STRATEGIC PLANNING COMMITTEE MEETING
MONDAY, January 13, 2014

Executive Suite Located at Highland Care Pavilion
1411 East 31st Street Oakland, CA 94602
Marla D. Cox, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session: HCP Conference Center Room A

MEMBERS
Stanley M. Schiffman, Chair
Michele Lawrence
J. Bennett Tate
Barry Zorthian, MD
James Lugannani

AGENDA

OPEN SESSION / ROLL CALL 3:30 – 3:35 p.m.

TAB #1 ACTION: Consent Agenda (3:35 – 3:40 pm)
Stanley M. Schiffman, Chair Strategic Planning Committee

A. Approval of the Minutes from the November 18, 2013 Strategic Planning Committee Meeting.

Recommendation: Motion to approve.

END OF CONSENT AGENDA

TAB #2 REPORT: Chief Strategy Officer Report (3:40 – 3:55 pm)
Carladenise A. Edwards, Ph.D., Chief Strategy Officer

TAB #3 DISCUSSION: Information Technology (IT) Strategic Plan (3:55 – 4:25 pm)
Dave Gravender, Chief Information Officer
TAB #4 DISCUSSION: Physician Hospital Organization (PHO) Update
(4:25 – 4:55 pm)
William Peruzzi, M.D., Chief Medical Officer

TAB #5 DISCUSSION: STRATEGIC CONSIDERATIONS
(4:55 – 5:30 pm)
Stanley M. Schiffman, Chair Strategic Planning Committee

TAB #6 INFORMATION: Committee Annual Work Plan / Issue Tracking & Follow-up
(5:30 – 5:40 pm)
Stanley M. Schiffman, Chair Strategic Planning Committee

Public Comments

Board of Trustees Remarks

ADJOURNMENT
THE MEETING WAS CALLED TO ORDER AT 3:30PM.

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Stanley M. Schiffman, Michele Lawrence, J. Bennett Tate and Barry Zorthian, MD.

TAB #1  CLOSED SESSION – None

TAB #2  ACTION: Consent Agenda
Approval of the Minutes from the September 23, 2013 Strategic Planning Committee Meeting.

ACTION: A motion was made and seconded, and the Committee approved the minutes.

TAB #3  REPORT: Chief Strategy Officer Report
Carladenise Edwards, Chief Strategy Officer provided an update on the priority initiatives the Strategic Planning Committee is tracking in FY2014. The initiatives discussed were:

- Physician Hospital Organization which is in development and under Dr. Peruzzi’s leadership. The team is aiming to complete development and integration of physicians within the next 6 months. A timeline will be presented at the next meeting.
- San Leandro Hospital has seen a slight increase in its daily census.
- Alameda Hospital District is still scheduled to close on February 28th. The board was scheduled to review the Joint Powers agreement on November 21.
• **Alameda Alliance and AHS Health Plan Strategy** - Carladenise shared that the Alliance's application for the commercial product that is expected to be offered through Covered CA is pending. Carladenise reported that this has no impact on the Alliance provision of Medi-cal benefits or our current Medi-cal patients.

**TAB #4**

**UPDATE: Ambulatory Care Strategic Plan**
Benita McLarin, V.P., Ambulatory Health Care Services provided a status update on the Ambulatory Strategic Plan. She shared the progress her team has made in expanding services through the opening of new clinics and access points.

**TAB #5**

**DISCUSSION: STRATEGIC CONSIDERATIONS**
The committee talked at length about how we measure the impact of the activities on patient wait times and volume. The meeting concluded with a presentation on the process for reporting on the strategic goals that will provide the Board and the management team clarity on progress toward our strategic plan initiatives. Carladenise will provide the Committee with a matrix to track progress and present data in a manageable format.

Public Comments - None

Board of Trustees Remarks - None

**ADJOURNMENT** 5:33 p.m.
This memorandum is a brief update on the priority initiatives the Strategic Planning Committee (SPC) is tracking in FY2014. I will share detail during the January 13, 2014 SPC meeting on each of the areas we are tracking.

