. Review paid search metrics and Google analytics

2012 Timeline Overview

Timing of marketing and communications will be largely determined by the actual start date of the practice. Approximate start date: September 2012.

APRIL 2012

Internal marketing and communications will begin immediately after completing the Professional Services Agreement with the physicians.

- Medical Staff introductions and presentations
- Hospital-wide announcements: employees, medical staff, auxiliary

MAY 2012

In collaboration with orthopedic physicians, practice philosophy and message will be developed. Topics for presentations and articles will be determined.

JUNE 2012

8-10 weeks prior to opening, development of web page, postcard and print ads will begin.

AUGUST 2012

Physician Mixer will be scheduled within one month of opening.

SEPTEMBER 2012

Physicians are onsite and practice begins.

- Direct mail postcard will drop immediately after orthopedic practice opens.
- Print ads will publish the week of the opening and then weekly for 4-6 weeks. These will be widely placed in the publications listed above. Frequent ad placements will continue for 6-8 months.
- Web page to go "live" immediately upon opening.
- Physician outreach and visits begin: Doctors offices, chiropractors, rehab facilities, health clubs, youth organizations.
- Minimum of monthly community events/presentations will be scheduled beginning the first month of opening.

OCTOBER 2012

- Report to the Community will mail in early October.
- Community Health Fair – October 20, 2012

NOVEMBER & DECEMBER 2012

- Ad/article placement and physician outreach continues.
- Develop community educational series to launch January 2013.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: March 26, 2012

FOR: April 2, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: Approval of Proposed FY 2012 Executive Performance Metrics and Incentive Plan

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Recommendation:

Based upon the discussion of performance metrics at the last Executive Closed Session of the District Board, management's proposal for performance metrics for FY 2012 have been revised. In addition, management is proposing the following Executive Incentive Plan for FY 2012. Management proposes that the metrics and incentive plan for FY 2012 be divided into two components:

(1) the successful transition of Waters Edge into Alameda Hospital and its financial performance as measured against the business plan pro formas, and

(2) metrics and incentive compensation that would be awarded **only** if the original FY 2012 budget targets were achieved or exceeded.

It is also recommended that the first component would be extended to the three executives, as identified below, who were directly involved in planning, projecting and negotiating the transition of the Waters Edge facility into Alameda Hospital. It is recommended that the second component be extended only to those executives who have participated in the past, namely, the CEO and the Associate Administrator. Since the CFO position is currently vacant, any CFO hired between now and award of a FY 2012 incentive would not be eligible to participate. Finally, it is recommended that the **total** incentive payment awarded for components 1 and 2 would not exceed the total potential incentive percentages included in the previous incentive program. In previous years, the CEO was eligible for a bonus in the range of 25% (for achieving budgeted level performance) to 37.5% (for achieving "stretch" level performance). The Associate Administrator and CFO were eligible for a bonus in the range of 15% (for achieving budgeted level performance) to 22.5% (for achieving "stretch" level performance).

INTRODUCTION:

A key component of the evaluation of the CEO and other senior executives by the Board of Directors is the establishment of measurable performance metrics. This document outlines proposed performance metrics for FY 2012. Following the end of the Fiscal Year audit, the Board of Directors will determine the degree of achievement of the performance metrics for the

CEO; the CEO will determine the degree of achievement for the other senior executives. In FY 2012, given the Hospital's commitment to not introducing any new forms of compensation, it is recommended that the performance metrics only be applied to the previous participants in the Executive Performance Plan, namely the CEO, CFO and Associate Administrator. This year there is no incumbent, so there is not a CFO eligible to participate in the program.

1. **Waters Edge Incentive Compensation**

   In FY 2012 a major priority initiative was development of a business plan for the transition of Waters Edge to the Alameda Hospital license, successfully negotiating terms for an agreement with the former operators, and managing complex work plan to transfer licensure and obtain CMS certification of the facility for the Hospital license. This was the culmination of several years of pursuing a successful partnership between a SNF within the District and the Hospital. As a part of this process, key executives met with the leadership of every skilled nursing facility with the exception of one smaller facility. Bringing Waters Edge into the organization will have significant and long term positive impact on the financial state of the Hospital. It will be a key element in improving financial performance that should ultimately benefit the entire work force and our ability to implement wage increases to our workforce in the future. Furthermore, any incentives paid resulting to the Waters Edge component should be covered by added revenue generated through the addition of the program effective April 1, 2012.

   Management recommends that one half of the potential percentage incentive for the CEO and the Associate Administrator be attributed to performance relating to the Waters Edge component. This equates to 12.5% of base salary for the CEO and 7.5% for the Associate Administrator. The third executive directly involved in the Waters Edge planning and negotiations, the Director of Human Resources would also be eligible for up to a 7.5% of base salary bonus.

   A. Change in hospital licensure due to addition of 120 beds from Waters Edge and Recruitment of Long Term Care Director:

   Management recommends 50% of the Water's Edge incentive be made at the time of completion of license transfer, receipt of CMS certification and hiring of the LTC Administrator in acknowledgment of the extraordinary effort and time that has gone into the completion of this strategic milestone and its long term future impact on the organization.

   B. Achievement of marginal contribution targets:

   The remaining 50% of the Water's Edge incentive component would be based on achievement of the marginal contribution targets projected in the year one pro forma for Waters Edge as presented to the Board for the first three months of operation under the Hospital license. This part of the Water's Edge incentive component would be payable following completion of the FY 2012 audited financial statements.

2. **General Incentive Payments for FY 2012:**

Executive performance metrics are intended to promote and reward success in achieving the key, measurable strategic goals and priorities each year. The recommended basis of revenue over expense for the year will **include** the Hospital, South Shore and any new business entity or location which the hospital may operate under its license (e.g. Waters Edge, Wound Care, the 1206(b) clinic). The basis will **exclude** the CW&S and the 501(c)3 corporations. The excess of revenue over expense will also be adjusted to exclude any start-up program expenses which cannot be capitalized (e.g. one-time-consulting fees for integration of Waters Edge into the organization). The time frame used to measure the incentive metrics will be the FY 2012 (July 1, 2011-June 30, 2012).

Management recommends the following metrics as the basis for the second component of the FY2012 incentive pay-outs. While there are some factors that determine the actual revenue over expense, such as expense control and goals for revenue growth that are under the control of management, there are other factors over which management has little control or ability to predict at the time the budget is developed. Nevertheless, management recommends that pay-out of any incentive based on routine metrics does not seem equitable when the overall budget targeted has not been achieved; management recommends that the achievement of the budgeted bottom line remain on a "pass/fail" threshold for the payout of an incentive for all metrics. Therefore it is recommended that no payout be made for any of the metrics under the general component of the incentive unless the budget is achieved.

The measures are purposely few in number and measurable. Each represents a fundamental deliverable which influences advancement of our strategic objectives. The percentages would be applied against the appropriate level of incentive payment (i.e. "basic" or "stretch") for each participant.

The remaining 5 metrics in the plan would be paid at one of two levels based on the actual excess of revenue over expense of the audited financial results:

"Basic" Excess of Revenue over Expense: $ 540,000 (FY 2012 Budgeted net margin)

"Stretch" Excess of Revenue over Expense: $1,000,000

The potential bonus recommendations for the basic and stretch targets as a percentage of their base compensation are as follows:

Participant	Base Bonus	Additional Stretch Bonus
CEO	12.5%	12.5%
Associate Administrator	7.5	7.5
CFO	7.5	7.5

		Weighting
1.	Achieve or exceed the FY 2012 budgeted excess of revenue over expense:	**40% of total**
	• "Basic" Financial Achievement: $ 540,000 (FY 2012 budgeted excess of revenue over expense)	
	• "Stretch" Financial Achievement $ 1,000,000	
2.	Recruitment of one or more new orthopedists to community in order to increase Hospital volume of surgical procedures.	**15% of total**
3.	Revenue Cycle: Performance Metrics by June 30, 2012	**15% of total**
	• 90% of all Acute AR accounts (excluding Self-Pay) at 60 days or less.	
	• Long Term Care AR Accounts at 1.25 times prior months LTC gross revenue	
4.	Achieve construction completion and program start up of Wound Care Program by July 31, 2012	**15% of total**
5.	Complete and submit SB 90 Seismic Compliance Extension Application prior to March 31, 2012 deadline:	**15% of total**
	Total %	**100%**

Management proposes that the number of management participants in a performance metrics program should be expanded in the future, but only recommends implementation of this modification of the program after a complete fiscal year of meeting budgeted financial targets.

April 2, 2012

City of Alameda Health Care District

2009-2013 Goals and Objectives

2nd Quarter - FY 2012 Update

Financial Strength	
Achieve long-term financial viability	
Measures of success:	
■ Achievement of positive operating margin = 3% of net revenues by 2013	
■ Generate operating profitability levels necessary to support capital needs/service debt	
■ Raise $500,000 per year through Foundation fundraising initiatives	
■ Shift reliance on parcel tax from support of operations to support for capital investments and strategic development projects	
■ Sustain Performance vis-à-vis operating benchmarks at 90th percentile levels (e.g., FTE/Adj. Occupied Bed, Length of Stay, Costs per UOS)	
Initiatives	**Status**
(A) STRATEGY: Seek $250,000 contribution from Alameda County to assist with capital improvements of clinic space at Marina Village designed to serve low income patients	
(B) STRATEGY: Seek $1 million from Alameda County to underwrite uncompensated care delivered in Alameda Hospital Emergency Department	
(C) STRATEGY: Improve Revenue Cycle Metrics *	
Reduce volume of late charges as a percentage of gross charges (posted after bill drop) by 10%. (Current baseline: 0.9% for the last 4 months)	• Reduce volume of late charges reported daily by 85%. Timeline 6 months. • Reduce bill hold days from 5 to 3. Timeline 12-18 months. • Increase Point of Service collections (measurement based on stats not $): o 50% of eligible co-payments and deductibles collected in 4 months o 75% of eligible co-payments and deductibles collected in 6 months o 85% of eligible co-payments and deductibles collected in 9 months • Achieve CDM compliance in 9 months • Build Meditech Proration module for primary payors in 6 months; secondary in 9 months • AR reduction goal; timeline 180 days: o Hospital Medicare ATB 90/10 split at 60 days o Hospital Medi/Cal ATB 80/20 split at 60 days o All other 3rd party payors 75/25 split at 60 days
Increase percentage of AR less 60 days to 65% from current 60%	
Achieve Reimbursement in compliance with contract terms to 90%	
Reduce percentage of self pay by 10%	

(E) STRATEGY:	Reduce readmission rates (same DRG within 30 days) by 3% by end of FY 2012. Baseline = 29% for all DRG's
Develop a plan to reduce the DRG's that affect Value Based Purchasing (VBP): Heart Failure, Acute Myocardial Infarction, and Pneumonia using CMS Core Measures values as baseline	Evaluating internal data for Q-1 2012 (Jan-Mar). CMS current data not available.
(F) STRATEGY:	Reduce the percentage of observation patients to inpatient from 25% (baseline) to 19% (a 25% reduction) within the first 6 months of FY 2012 with the assistance of Executive Health Resources (EHR).
Concurrent review of weak inpatient or for observation status for possible conversion to inpatient by EHR.	Q1 FY 2012 = 19.3% observation rate which is slightly above the goal of 19%.

Growth	
Pursue fiscally responsible growth in services that target the most pressing acute and non-acute healthcare needs of the community.	
Measures of success:	
■ Market share growth. ■ From 31.25 percent to 35.0 percent – Alameda Island (ZIP Codes 94501 and 94502). ■ From 0.94 percent to 1.10 percent - Off-Island.	
■ Service line growth: volume targets defined by service line.	
■ Development of new access points and locations.	
■ Increase inpatient census by 5 ADC by 2013 to offset loss of Kaiser revenue and to support basic INP/ER infrastructure.	
Initiatives	**Status**
(A) STRATEGY:	Secure partnership with one additional long-term care facility within the District
	Waters Edge Sublease signed November, 2011. Transition Agreement in progress. Licensure transfer application submitted to State in November, 2011 Anticipated licensure and certification – April 2012
(B) STRATEGY:	Complete implementation of Wound Care Program, achieving volumes (IP and OP) services as projected in pro forma
For 6 months of FY 2012: 125 patients, 1,250 patient visits, $26,000 Net Income	Projected implementation in early Spring, 2012

(C) STRATEGY:	Implement one new surgical program reflecting an integrated continuum of services from pre-surgical to post surgical care. Programs to be considered include orthopedics and plastic surgery. This should contribute to the 5 % increase in surgeries.			
		Development of an orthopaedic program and recruitment of new orthopaedists (March 2012)		
(D) STRATEGY:	Increase selective higher outpatient services by the following:			
Diagnostic Imaging – 2% Increase		YTD Volume: 16,563	Budget: 17,643	% Inc/Dec.: -6.1%
Therapy: 5% Increase		YTD Volume: 8,703	Budget: 9,892	% Inc./Dec.: -12%
Surgery: 5% Increase		YTD Volume: 1,504	Budget: 1,456	% Inc./Dec.: 3.2%
(E) STRATEGY:	Increase nursing home admissions by 2% through improved transfer systems and quarterly communication from Case Management and SNF Liaison to nursing home leadership. Baseline = 19%			
		Q1 FY 2012 (July –September)at 19.2% compared to Q1 FY2011 (July – September) at 17.8% an increase of 1.4% from prior year, but slightly below goal by 0.8% December, 2011 Communication with Alameda skilled nursing facilities regarding Waters Edge Sublease Outreach continues through work of SNF Liaison (meeting with Oakland Rehab Center in November, 2011)		

Facilities and Technology	
Enhance our facility and technological capabilities to foster the achievement of our goals.	
Measures of success:	
■ Percentage of physicians who sign up for electronic access.	
■ Volume of hits to hospital website.	
■ Fund depreciation to TBD% in order to create capital reserve fund .	
Initiatives	Status
(A) STRATEGY: Develop master facility plan for Marina Village Space	
	In process.

(B) STRATEGY:	Improve HCAHPS scores for cleanliness of facility to 67.5% (quarterly average)
	Cleanliness went from 64% in Q2 and Q3 to 59% in Q4. PI Team Charter began work in January to look at cleanliness of facility and ways to improve scores. Preliminary scores show improvements (68%) in Q1 2012.
(C) STRATEGY:	Improve signage and way-finding systems in the following areas to improve image and reduce traffic through inpatient areas. Incorporate Bilingual signage where appropriate.
1. South Shore Skilled Nursing Unit	New signs being developed and ordered for installation in April.
2. South Shore Center Medical Office Building	Not complete.
3. East Building (Clinton and Doctor's parking lot entrance)	Not complete.
(D) STRATEGY:	Implement ECHO System upgrade
(E) STRATEGY:	Finalize scope and budget for implementation of required NPC-2 work. Meet reporting milestones for seismic extension provided by SB90
	NPC-2: Completing testing for structural engineer to determine options for compliance for bulk oxygen anchorage and bracing. SB90: Working with consultants to submit application prior to the March 31, 2012 required date. Submitted SB90 Application for original hospital building and Stephens Wing on March 20, 2012.
(F) STRATEGY:	Evaluate all Meditech modules which are currently being underutilized (ESS, PCS, EDM), making appropriate recommendations, if any, that should be activated.
(G) STRATEGY:	Evaluate formation of a dedicated surgical inpatient unit as mechanism to enhance quality of patient care and to increase surgical volume
	3-South rooms 3103-3112 have been designated as post-surgical beds, making a total of 5 beds making single patient rooms out of double. Patient population will consist of patients having orthopedic, vascular, and general surgery that requires an in-patient stay postoperatively. Currently identifying equipment, repair, and maintenance needs. Creating supply and medication levels to begin stocking supply room. Identifying computer, phone, and supply needs for nursing station. Developing staffing matrix with an emphasis on nurses with comprehensive postoperative care experience in orthopedics, vascular, and general surgery.

(H) STRATEGY:	Explore use of Hospital website for improved patient accessibility and access to information, including online registration and appointment scheduling.
	Exploring online pre-registration forms to secure host site. Functionality of and access to District Board web page has been enhanced.
(I) STRATEGY:	Complete 3 year schedule, key milestones, budget and impact on cash flow of progression to full meaningful use no later than October 2011.
	In process.
(H) STRATEGY:	Define alternative plan for reducing manual labor necessary to capture payroll information (in wake of discontinuing McKesson Project) by September 2011
	Not done, pending selection of new CFO.

Physicians	
Ensure that the Hospital attracts qualified and capable physicians through collaboration and alignment.	
Measures of success:	
■ Increase number and reduce average age of active physicians through targeted recruitment.	
■ Achieve annual recruitment goals.	
■ Increase volume of work by Alameda surgeons.	
Initiatives	**Status**
(A) STRATEGY: Continue to strengthen partnerships with key physician groups (Affinity, ABMG, Hill, AFP) to secure referral patterns, improve patient management, and coordinate approach to health plans.	
1. Enhanced use of long term care placement to reduce acute care utilization	Meetings held between leadership at both Affinity and UCSF. Multiple meetings held with University Health Care Alliance (February 2012).
2. Coordinated management of patients with chronic disease (e.g. CHF, Diabetes)	
3. Quarterly meetings	
(B) STRATEGY: Complete an inventory of physician practice based information systems and establish plan for gradual implementation of connectivity with MediTech system	

(C) STRATEGY:	Establish data collection system for tracking admission and referral patterns by physician and/or institution (e.g. SNF's) or point of entry (e.g. Emergency Department
	New Director of Decision Support and Financial Planning to set up tracking system.
(D) STRATEGY:	Track utilization under new contracts (e.g. Alameda Alliance, Medi-Cal, Blue and Gold Plan, etc)
	New Director of Decision Support and Financial Planning to set up tracking system.
(E) STRATEGY:	Complete first physician satisfaction survey by 4th quarter of FY 2012
	Not started.
(F) STRATEGY:	Maintain regular contact with East Bay physicians who are seeking practice setting alternatives other than those offered by existing large multispecialty groups.
	Ophthalmologist Jennifer Taylor, MD joined Medical Staff (October 2011) Recruited Pleasanton physician Bhoomika Kamath, MD to AFP (November 2011) Fall Physician Newsletter sent November 2011 Fall Physician Mixer held November 2011 Spring Physician Mixer planned for April / May 2012 New specialty physicians being solicited (Feb / Mar 2012) Two new orthopaedists being actively recruited (March 2012)
(G) STRATEGY:	Complete evaluation of outsourcing management of 1206 (B) clinic to practice management company
	Solicited one request for proposal from Affinity, who chose not propose at this time.