1. Physician Hospital Organization Development
   a. William Peruzzi, MD AHS Chief Medical Officer will share the status of the PHO’s development during the January 13th Strategic Planning Committee meeting.

2. Strategic Partnerships
   a. Hospital Network Development
      i. San Leandro Hospital has had a steady increase in inpatient volume since the transition on October 30, 2013. On Monday, January 6, 2014, AHS hosted a forum with San Leandro’s local elected officials where officials were able to meet AHS leadership, take a tour, and participate in a Question and Answer session.
      ii. Alameda Hospital District transition is in progress. The transaction is scheduled to close on February 28, 2014. The due diligence and transition work is on-going.

   b. AHS Managed Care Strategy
      i. AHS is working toward establishing managed care contracts with each of the managed care companies in our region. We have identified 21 payors,
including IPAs and Medical Groups. To date, we have 10 agreements in place and 11 that are in negotiation.

c. Community Health Center Network (CHCN)
   i. AHS Leadership held a white board session with CHCN on Thursday, January 9. The purpose of the meeting was to discuss the formation of a strategic partnership that will enable both organizations to improve their existing working relationship and better serve the patients in our networks. The outcome of that meeting will be shared during the SPC meeting on Monday, January 13th.

3. Access
   a. Benita McLarin presented the status of the Ambulatory Expansion plan during the November SPC meeting. To date, there are no significant updates to report.

4. System Transformation/Population Health Management (Shared with QPSC)
   a. No report at this time.

5. Information Technology Strategy
   a. Dave Gravender, AHS CIO will present the IT Strategic Plan during the January 13th meeting.

6. Strategic Plan Progress
   a. Attached to this report are three documents for discussion during the SPC meeting.
      i. Strategic Plan Dashboard Development
      ii. Strategic Plan Dashboard Worksheets
      iii. Strategic Plan Framework and Definitions
Alameda Health System

Strategic Plan Dashboard

Strategic Plan Period FY2012-FY2021
Friday, January 10, 2014
**Background**

In 2012, Alameda Health System completed a three year strategic plan (FY13 – FY15). The objectives of the strategic planning process were to:

- Improve the health system’s capacity to successfully manage the health of the population
- Develop strategies that are ambitious, yet predicated on moving the organization toward increased financial sustainability
- Integrate various planning components in development or underway across the health system

The plan was adopted by AHS BOT in November of 2012 and implementation began in January of the following year. The strategic plan dashboard is a tool being developed by the Strategy Division to assist leadership with monitoring the organization’s progress toward its strategic goals. Dashboards can serve as valuable accountability tools that highlight accomplishments, as well as risk to success that require immediate action or mitigation.

**Purpose**

This document represents the first iteration of a summary of AHS Strategic Plan adopted by the Board of Trustees in 2012. This document outlines the organization’s goals and objectives and the related strategies along with the timeframes for implementation. Please note – this document reflects what is presented in the current plan completed by Kurt Salmon and Associates (KSA) in October 2012. The Strategy Division is aware that there may be apparent gaps in this document. These gaps are reflection of the additional work required to perfect the plan and position the organization for continued success. The attached document is intended to:

- Serve as tool for AHS’ current leadership to assess the strategies and tactics outlined in the plan,
- Identify the gaps that need to be filled based on our understanding of the current health care environment, and
- Serve as a roadmap to the development of the final Executive Level Strategic Plan Dashboard

**Content**

The proceeding pages include the following content for discussion.
• **Summary of AHS Strategic Plan (Page 1 of 3):** This page includes a detailed summary of the following elements of the strategic plan: Goals, Objectives, Strategies, and Implementation Tactics. It also highlights how many there are of each element in the strategic plan. As noted above, there are gaps that need to be filled in order to develop a complete picture for successful implementation.

• **Strategic Plan Dashboard (FY2012-2022) (page 2 of 3):** This page will serve as the foundation for the executive level dashboard that the Strategic Planning Division is developing. It includes the goals, a description of the objectives, and the performance metrics. On this page, the strategic planning division took the liberty of reformatting or repositioning objectives, strategies, and tactics included in the plan, so that they align with the appropriate goals. This helped eliminate some of the gaps that are visible on the previous page.