Quality/Service
Achieve superior clinical and service results on a consistent basis.
Measures of success:
■ Patient satisfaction (patient experience) as measured by 95% or more willing to recommend hospital to a friend
■ Joint Commission Core Measure compliance
■ Joint Commission/CMS/CDPH Accreditation

■ QI/Risk Reports that demonstrate improvement in problem areas	
■ Improve accuracy of information collection at time of registration	
Initiatives	**Status**
(A) STRATEGY: Improve aggregate HCAHPS scores (willingness to recommend) to 66%. Current baseline:	
	Q2 2011 score was 68%. Q3 2011 score was 65%. Q4 2011 score was 57%. Preliminary score for Q1 2012 shows improvement at 67%.
(B) STRATEGY: Redesign hospital website functionality as portal for patient service	
1. Evaluate on-line registration and appointment scheduling	Exploring online pre-registration to secure site
2. Add testimonials from patients and physicians	Reviewing web site redesign options to improve functionality. Access to District Board information has been improved.
3. Report key quality data on website	Hospital Compare Quality Data Link on main webpage. Monthly Board Quality Metrics posted with Board packets.
4. Add key educational and instructional material for patients discharged or treated as outpatients	Outpatient Imaging forms currently available on website. New Inpatient Discharge/Transfer Physician Order sets developed and fully implemented in Q3 2011 which include instructions for medication use and diagnosis specific instructions with referrals to outside agencies for cancer, cardiac disease, smoking cessation, etc.
(C) STRATEGY: Improve HCAHPS scores for cleanliness and noise and communication by 10%.	
	Although Q3 2011 scores improved, Q4 scores showed a drop to previous levels. Performance Improvement Charter for cleanliness was instituted in January 2012 which includes participation of all departments. A charter to improve the "noise at night" score is also being considered. Preliminary scores for Q1 2012 are improved in these focus areas.
(D) STRATEGY: All Core Measure scores above the 90th percentile – at or above State and National Averages	
	18 of the 27 indicators are at or above the State and National averages in the most recently reported Hospital Quality Measures.
(E) STRATEGY: Provide additional resources to patients upon discharge to raise awareness of hospital as broad health resource (e.g. Vial of Life, battery operated or crank radio or flash light, etc.)	
	Not started.

(F) STRATEGY:	Complete The Joint Commission (TJC) certification process for Primary Stroke Program
	Certification awarded on September 30, 2011 Custom stroke signs and symptoms magnets are provided at discharge for stroke patients. Free Community Stroke Risk Assessments continue to be offered.
(G) STRATEGY:	Implement childhood obesity prevention program in conjunction with schools (Let's Move Alameda)
	2012 Let's Move Alameda initiatives will focus on a "community-wide" pledge in addition to the Let's Move Into Summer campaign incorporating activity and nutrition.

People	
Foster a culture of exemplary performance through recruitment and retention practices that are founded on adherence to core performance standards and the continual development and celebration of our employees.	
Measures of Success:	
■ Increase number of Staff Nurse III among nursing staff by 2 in FY 2010-11 and by 1 each year thereafter (4 SN III in FY 2010).	
■ Maintain employee vacancy rates below regional benchmarks.	
■ Develop and monitor employee satisfaction surveys.	
■ Turnover rates of ***15%*** or less (Q42009 = 3.58%).	
■ Less comments about non-English in the workplace.	
■ Annual performance evaluations include aggregate measurement of service excellence.	
Initiatives	**Status**
(A) STRATEGY:	Establish annual master calendar of quarterly Town Hall Meetings with employees to communicate effectively and maintain employee confidence and inclusiveness
	Master Calendar developed, meetings scheduled for January, April, July, October. Town Hall Meetings were held on January 31 and February 1, 2012.
(B) STRATEGY:	Conduct quarterly update forums for medical staff at one of medical staff educational conferences
	Not started.

(C) STRATEGY:	In addition to maintaining ongoing annual events, consider increasing key employee morale building events that may include:
1. Annual picnic for employees, medical staff, auxiliary and their families	Currently in planning stage.
2. Administrative Hospital Rounding for all shifts / departments	Will reinstate Rounding in conjunction with Joint Commission preparation and tracer activities in third quarter.
3. Weekend Pet parade	Currently in planning stage.
4. Fall Pumpkin Carving contest	Held October 31, 2011 Additional morale building events: Hospital Night Oakland A's baseball Game: Held September 6, 2011. Annual Holiday Cheer and Employee Appreciation: Scheduled for December 14-15, 2011
(D) STRATEGY:	Hold quarterly lunches with new employees (approximately 90 days after employment) and executive staff to communicate further and obtain input from new hires
	First luncheon was temporarily deferred and will be scheduled during the second quarter of 2012.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: March 29, 2012

FOR: April 2, 2012 District Board Meeting

TO: Board of Directors, City of Alameda Health Care District

FROM: Deborah E. Stebbins, CEO

SUBJECT: Update on Management of Rehabilitation Services

RECOMMENDATION:

For the reasons outlined in the following discussion, management would like to continue consideration of outsourcing long term care rehabilitation services to Select Therapies. We will bring a business plan outlining the financial and qualitative benefits to the next Finance and Management Committee and District Board meetings. We will seek a full time manager for the inpatient and outpatient rehab services and qualified internal applicants are welcome to apply.

BACKGROUND AND DISCUSSION:

Over the past month, management has had continued discussions about our current and future needs for Rehabilitation Services. The addition of Waters Edge Skilled Nursing Facility to the hospital, together with our interest in enhancing our acute inpatient and outpatient rehabilitation programs, are driving our approach on how to best structure and manage the department going forward.

Under the direction of Richard Espinoza, our new Long Term Care Administrator, we are striving to implement policies & procedures and clinical protocols that are consistent throughout our Long Term Care (LTC) units (Subacute, South Shore and now Waters Edge). This consistency is especially important now that LTC services have become such a significant part of our overall patient population. In addition, all three facilities will be surveyed as one unit by the California Department of Public Health and having standardized clinical and administrative policies & procedures will be necessary.

Waters Edge recently contracted with Select Therapies, a professional rehabilitation management firm specializing in long term care therapy, to provide Physical Therapy, Occupational Therapy and Speech Therapy services to the residents at that facility. In meeting with Select Therapies, we believe they can provide the types of comprehensive clinical programs and services necessary for the success of our LTC units, many of which are different than the acute care setting.
As with most service contracts at Waters Edge, we feel it important to maintain the continuity and high quality of care provided at the facility during transition to the hospital.

A strong rehab program is critical to the success of our LTC service lines. The positive affects of a well managed LTC rehabilitation program include:

- Coordination of Care: Effective and efficient communication with physicians and nursing personnel is essential in providing excellent coordination of care.
- Care Plan: Well documented care plans lead to successful outcomes, both clinically and financially, for monitoring of skilled and custodial residents at all three LTC facilities. This includes quality assurance monitoring, Prospective Payment System (PPS), MDS 3.0 reimbursement and regulatory requirements, and performance improvement activities that are consistent throughout all LTC service lines.
- Quality of Life: It is vital to provide consistent rehabilitation services for the custodial nursing and subacute residents to prevent decline in function and to assist in developing plans and treatment to increase overall function for the resident.
- Facility Specific Programs: These programs will be based on unique resident needs such as homeward bound and community re-entry programs, wheelchair and bed positioning, contracture management and splinting, pain management, behavior / dementia management, fall prevention, post fall intervention, environmental adaptations, continence improvement, cognitive function and wound care.
- Financial Management: Proper oversight requires up-to-date and detailed understanding of Medicare (PPS), MDS 3.0, Medicare part B caps, Medi-Cal and other third party reimbursement contracts. When properly monitored daily, this will ensure that appropriate reimbursements are received for the care that is provided under contract.
- Marketing and Community / Physician Outreach: A long-term care program with a quality innovative rehabilitation component is very attractive to perspective physicians, residents, families and referring acute care hospitals when choosing a facility.
- State Surveys and Regulatory Compliance: Waters Edge, South Shore and the Subacute Unit of Alameda Hospital comprise our skilled nursing services. Consistency is an expectation throughout the policies, procedures, education, training, and ancillary services provided by each of these units.

Given the above factors, we feel that it is important to have all of our LTC rehabilitation services be provided by Select Therapies who can provide spectrum of programs and resources that are needed to make all of our LTC service lines successful. Although we acknowledge that our hospital based rehabilitation staff has done a respectable job working with the residents in the Subacute Unit and at South Shore, we continue to receive feedback that there is a need for improved communication with nursing personnel, coordination of scheduling of resident therapy sessions, processes for managing resident care plans and modifying those plans when there is a change in condition in conjunction with changes in the residents insurance benefits. Furthermore, the addition of Waters Edge will increase our skilled nursing capacity by over 100 residents, many of whom will be high rehabilitation utilizing residents, and we do not currently have the capability to manage this in-house. If this recommendation is approved at the next Board meeting, Select Therapies would give preference to our employees as they absorb this additional workload.

We also believe that there is a need to enhance and grow our outpatient and acute inpatient rehabilitation programs provided here at the hospital. This would require establishing a supervisor or manager to oversee these two specific service lines and we will encourage any of our existing staff who may have an interest to apply.

As we move forward with developing a comprehensive orthopedics program here at the hospital, having a strong and focused outpatient / acute inpatient rehabilitation program to support the needs of the orthopedic physicians and their patients will be a critical component of the programs success.

In addition to being clinically driven, this is also a business decision. As such, it needs to make sense financially as well and we are developing a business plan that will support this recommendation. The business plan will provide an overview of the current financial situation and identify goals and objectives for improving the level of care provided by our rehabilitation services department while optimizing reimbursement opportunities at South Shore and the Subacute Unit under Select Therapies management and for the outpatient / acute programs under our own management. The business plan will also identify growth opportunities as well as the recommended staffing levels, equipment and other expenses needed to make the plan work.

We have and will continue to meet with staff of the Rehabilitation Services Department in order to communicate what we are planning to do and why. We will also solicit their input and ideas on how to grow and improve these service lines as they are an integral part this plan and its success.

We plan to present the business plan and recommendations to the Finance and Management Committee in April and to the District Board in May.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: March 28, 2012

For: April 2, 2012 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: Deborah E. Stebbins, Chief Executive Officer

Subject: March CEO Report to the Board of Directors

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1. **Subacute Expansion:**

   Following up on discussions with Senator Hancock's office regarding strategies to add 12-14 beds to our Subacute unit and relocate all acute care beds to the South Building, we were advised to hold a conference call with Paul Coleman, Deputy Director of OSHPD and representatives of the CDPH District Licensing Office. Based on those discussions, Mr. Coleman affirmed that OSHPD has little flexibility to waive the enforcement of current construction codes when the bed classification is being changed. Hence we would be required to provide one ADA accessible bathroom per every six patients on 3 West if it were converted from Med/Surg to Subacute. However, as opposed to earlier construction plans we developed this would not necessarily have to necessitate an upgrade to four different bathrooms. Instead, since our Subacute residents generally rarely use private bathrooms in their individual rooms, these ADA toilets could be centrally located in one or two locations on the unit. We are working with our architects to draw up alternative construction solutions that might be far less than the original estimated modifications of $2 million. We will then have follow-up discussions with OSHPD about the feasibility of more cost effective approaches.

2. **Wound Care Update:**

   Construction on the space in Marina Village commenced on March 12 and is slated for completion in June. In the demolition work completed thus far, there have been no unexpected structural complications.

   Beth Brizee, the new Program Director (an employee of Accelecare) of the program started on March 19. Beth is an RN who has worked extensively in the long term care and wound care service lines in the East Bay for the past several years. She will work during construction on formulating policies and procedures, initiating key referral and marketing contacts and hiring the rest of the Clinic staff.

As of March 28, eight physicians are participating in the Wound Care Clinic physician panel. Interviews with the Medical Director candidates are expected to start the week of April 9, 2012.

3. **Waters Edge**:

We have completed all the transition planning, including processing all Waters Edge staff to the Alameda Hospital payroll. We currently are anticipating a transition of licensure effective Sunday, April 1, 2012. While our applications have been reviewed and tentatively approved by both the licensing department at the District and State level and by CMS, there has been the need for more discussion and review between the agencies and ourselves than we experienced during the acquisition of the South Shore license. Final review by the CMS legal counsel is occurring at the time of this writing. Since the content of all of our discussions with both the licensing and CMS has demonstrated support and insight into the benefits to the continuum of services to seniors as a result of the incorporation, we fully expect the transition will take place on April 1. If we receive any additional information about this prior to the Board meeting we will send out updates.

4. BLS Transport Discussions with Alameda Fire Department:

We have held one meeting with Fire Chief Mike D'Orazi and his staff about establishing a contract between the Hospital the Alameda Fire Department (AFD) for the transport of Basic Life Support (BLS) patient transport, e.g. transfer between the hospital and nursing homes and/or assisted living facilities or other acute hospitals. AFD is pursuing this expansion of their current responsibility for transport of all Advanced Life Support transport as a way of supplementing the costs of running the ALS services within Alameda. Part of the relationship would include the Fire Department assuming all responsibility for securing back up from other ambulance providers if they are not able to provide a 30 minute response time for a BLS request. AFD is currently putting a proposal together for our review; assuming we can reach competitive terms as with our other ambulance service providers, management feels this affiliation would support appropriate collaboration between two important City resources.

5. Intergovernmental Match for FY 2012:

AB 113 authorized the Medi-Cal Intergovernmental Transfer Program for District hospitals on a permanent basis. We have submitted our funds, $820,882, to qualify for the 2011-2012 match this week. This year we expect the turnaround of our deposit and matching funds will take a much shorter period of time than it did last year when the final process for administering AB 113 were still being worked out. As negotiated by the District Hospital Leadership Forum through

their planning with the State, we expect to receive $1,387,000 back from the State during the first week in May, resulting in a net match of $566,118.

6. **Workers Compensation Rebate**:

   As you will recall, last year we switched from Liberty to the Alpha Fund (a cooperative workers compensation pool associated with ACHD) for our workers compensation coverage due to their more favorable rates. Our workers compensation mod rating has continued to improve over the last couple of years, decreasing from over 1.0 to 0.8. Waters Edge mod rate has been in the mid 0.5 range so we expect our experience to continue to be positive.

   We still had reserves with Zurich (our workers compensation carrier before Liberty). These claims have almost all been resolved. As they get resolved we continue to get rebates from the Zurich reserves. This last week we received an annual rebate check from Zurich for $65,000.

7. **AB 97 Injunction:**

   There was some confusion at the last Finance and Board meetings regarding the posture the State was taking with regard to potential enforcement of AB 97 with regard to non-Subacute DP SNF reimbursement. I have attached two communications from CHA that have clarified the State's position. In essence, the U.S. District Court ruled in favor of a State request for a modification of the court's previous order for a preliminary injunction on State DP SNF rate reductions. The modification means that the State will be able to implement rate cuts of services provided between June 1, 2011 and December 28, 2011 but not yet paid for as of December 28, 2011 (the date the original injunction was granted). The State cannot, as of the present time, retroactively adjust reimbursement for claims already paid as of December. For us the State rate recovery for that period amounts to approximately $35,000 since most of the claims for the period had already been paid.

   The injunction on a rate reduction after the December 28 date remains in effect, but we have not received confirmation the State will not continue to fight that issue in the Courts.

   AB 97 continues to not apply to Subacute SNF patients per the decision of CMS that such rate reductions would have significant adverse impact on patient access.

8. **FY 2013 Budget:**

Management has begun our FY 2013 operating and capital budgeting process. Attached are volume assumptions relating to the base budget. From these figures we will project incremental volume, revenue and expense impact from some of our new programs, including Waters Edge, Wound Care and, if approved, the Comprehensive Orthopedic Program.

Deborah Stebbins - CHA Memo: Supreme Court Ruling in Medicaid Rate Cut Case - 2-22-12

From: "California Hospital Association" <info@calhospital.org>
To: Deborah Stebbins <dstebbins@alamedahospital.org>
Date: 2/22/2012 4:39 PM
Subject: CHA Memo: Supreme Court Ruling in Medicaid Rate Cut Case - 2-22-12
Attachments: Supreme Court Ruling 09-958.pdf

February 22, 2012

TO: CHA Member Chief Executive Officers, Chief Financial Officers, Legal Counsel, Government Relations/Public Policy

FROM: Anne McLeod, Senior Vice President, Health Policy

SUBJECT: Supreme Court Ruling in Medicaid Rate Cut Case

The U.S. Supreme Court issued the attached decision this morning in Douglas vs. Independent Living Centers, addressing whether or not providers may sue state officials to challenge Medicaid rate cuts because rates are so inadequate they violate the federal requirement that rates be consistent with quality of care and are sufficient to ensure beneficiaries have equal access to services (the "equal access provision"). The court, in a 5-to-4 decision, indicated that beneficiaries and providers likely may challenge these types of rate cuts in federal court.

CHA and other plaintiffs sued the Department of Health Care Services under the Supremacy Clause of the constitution, arguing that the reductions to Medi-Cal rates were preempted by federal law. The Supreme Court heard the case last fall and today issued a ruling remanding it back to the Ninth Circuit Court, concluding that actions taken by the Centers for Medicare & Medicaid Services (CMS), which retroactively approved the state rate cuts in October 2011 — after the case was briefed and argued — made the Supremacy Clause question no longer applicable. As a result of the changes in case circumstances, the court did not decide whether the plaintiffs could maintain a claim against the state under the Supremacy Clause.

The majority opinion, written by Justice Stephen Breyer, indicates that CMS' actions approving the California Medicaid rates do not change the "underlying substantive question" of whether the reductions are allowed under federal law. The court indicated that the plaintiffs claim may now be one directly against CMS under the Administrative Procedures Act (APA) to challenge the agency's approval of the rate cuts. The Court stated "... the APA would likely permit respondents to obtain an authoritative judicial determination of their claim."