• **AHS Strategic Plan Gantt Chart (page 3 of 3):** – This detailed chart includes the extensive detail found in the plan related to the timing of each implementation tactic. The purpose of this document is to offer a visual presentation of the numerous tactics defined and the recommended implementation timeframe as described in the Strategic Plan.

**NEXT STEPS**

The attached documents are being reviewed by the executive leadership team and a full assessment of each objective and its related strategies and tactics will be completed. The assessment will include an evaluation of the current relevance, any gaps that need to be filled, progress made to date, feasibility of completing within the designated timeframe, and identification of resources required for successful completion.

The goal is to improve the current work product, present any necessary changes or revisions to leadership, and finalize the dashboard that will be used to monitor our progress for the remainder of the implementation period.
<table>
<thead>
<tr>
<th>Strategic Pillars</th>
<th>Strategic Goals</th>
<th>Objectives</th>
<th>Strategies</th>
<th>Implementation Tactics</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHS “PILLARS” foundation upon which AHS strives to fulfill its vision.</td>
<td>GOALS define what the organization must achieve in order to support AHS’s pillars, fulfill its mission, and achieve its vision.</td>
<td>OBJECTIVES define what will be achieved within the planning timeframe in greater detail than Goals.</td>
<td>STRATEGIES outline how an organization will achieve its goals.</td>
<td>TACTICS: specific activities that support strategy.</td>
</tr>
<tr>
<td>Growth &amp; Access</td>
<td>1 ACCESS</td>
<td>Market competitive standard for access in the communities we serve that organizational growth</td>
<td>1. Implement staged specialty recruitment initiative to achieve payor mix-market share goals as outlined in 2011 ISFP with ADAC &amp; new patient populations</td>
<td>1. Complete implementation of remaining NBO recommendations from Multicare RC assessment</td>
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<td></td>
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<td></td>
<td>2. Focus internal BD recruitment to develop Institute on Aging and meeting DSRIP milestones</td>
<td>2. Redesign revenue cycle organization (see pg 70 for project plan) to be superior to national benchmarks</td>
</tr>
<tr>
<td></td>
<td>2 SUSTAINABILITY</td>
<td>Financial sustainability that supports growth and reinvestment to sustain our mission</td>
<td>3. Increase number of specialty referrals across all payors from community designated community clinic (e.g., CHCN) referrals</td>
<td>3. Reorganize ACMC physician sponsors</td>
</tr>
<tr>
<td></td>
<td>3 INTEGRATION</td>
<td>Effective physician and hospital partnerships that support clinical integration leading to improved quality and experience for patients</td>
<td>4. Implement organizational-wide initiatives to develop, confirm and reinforce vision for a culture of service</td>
<td>4. Develop partnerships and programs to improve clinical quality and support</td>
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<td>4 EXPERIENCE</td>
<td>Patients feel valued, cared for and continue to choose us as their medical home/provider of care</td>
<td>5. Leverage revamped Foundation to increase philanthropic giving and community awareness of ACMC and new patient populations</td>
<td>5. Complete implementation of DSRIP initiatives relating to improved patient experience as tactical elements to support future market expectations</td>
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<td></td>
<td>5 NETWORK</td>
<td>Community engagement and external partnerships that align resources necessary for a sustainable, clinically integrated network of care</td>
<td>6. Implement cross-functional service line structure to advance patient-centered care and align accountability for clinical, improved patient experience and financial sustainability</td>
<td>6. Develop Institutes of Care for select specialty areas</td>
</tr>
<tr>
<td></td>
<td>6 WORKFORCE</td>
<td>Culture of excellence in the workforce that empowers staff to embrace and lead transformation to a high performance health system</td>
<td>7. Develop relationships with community clinics to support specialty referrals to ACMC</td>
<td>7. Develop relationships with community clinics to support specialty referrals to ACMC</td>
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<td>8. Complete tactical implementation plans to improve access as outlined in DSRIP</td>
<td>8. Complete tactical implementation plans to improve access as outlined in DSRIP</td>
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<td>9. Continue advancement of Behavioral Health Services through continued operational improvement &amp; facility development</td>
<td>9. Continue advancement of Behavioral Health Services through continued operational improvement &amp; facility development</td>