We are pleased the Supreme Court appears to have recognized the ability of beneficiaries and providers to challenge Medicaid rate reductions under APA. This ruling will preserve the ability of beneficiaries and providers to ensure rates are minimally adequate so Medicaid recipients will have access to services. Without this ability, state budget pressures would likely result in more rate cuts, and patients would be denied access to services. As California moves toward implementation of the Medicaid expansion under the Affordable Care Act, access for patients could become that much more difficult.

Last year, Governor Brown, Health and Human Services Secretary Diana Dooley and CHA agreed to a comprehensive legislative package that included Medi-Cal reductions, the hospital fee program, extension of the 2013 seismic deadline to 2020, settlement of most CHA Medi-Cal lawsuits against the state, and other actions to help resolve the state General Fund budget deficit. In light of that agreement, CHA is still determining what actions are available to hospitals now that the Supreme Court decision has been made in this important case. As we work through the options with our attorneys, we will keep you informed.

For more information, please contact me at (916) 552-7536 or amcleod@calhospital.org, or Jana Du Bois, CHA vice president, legal counsel, (916) 552-7636 or jdubois@calhospital.org.

To unsubscribe from CHA memos, please send an e-mail to info@calhospital.org.

Deborah Stebbins - CHA Memo: Medi-Cal DP/NF Rates; Court Rules on Recovery - 3-20-12

From: "California Hospital Association" <info@calhospital.org>
To: Deborah E. Stebbins <dstebbins@alamedahospital.org>
Date: 3/20/2012 2:36 PM
Subject: CHA Memo: Medi-Cal DP/NF Rates; Court Rules on Recovery - 3-20-12

March 20, 2012

TO: CHA Member Skilled-Nursing Facilities

FROM: Patricia Blaisdell, Vice President, Post Acute Care Services

SUBJECT: Medi-Cal DP/NF Rates; Court Rules on Recovery

The U.S. District Court has ruled on the state's request for a modification of the court's previous order for a preliminary injunction prohibiting the Department of Health Care Services from implementing reductions to Medi-Cal reimbursement for distinct-part skilled-nursing facilities. The modification means the state will be able to implement rate cuts on reimbursements paid for a limited period prior to December 28, the date of the injunction. Payments for services that had been provided, but not yet paid as of that date, are subject to the rate cut.

The state argued under the 11th Amendment that a federal court cannot issue retroactive relief, and that the state should be able to recover the difference between the rate paid and the reduced rate for services provided prior to December 28. In a decision handed down March 8 and clarified March 16, the judge agreed with the state's argument, but limited retroactive implementation of the rate cuts to reimbursements for Medi-Cal services rendered but not paid as of December 28.

The decision means the state may legally proceed with retroactive adjustments for services that had been rendered but not paid as of December 28, and recover the difference between the current rates and rates equal to 2008-09 rates reduced by 10 percent. The state cannot, at the present time, retroactively adjust reimbursement for claims already paid as of that date.

For additional information, please contact Jana Du Bois, CHA vice president, legal counsel, at (916) 552-7636 or jdubois@calhospital.org, or me at (916) 552-7553 or pblaisdell@calhospital.org.

Alameda Hospital

Budget Volume Assumptions

FYE 2013

- FY 2013 Baseline Budget even with FY 2012 Forecast
  - Adjustment to FY 2013 CT Scan and Radiology Visits to account for remodeling downtime in Fall 2011

- Separate 3 West Nursing Unit into 3 Medical and 3 Surgical

- Expansion of Orthopedic Program with two new physicians in the fall
  - Additional 96 surgeries, patient stay average 4.4
  - Outpatient Therapy and Imaging visits

- Implementation of Wound Care Program July 1, 2012
  - Additional 1 inpatient per month
  - Outpatient Wound Clinic visits, plus laboratory, therapy and imaging visits

- Water's Edge long term care under Hospital umbrella on April 1, 2012
  - Projections based on pro forma as no history under Alameda Hospital yet

Alameda Hospital
Inpatient Acute Volume Summary
FY 2013 Budget

	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments Ortho Program	Adjustments Wound Care	Adjusted Budget FY 2013
Discharges - Acute	2,802	2,527	2,787	2,781	96	12	2,889
ALOS - Acute	3.8	4.1	4.0	4.0	4.4	3.0	4.0
Patient Days - Acute							
CCU	1,406	1,552	1,485	1,485	-	-	1,485
DOU	4,445	4,023	4,128	4,128	-	-	4,128
3 West	4,728	4,868	5,534		-	-	-
3 Medical				4,781	-	36	4,817
3 Surgical				730	422	-	1,152
Total Acute	10,579	10,443	11,146	11,124	422	36	11,582
Average Daily Census							
CCU	3.9	4.3	4.1	4.1	-	-	4.1
DOU	12.2	11.0	11.3	11.3	-	-	11.3
3 West	13.0	13.3	15.1		-	-	-
3 Medical				13.1	-	0.1	13.2
3 Surgical				2.0	1.2	-	3.2
Total Acute	29.0	28.6	30.5	30.5	1.2	-	31.7
Available Beds	66	66	66	66	-	-	66
Occupancy Percent	43.9%	43.3%	46.1%	46.2%			48.1%
CMI - Medicare	1.4174	1.4256	1.3594				
CMI - Total	1.3398	1.3332	1.2955				

Notes:

For comparability purposes, Kaiser volume has been excluded from prior years.

Alameda Hospital
Inpatient Long-Term Care Volume Summary
FY 2013 Budget

	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments	Adjusted Budget
Discharges						
Sub-Acute	13	24	52	52		52
South Shore	128	109	74	74		74
Water's Edge	-	-	33	132		132
Total Long Term Care Discharges	141	133	159	258		258
Patient Days						
Sub-Acute	11,977	11,861	11,898	11,898		11,898
South Shore	7,832	7,965	7,882	7,882		7,882
Water's Edge	-	-	8,159	38,774		38,774
Total Long Term Care Days	19,809	19,826	27,939	58,554		58,554
Average Daily Census						
Sub-Acute	32.8	32.5	32.5	32.6		32.6
South Shore	21.5	21.8	21.5	21.6		21.6
Water's Edge (1)	0.0	0.0	89.7	106.2		106.2
Total Average Daily Census	54.3	54.3	143.7	160.4		160.4
Payer Mix						
Sub-Acute						
Medicare	1%	1%	1%	1%		1%
Medi-Cal	94%	94%	96%	96%		96%
Other	5%	5%	3%	3%		3%
South Shore						
Medicare	14%	14%	14%	19%		19%
Medi-Cal	85%	85%	85%	80%		80%
Other	1%	1%	1%	1%		1%
Water's Edge						
Medicare	n/a	n/a	10%	13%		13%
Medi-Cal	n/a	n/a	81%	76%		76%
Other	n/a	n/a	10%	11%		11%
Available Beds (1)	60	60	170	170		170
Occupancy Percent	90.5%	90.5%	84.5%	94.4%		94.4%

1) Water's Edge to begin operation under Alameda Hospital license April 1, 2012, projected at 91 calender days and 110 beds

Alameda Hospital
Surgery & Outpatient
FY 2013 Budget

	Actual FY 2009	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments Ortho Program	Adjustments Wound Care	Adjusted Budget FY 2013
ECC Visits	17,337	17,624	16,816	16,800	16,800	-	-	16,800
Outpatient Registrations	29,948	29,079	23,796	22,950	23,839	5,910	696	30,445
Per Day								
ECC	47.5	48.3	46.1	45.9	46.0	-	-	46.0
Registrations	82.0	79.7	65.2	62.7	65.3	16.2	1.9	83.4
Surgeries								
Inpatient	588	592	502	468	468	96	-	564
Outpatient	1,288	1,351	1,708	1,807	1,807	54	-	1,861
Total	1,876	1,943	2,210	2,274	2,274	150	-	2,424

Alameda Hospital
Five Year Detail Trend of Outpatient Visits + Budget

	Actual FY 2009	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments Ortho Program	Adjustments Wound Care	Adjusted Budget FY 2013
ATC Satellite Lab	167	2,617	3,145	143	-	-		-
Cardio Fit	1,330	1,337	1	-	-	-		-
CT Scan	567	525	483	440	460	787		1,247
EEG	-	-	-	24	24			24
EKG	867	892	865	823	823			823
IV Therapy	2,027	1,676	1,132	891	891			891
IVT Other	-	386	735	772	772			772
Laboratory	9,830	6,560	5,800	7,846	7,846		200	8,046
MRI	479	454	501	545	545	938		1,483
Nutrition	22	12	14	33	33			33
Nuclear Medicine	213	125	161	148	148		38	186
Outpatient - Clinic	22	16	344	631	631			631
Occupational Therapy	472	451	479	301	301			301
Physical Therapy	3,515	3,381	3,046	3,084	3,084	4,142	30	7,256
Respiratory Therapy	80	177	73	79	79			79
Speech	75	20	28	63	63			63
Surgery	5,184	4,182	1,672	1,780	1,780			1,780
Ultrasound	33	1,194	1,200	1,201	1,201			1,201
Radiology	8,565	7,174	7,035	6,207	7,300	575	138	8,013
Wound Care	-	-	-	-	-		2,500	2,500
Other	83	1,587	30	4	4			4
Total Visits	33,531	32,766	26,744	25,011	25,985	6,442	2,906	35,333
O/P Registrations	29,951	29,082	23,796	22,950	23,839	5,910	696	30,445

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Handouts & Presentations from April 2, 2012 District Board Meeting

Alameda Hospital Orthopedic Program Pro Forma 3/28/2012

	Year 1	Year 2	Year 3	Total	Source:
CLINIC					
Volume					
Sports - Office Visits	1,452	3,270	4,067	8,789	
Spine - Office Visits	1,171	2,163	2,756	6,090	
Total	2,623	5,433	6,823	14,879	All volume data for both office visits and procedures taken from physician projections for spine and sports medicine presented to Hospital Management
Sports - Office Procedure/Hospital Surgery	113	230	313	656	from Practice and Liability Consultants
Spine - Office Procedures/Hospital Surgery	104	205	278	587	
Total	217	435	591	1,243	
Physician Office Net Revenue					
Sports - Office Visit Professional Fee	177,144	398,940	508,375	1,084,459	Each physician's volume calculated at MCR rate of the average of the top 10
Spine - Office Visit Professional Fee	142,862	263,886	336,232	742,980	procedure codes for each specialty or $122 per visit for each physician
Total	320,006	662,826	844,607	1,827,439	
Sports - Hospital Surgery Professional Fee	127,916	260,360	355,255	743,531	Dr. D. revenue calculated at $1132/procedure
Spine - Hospital Surgery Professional Fee	181,584	357,930	485,388	1,024,902	Dr. P. revenue calculated at $1746/procedure
Total	309,500	618,290	840,643	1,768,433	
Total Office Net Revenue	**629,506**	**1,281,116**	**1,685,250**	**3,595,872**	

Clinic Expenses	FTE		FTE		FTE			
Staff Salaries	2.5	95,680	3.5	122,720	4.5	243,360	461,760	YR 2-Add Medical Assistant; YR 3-Add Physician Assistant
Physician Salaries	2.0	600,000	2.0	582,000	2.0	739,000	1,921,000	
Total Salaries		695,680		704,720		982,360	2,382,760	
Benefits		187,834		190,274		265,237	643,345	27% of Total Salaries
Consulting & Legal - Practice Start up		17,000		-		-	17,000	
Supplies		25,000		25,750		26,523	77,273	
Purchased Services-Billing Company		47,213		96,084		126,394	269,690	
Rent		31,200		31,200		31,200	93,600	
Malpractice Insurance		19,000		27,000		40,000	86,000	
Contingency		20,000		20,000		20,000	60,000	
Total Non-Wage		347,247		390,308		509,353	1,246,908	
Total Clinic Expenses		**1,042,927**		**1,095,028**		**1,491,713**	**3,629,668**	
Clinic Direct Margin		**(413,421)**		**186,088**		**193,537**	**(33,796)**	

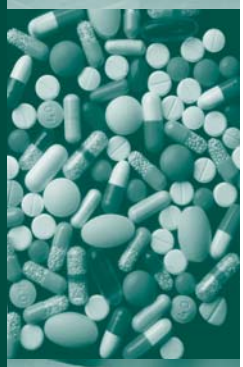
Alameda Hospital Orthopedic Program Pro Forma 3/28/2012

	Year 1	Year 2	Year 3	Total	Source:
HOSPITAL					
Volume					
Sports - Inpatient Surgery Cases	48	96	131	275	Volume based on a 70/30 split of the procedures predicted for each practice by
Spine - Inpatient Surgery Cases	48	96	131	275	D. Pharis (70% Surgery Cases-30% Office Procedures)
Sports - Outpatient Surgery Cases	28	56	76	160	YR 1-YR 2 volume increase 200%, YR2-YR 3 volume increase 136% as calculated
Spine - Outpatient Surgery Cases	26	52	71	149	by D. Pharis in procedure volume for each practice
Total Hospital Cases	150	300	408	858	
Total Cases Per Month	13	25	34	72	Total Cases per year divided by 12
Total Cases Per Week	3	6	9	18	Total Cases per year divided by 4
Hospital Surgery Case Net Revenue					
Sports - IP	667,200	1,334,400	1,814,784	3,816,384	Based on Alameda Hospital current Orthopedic average net revenue per case
Spine - IP	667,200	1,334,400	1,814,784	3,816,384	including all ancillary revenue directly related to the hospital surgery cases--
Sports - OP	111,776	223,552	304,031	639,359	lab, xray, physical therapy--does not include revenue from ancillary volume
Spine - OP	103,792	207,584	282,314	593,690	generated on an outpatient basis--see below
Total Hospital Surgery Case Net Revenue	**1,549,968**	**3,099,936**	**4,215,913**	**8,865,817**	
Ancillary Outpatient Volume & Revenue					
Total Radiology Exams	2,300	4,765	5,984	13,049	Volume based on 87.7% of office visit volume per CDC publication "National
Net Radiology Revenue	**446,272**	**924,360**	**1,160,852**	**2,531,483**	Health Statistics Report" #27 dated 11/3/2010
(Based on AH current net revenue for Xray)					Not surgical procedure or in-patient related
Physical Therapy Visits	4,142	8,478	10,960	23,580	Volume based on an average of 9 visits per Surgery and 2 visits per remaining
Net Physical Therapy Revenue	**111,834**	**228,906**	**295,920**	**636,660**	Office Visit (9 visits taken from Academy of Orthopedic Surgeons paper
(Based on AH current net revenue for PT)					"Benchmarking Physical Therapy Programs" July 2011 Issue)
Total Hospital Net Revenue	**2,108,074**	**4,253,202**	**5,672,685**	**12,033,960**	
Hospital Expenses					
Direct Variable Surgery Expenses - IP	604,800	1,209,600	1,645,056	3,459,456	Based on Alameda Hospital current average expenses for Orthopedic services
Direct Variable Surgery Expenses - OP	90,666	181,332	246,612	518,610	related to surgical and non-surgical patient encounters
Direct Variable Radiology Expenses	110,418	228,708	287,221	626,346	Based on Alameda Hospital current Imaging Department direct costs
Direct Variable PT Expenses	95,266	194,994	252,080	542,340	Based on Alameda Hospital current Rehab Department direct costs
Total Incremental Hospital Expenses	901,150	1,814,634	2,430,969	5,146,752	
Hospital Direct Margin	1,206,924	2,438,568	3,241,716	6,887,208	
Clinic Direct Margin	**(413,421)**	**186,088**	**193,537**	**(33,796)**	
Hospital Direct Margin	**1,206,924**	**2,438,568**	**3,241,716**	**6,887,208**	
Total Program Direct Margin	**793,504**	**2,624,656**	**3,435,253**	**6,853,412**	

National Ambulatory Medical Care Survey

Factsheet

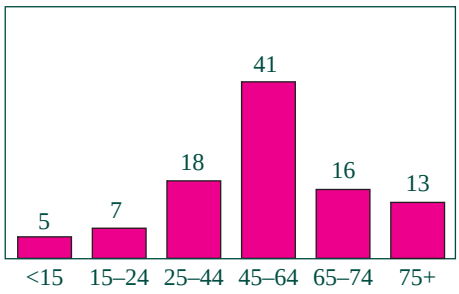
ORTHOPEDIC SURGERY



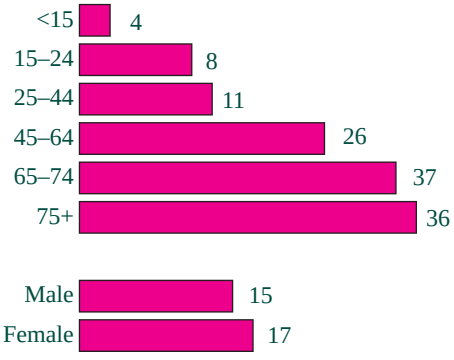
In 2009, there were an estimated 49 million visits to nonfederally employed, office-based physicians specializing in orthopedic surgery in the United States. More than half of the visits were made by persons aged 25–64 years.

Percent distribution of office visits by patient's age: 2009



The annual visit rate increased with age until age 74.

Annual office visit rates by patient's age: 2009



Number of visits per 100 persons per year

Primary expected source of payment included:

- Private insurance — 69%
- Medicare — 26%
- Workers' compensation — 10%
- Medicaid — 6%

The major reason for visit was:

- New problem — 35%
- Pre- or post-surgery/injury follow-up — 28%
- Chronic problem, routine — 20%
- Chronic problem, flare-up — 15%

The top 5 reasons given by patients for visiting orthopedic surgeons were:

- Knee symptoms
- Postoperative visit
- Shoulder symptoms
- Hip symptoms
- Back symptoms

The top 5 diagnoses were:

- Arthropathies and related disorders
- Rheumatisms, excluding back
- Spinal disorders
- Sprains and strains
- Fracture of lower limb

Medications were provided or prescribed at 54 percent of office visits. The top 5 generic substances utilized were:

- Acetaminophen with hydrocodone
- Ibuprofen
- Acetaminophen with oxycodone
- Meloxicam
- Lidocaine

For more information, contact the Ambulatory Care Statistics Branch at 301-458-4600 or visit our Web site at <www.cdc.gov/namcs>.