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<td>10. Revise and implement a new retail services business model and secure new supporting facility to meet current &amp; expected future market expectations</td>
<td>10. Revise and implement a new retail services business model and secure new supporting facility to meet current &amp; expected future market expectations</td>
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<td>11. Implement support strategy.</td>
<td>11. Implement support strategy.</td>
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<td>12. Establish a new physician operating model complete with requisite infrastructure to support participating physicians</td>
<td>12. Establish a new physician operating model complete with requisite infrastructure to support participating physicians</td>
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<td>13. Increase patient experience and satisfaction scores</td>
<td>13. Increase patient experience and satisfaction scores</td>
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<td>15. Prioritize efforts to improve clinical quality and reported by major reporting agencies</td>
<td>15. Prioritize efforts to improve clinical quality and reported by major reporting agencies</td>
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<td>16. Supplement on-going clinical quality improvements with targeted performance improvement initiatives focused on select clinical service lines as platform for clinical delivery transformation integrated with ADAC physician partners</td>
<td>16. Supplement on-going clinical quality improvements with targeted performance improvement initiatives focused on select clinical service lines as platform for clinical delivery transformation integrated with ADAC physician partners</td>
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<td>17. Implement partnership agreements with select healthcare organizations based on a standardized framework to advance goals 1-4</td>
<td>17. Implement partnership agreements with select healthcare organizations based on a standardized framework to advance goals 1-4</td>
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<td>18. Develop and launch initiatives to implement evidence-based practices</td>
<td>18. Develop and launch initiatives to implement evidence-based practices</td>
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<td>19. Engage medical staff to increase understanding of rationale, vision, and structure of new POM (Communicate framework to ADAC physician sponsors)</td>
<td>19. Engage medical staff to increase understanding of rationale, vision, and structure of new POM (Communicate framework to ADAC physician sponsors)</td>
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<td>20. Establish system-wide structural issues that impede improvement of overall patient experience</td>
<td>20. Establish system-wide structural issues that impede improvement of overall patient experience</td>
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<td>21. Drive improvement through individual departmental / unit patient experience plans</td>
<td>21. Drive improvement through individual departmental / unit patient experience plans</td>
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<td></td>
<td>22. Create &amp; enhance current accountability structure and incentives to reinforce expectations</td>
<td>22. Create &amp; enhance current accountability structure and incentives to reinforce expectations</td>
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<td>23. Complete implementation of DSRIP initiatives relating to improved patient experience as tactical elements to support improved patient experience and satisfaction scores</td>
<td>23. Complete implementation of DSRIP initiatives relating to improved patient experience as tactical elements to support improved patient experience and satisfaction scores</td>
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<td>24. Increase caregiver time in patient care through reductions in non-productive time</td>
<td>24. Increase caregiver time in patient care through reductions in non-productive time</td>
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<td>25. Increase caregiver time in patient care through reductions in non-productive time</td>
<td>25. Increase caregiver time in patient care through reductions in non-productive time</td>
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<td>26. Increase caregiver time in patient care through reductions in non-productive time</td>
<td>26. Increase caregiver time in patient care through reductions in non-productive time</td>
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<td>27. Improves the organizations vision and progress</td>
<td>27. Improves the organizations vision and progress</td>
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</tbody>
</table>
## Alameda Health System