NAMCS data are widely used in research studies appearing in nationally recognized medical journals, including *JAMA, Journal of Family Practice,* and *Spine*. Here are just a few publications using NAMCS data:

Friedman BW, Chilstrom M, Bijur PE, Gallagher EJ. Diagnostic testing and treatment of low back pain in United States emergency departments: a national perspective. *Spine* (Phila Pa 1976). 35(24):E1406–11. Nov 2010.

Sacks JJ, Luo YH, Helmick CG. Prevalence of specific types of arthritis and other rheumatic conditions in the ambulatory health care system in the United States, 2001–2005. *Arthritis Care Res* (Hoboken). 62(4):460–4. Apr 2010.

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Avasarala J, Odonovan CA, Roach S, Camacho F, Feldman S. Analysis of NAMCS data for Multiple Sclerosis, 1998–2004. *BMC Med*. 5(1):6. Apr 2007. [Epub ahead of print]

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The complete list of publications using NAMCS data, which includes hundreds of articles and reports, is available on our Web site.

Demographic Factors Affecting Orthopedics

1990

- 31.1 million Americans were 65 years of age or older
- 1 in 8 Americans was elderly
- 3.6 million people were estimated to be 85 years and over

2020

- 54 million Americans will be 65 years of age or older
- 1 in 6 will be elderly
- 18.2 million are estimated to be 85 years and over
- Arthritis will affect more than 18% of all people in the US (nearly 60 million)
- Demand for hip and knee replacements is expected to increase by 2020

From “Demographics: Shaping the Future of Physical Therapy”, PT Magazine

Factors Affecting Orthopedics Going Forward

- Patients with an orthopedic conditions increased from 28% to 30% from 2001 to 2011
- Obesity
  - More than 44 million Americans are obese, an increase of 74% since 1991
  - 1991-- only 4 states had obesity rates of 15% or higher
  - 2001-- every state except Colorado showed obesity rates of 15% or more
  - 2001--29 states reported rates of 20% or greater
- Patients may also be undergoing joint replacement at a younger age, a trend that is exacerbated by rising obesity rates.
- One in three women and one in eight men aged 50 years and older will experience an osteoporotic related fracture in their lifetimes

Alameda Hospital

Orthopedic Program & Surgeon Recruitment Presentation City of Alameda Health Care District Board of Directors Meeting

April 2, 2012

Tony Corica, Director of Physician Relations
Mary Bond, MBA, RN, CNO

Physicians remain the key initiators and providers of medical care. Little takes place in Medicine that is not ordered by, reviewed by, or performed by a physician

Current State of Orthopedics in Alameda

- Current orthopedists are all over 57
- Residents are searching for the latest in orthopedic practices
- Many residents go off-island to receive their orthopedic care
- There is no spine surgeon on the island

Current Opportunity

- Nicholas Pirnia, MD
  - Fellowship trained in Spine Surgery
- James DiStefano, MD
  - Fellowship trained in Sports Medicine
- Both worked at Alameda Hospital as residents during the Kaiser Surgery Program
- Both have lived in the Bay Area
- Neither are affiliated with any group
- Both are interested in building a multispecialty orthopedic program based at Alameda Hospital
- Building a comprehensive Orthopedic Program needs a focused effort by physician leaders who will assist with protocol development, staff training, marketing and referral development.
  - Both Drs. Pirnia and DiStefano **WANT** to undertake this role

Nicholas Pirnia, MD
Spine Surgery

James DiStefano, MD
Sports Medicine

What the New Orthopedists Will Bring to Alameda

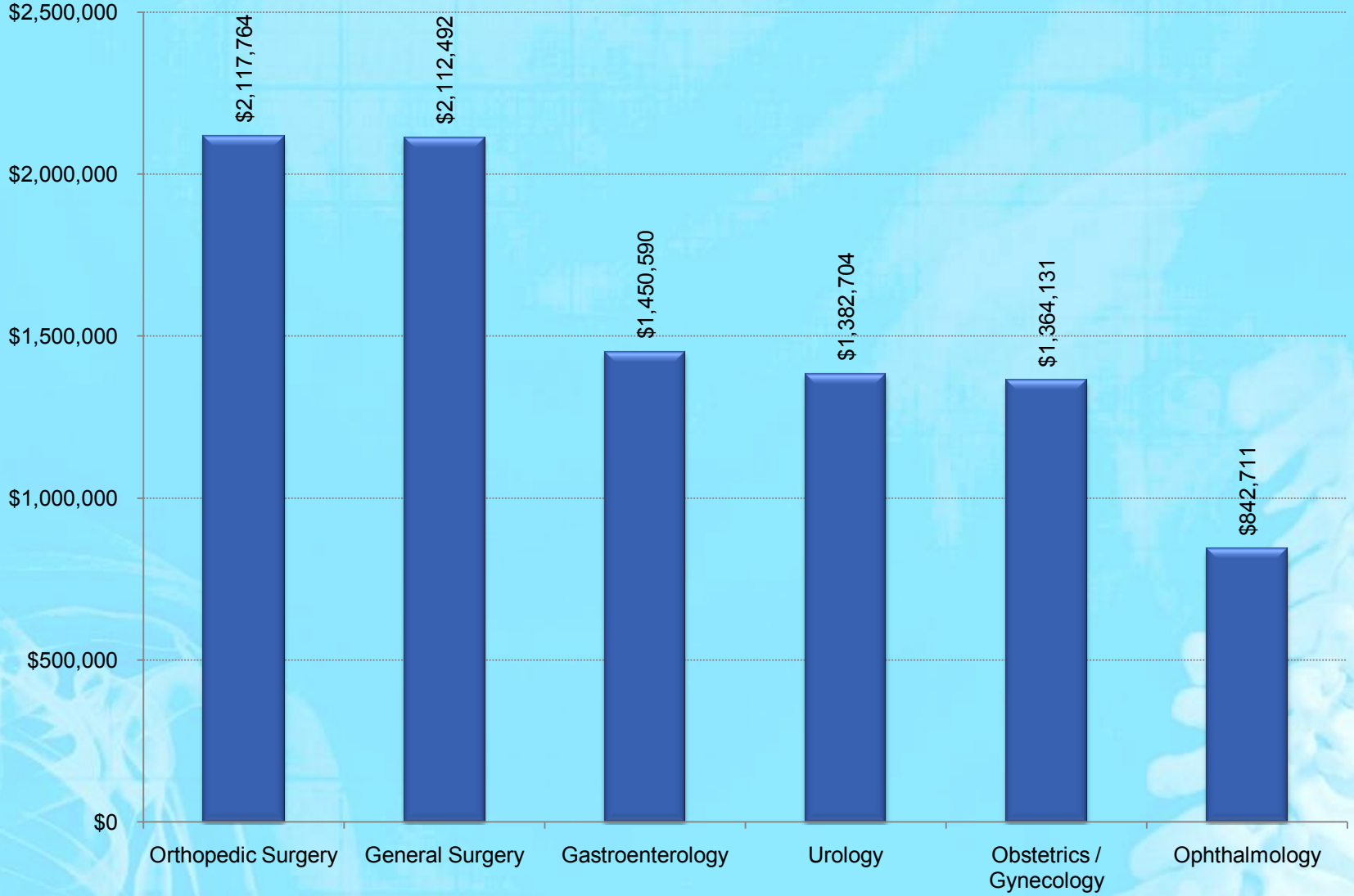
- Being fellowship trained in the latest orthopedic approaches, techniques, and minimally invasive procedures
- Provide the Hospital with a succession plan for orthopedics
- Better meet the needs of Alamedans by establishing a multidisciplinary orthopedic practice of sports, spine and general orthopedics.
  - Physicians understand the importance of community outreach, marketing and social media in order to make themselves and the orthopedic program successful.
- May generate new sources of patient volume from outside Alameda
  - They are known to other orthopedists in the bay area that could lend itself to increased opportunities for work at Alameda Hospital.
    - Rakesh Donthineni, MD
    - Drs. Shah and Krosin at Alameda County

Orthopedic Capabilities at Alameda Hospital

- Kaiser surgery experience (2005-10) resulted in Alameda Hospital having the facilities and staff experienced in supporting a spine program and sports medicine program, in addition to general orthopedics

- Operating Room has the capacity to increase the volume of invasive procedures and surgeries

Survey of Hospital Revenue/Specialty 2010*



*From Merrit Hawkins 2010 Physician Inpatient/Outpatient Revenue Survey-A survey showing net annual revenue generated by physicians in various specialties on behalf of their affiliated hospitals

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Quantitative Analysis

The financial benefits that newly recruited physicians may bring to a hospital

- A full time orthopedic surgeon should annually generate approximately $2.1M in combined inpatient and outpatient revenue for the Hospital
  - These benefits may support the hospital mission of providing quality care to the community by creating revenue streams necessary to its continued or its enhanced operation

- Alameda Hospital's busiest orthopedic surgeon generated over $1.7M to Alameda Hospital in the FY 2011

	Year 1	Year 2	Year 3	Total
Clinic Direct Margin	**(413,421)**	**186,088**	**193,537**	**(33,796)**
Hospital Direct Margin	**1,206,924**	**2,438,568**	**3,241,716**	**6,887,208**
Total Program Direct Margin	**793,504**	**2,624,656**	**3,435,253**	**6,853,412**

Qualitative Analysis

The impact of recruited physicians on the quality of care provided to the Community

- Physicians trained in the latest orthopedic approaches, techniques and minimally invasive procedures
- Patients not having to leave the Island.