### Strategic Plan Dashboard (FY2013-2021)

<table>
<thead>
<tr>
<th>Strategic Goals</th>
<th>Description of Objective</th>
<th>Objectives</th>
<th>Measure of success</th>
<th>Target</th>
<th>Progress to target</th>
<th>FY12 Baseline (Actual)</th>
<th>FY12 Result</th>
<th>Performance (FY13 Plan)</th>
<th>Performance (FY17 Plan)</th>
<th>Performance (FY21 Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOALS</strong></td>
<td>Define what the organization must accomplish in order to support AHS’s pillars, fulfill its mission, and achieve its vision</td>
<td>OBJECTIVES provide a quantitative description of the milestones/outcomes AHS must accomplish to achieve the goals</td>
<td>Detailed definitions of the specific, quantitative metrics aligned to each objective, each metric has a target value</td>
<td>Value AHS seeks to achieve over time</td>
<td>Percent of target attained by latest results</td>
<td>Expectation according to strategic plan</td>
<td>Expectation according to strategic plan</td>
<td>Expectation according to strategic plan</td>
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<tr>
<td>1 ACCESS</td>
<td>Market competitive standard for access in the communities we serve that supports organizational growth</td>
<td>(1) Reduce wait times to available clinic appointments to 30 day Medicaid standard for PCPs or specialists</td>
<td>Number of days to 3rd next available appointment (AHS average)</td>
<td>30</td>
<td>56%</td>
<td>190</td>
<td>30</td>
<td>30</td>
<td>30</td>
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<td>(2) Increase system scale to serve broader Alameda community (geography/demographics) increasing annual clinic visits 67% by 2017</td>
<td>Total number of adult clinic visits, excluding psych &amp; rehab</td>
<td>464,750</td>
<td>73%</td>
<td>277,083</td>
<td>—</td>
<td>464,750</td>
<td>760,000</td>
<td></td>
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<td></td>
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<td>(3) Expand geographic footprint to adding wellness centers or strategic access points in N. Oakland, San Leandro, Hayward</td>
<td>Establishment of wellness centers or access points in each geography</td>
<td>3</td>
<td>33%</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
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</tr>
<tr>
<td>2 SUSTAINABILITY</td>
<td>Financial sustainability that supports growth and reinvestment to sustain our mission</td>
<td>(1) Achieve financial performance consistent with Moody's Baa credit rating priority metrics by 2021</td>
<td>Days Cash on Hand - including available cash and cash equivalents</td>
<td>80</td>
<td>0%</td>
<td>tbd</td>
<td>47</td>
<td>58</td>
<td>82</td>
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<td></td>
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<td>(2) Realize annual operational improvements (cost savings and revenue enhancements) projected in 2011 EPS</td>
<td>Cash flow/EBIDA margin (%)</td>
<td>7.90%</td>
<td>13%</td>
<td>3.00%</td>
<td>8.10%</td>
<td>8.10%</td>
<td>8.10%</td>
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<td></td>
<td>(3) Diversify payer mix, increasing share of revenues derived from Medicare and Commercial payors by 2017</td>
<td>Cumulative cost savings and revenue enhancements (SODs) achieved since FY12</td>
<td>$45,859</td>
<td>Input needed</td>
<td>$ -</td>
<td>$45,859</td>
<td>$79,801</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>(4) Improve AHS Revenue Cycle to be superior to national benchmarks -- not further defined (is it included in #2?</td>
<td>Medicare share of inpatient discharges (%)</td>
<td>21%</td>
<td>Input needed</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
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<tr>
<td>3 INTEGRATION</td>
<td>Effective physician and hospital partnership that supports clinical integration leading to improved quality and experience for patients</td>
<td>(1) Establish a unified physician operating model and support infrastructure with 75% of medical staff participating by 2017</td>
<td>Percentage of employed or affiliated physicians enrolled in PHM</td>
<td>75%</td>
<td>0%</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
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<td>(2) Exceed competitor performance on CMS core measures by 2015 (Alta Bates, Alta Bates - Summit, Eden, Kaiser Oakland)</td>
<td>Percentage of AHS scores on CMS core measures exceeding all peer scores</td>
<td>100%</td>
<td>0%</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
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<td>(*) Enter into at least one Risk- or Value-Based contract, and achieve 100% cost and/or quality incentives, by 2021</td>
<td>Percentage of potential performance incentives achieved</td>
<td>100%</td>
<td>0%</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