  "Quality care close to home"
- Increased involvement through activities at the local schools, health clubs and youth organizations
- Educational opportunities for the community

Ability to Fund the Program

- The Hospital cash flow is projected to stabilize after September, 2012
- Drs. Pirnia and DiStefano plan to start working after mid-September

Evolving Physician/Hospital Relations

A growing number of physicians today are employed by hospitals

Summary of the Benefits an Orthopedic Program Brings to the Health Care District

- It allows Alamedans to receive “state of the art” multispecialty orthopedic care on the island
- It will attract patients to Alameda Hospital from off island
- Position us to become a destination hospital for orthopedics
- It will contribute significantly to the Hospital’s bottom line
- It provides a succession plan for orthopedics in the City of Alameda and Alameda Hospital

Orthopedic Program Pro Forma-Clinic

		Year 1		Year 2		Year 3	Total
CLINIC							
Volume							
Total Office Visits		2623		5433		6823	14,879
Total Procedures/Surgery Cases		217		435		591	1,243
Total Physician Volume		**2840**		**5868**		**7414**	**16,122**
Physician Office Net Revenue							
Total Office Professional Fee Net		320,006		662,826		844,607	1,827,439
Total Hospital Surgery Revenue		309,500		618,290		840,643	1,768,433
Total Office Net Revenue		**629,506**		**1,281,116**		**1,685,250**	**3,595,872**
Clinic Expenses	FTE		FTE		FTE		
Staff Salaries	2.5	95,680	3.5	122,720	4.5	243,360	461,760
Physician Salaries	2.0	600,000	2.0	582,000	2.0	739,000	1,921,000
Total Salaries		695,680		704,720		982,360	2,382,760
Total Non-Wage Expenses		347,247		390,308		509,353	1,246,908
Total Clinic Expenses		**1,042,927**		**1,095,028**		**1,491,713**	**3,629,668**
Clinic Direct Margin		**(413,421)**		**186,088**		**193,537**	**(33,796)**

Orthopedic Program Pro Forma-Hospital & Total Program Margin

HOSPITAL	Year 1	Year 2	Year 3	Total
Volume				
Total Hospital Cases	**150**	**300**	**408**	**858**
Total Cases Per Month	13	25	34	72
Total Cases Per Week	3	6	9	18
Total Hospital Surgery Case Net Revenue	**1,549,968**	**3,099,936**	**4,215,913**	**8,865,817**
Ancillary Outpatient Volume & Revenue				
Total Radiology Exams	2,300	4,765	5,984	13,049
Net Radiology Revenue	**446,272**	**924,360**	**1,160,852**	**2,531,483**
(Based on AH current net revenue for Xray)				
Total Physical Therapy Visits	4,142	8,478	10,960	23,580
Net Physical Therapy Revenue	**111,834**	**228,906**	**295,920**	**636,660**
(Based on AH current net revenue for PT)				
Total Hospital Net Revenue	**2,108,074**	**4,253,202**	**5,672,685**	**12,033,960**
Hospital Expenses				
Total Incremental Hospital Expenses	901,150	1,814,634	2,430,969	5,146,752
Hospital Direct Margin	**1,206,924**	**2,438,568**	**3,241,716**	**6,887,208**
Total Program Margin				
Clinic Direct Margin	**(413,421)**	**186,088**	**193,537**	**(33,796)**
Hospital Direct Margin	**1,206,924**	**2,438,568**	**3,241,716**	**6,887,208**
Total Program Direct Margin	**793,504**	**2,624,656**	**3,435,253**	**6,853,412**

City of Alameda Health Care District | Alameda Hospital
Primary Stroke Center

Patients Served in 2011

- 117 Total Stroke patients
- 41 Trans Ischemic Attacks
- 54 Ischemic Strokes
- 19 Hemorrhagic Strokes
- Brain Aneurysm
- May to December 17 Code Strokes
- TPA was given to 5 patients in 2011

Activities

Monthly

- Stroke Team Meetings
- Community Stroke Screenings

Quarterly Meetings

- Bay Area Stroke Coordinators
- Alameda County EMS- attended by Stroke Coordinator and Stroke Program Director or Emergency Medical Director

Stroke Education Classes for Hospital Staff and Nurses

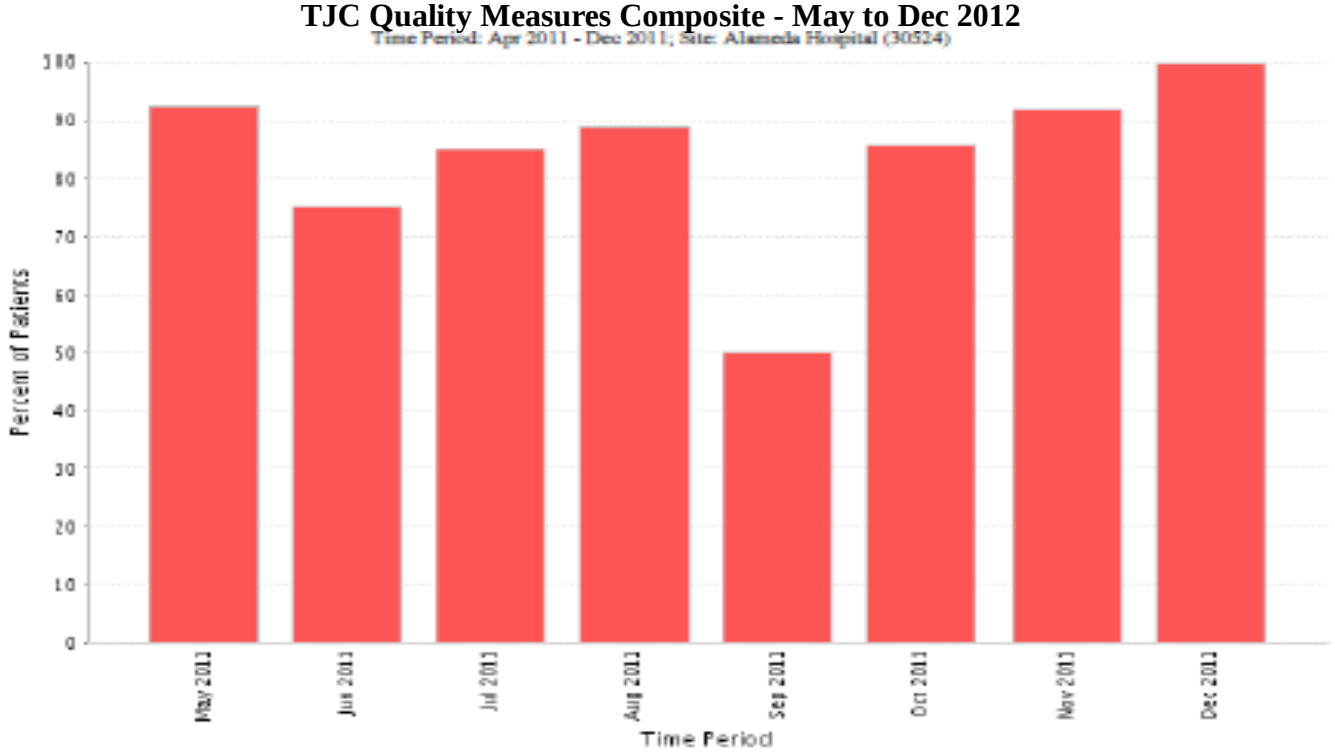
- Invitation extended to paramedics and EMTs of Alameda Fire Department and Paramedics Plus

TJC Quality Measures	Q-3	Q-4
• VTE Prophylaxis	75%	92%
• Discharged on Antithrombotic	100%	100%
• Anticoag for Atrial Fib	NA	100%
• Thrombolytic Therapy	0%	50%
• Antithrombotic by day 2	100%	91%
• Discharge on Statin	57%	83%
• Stroke Education	60%	100%
• Assessed for Rehab	100%	100%
• *TJC Recommendations:*		
• Vital Signs and Neuro Assessments Performed and Documented as Ordered (goal 90%)	NA	89%
GWTG Measures		
• TPA treat by 3 hours	NA	50%
• Early Antithrombotics	100%	100%
• DVT Prophylaxis	60%	90%
• Antithrombotics at Discharge	100%	100%
• Anticoag for A/fib	NA	100%
• Smoking Cessation	50%	100%
• LDL > 100, Disch on Statin	46%	86%

SIGNIFICANT ACHIEVEMENT FEBRUARY 2012

Bronze Award from Get With The Guidelines for achievement of 85% in each of the 7 GWTG measures for 90 days. Advertised in US News & World Report.

TJC Quality Measures Composite - May to Dec 2012



Distributed at April 2, 2012 District Board Meeting