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<tr>
<td>4 EXPERIENCE</td>
<td>Patients feel valued, cared for and continue to choose us as their medical home/provider of care</td>
<td>(1) Increase percentage of surveyed patients reporting a positive experience, consistently ranking above 75th percentile by FY15</td>
<td>AHS average percentile ranking across Press Ganey Patient Experience Surveys</td>
<td>75%</td>
<td>0%</td>
<td>*tbd</td>
<td>*tbd</td>
<td>*tbd</td>
<td>*tbd</td>
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<td>(2) Establish a culture of service across the organization by --tbd date not defined --</td>
<td>*Percentage of employees trained on and competent in AIDET methodology</td>
<td>*tbd</td>
<td>*tbd</td>
<td>*tbd</td>
<td>*tbd</td>
<td>*tbd</td>
<td>*tbd</td>
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</tr>
<tr>
<td>5 NETWORK</td>
<td>Community engagement and external partnerships that align resources necessary for a sustainable clinically integrated network of care</td>
<td>(1) Increase number of specialty referrals from community clinics -- date and target not defined --</td>
<td>Total Increase in specialty referrals from any community clinic over FY12 baseline</td>
<td>Define/ remove</td>
<td>Define/ remove</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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<td>(2) Increase AHS physical capacity through strategic partnerships, establishing a major hospital or physician group affiliation by FY15</td>
<td>Number of completed affiliations with major hospital or physician groups</td>
<td>1</td>
<td>100%</td>
<td>0</td>
<td>tbd</td>
<td>tbd</td>
<td>tbd</td>
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<td>(3) Engage the community on AHS vision and strategic direction -- not fully defined or reflective of goal</td>
<td>*Average score on HIC Best Community ratings survey</td>
<td>Define/ remove</td>
<td>Define/ remove</td>
<td>tbd</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
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</tr>
<tr>
<td>6 WORKFORCE</td>
<td>Culture of excellence in the workforce that empowers staff to embrace and lead transformation to a high performance health system</td>
<td>(1) Retain a highly committed and empowered workforce -- date and target not defined --</td>
<td>-- needs definition -- Employee turnover? Average tenure?</td>
<td>Define/ remove</td>
<td>Define/ remove</td>
<td>tbd</td>
<td>tbd</td>
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<td>(2a) Improve employee and physician satisfaction -- date and target not defined --</td>
<td>-- needs definition -- Employee engagement commitment indicator score of #</td>
<td>Define/ remove</td>
<td>Define/ remove</td>
<td>n/a</td>
<td>tbd</td>
<td>tbd</td>
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<td>(2b) Improve employee and physician satisfaction -- date and target not defined --</td>
<td>-- needs definition -- *Overall physician satisfaction scores of #, annual survey</td>
<td>Define/ remove</td>
<td>Define/ remove</td>
<td>n/a</td>
<td>tbd</td>
<td>tbd</td>
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<td>(3) Advance the skill level of employees -- date and target not defined --</td>
<td>-- needs definition -- *Percentage of employees proficient on X or Percentage employees</td>
<td>Define/ remove</td>
<td>Define/ remove</td>
<td>n/a</td>
<td>tbd</td>
<td>tbd</td>
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</tbody>
</table>

*Note: tbd = to be defined, n/a = not applicable.*
Strategic Plan Framework & Definitions

Purpose
This document was created by AHS’ Strategy Division to clarify the terminology used in a typical strategic plan, including the strategic plan adopted by AHS in 2012. The purpose is to establish standard definitions for terms that will be incorporated into the Strategic Plan Dashboard and future strategy development and planning discussions.

Context
Goals, objectives, strategies, and tactics are core components of a Strategic Plan. Day-to-day use of these words in multiple contexts often creates confusion about what they represent when associated with strategy. Though often used interchangeably in informal discussion, the terms are distinct and have standard definitions when applied to strategic planning. Clarifying the structure of a strategic plan and its associated terms can facilitate planning and execution.

Strategic Planning Framework
There are three overarching levels in a strategic planning framework, each comprising two of the six strategy components (i.e., mission & vision, goals & objectives, strategies & tactics). Each level is associated with a distinct time horizon which declines progressively from left to right (big picture to tactical steps), simultaneously, granularity and level of detail escalates.

STANDARD DESCRIPTION OF STRATEGY LEVELS
- **LEVEL 1: Mission and Vision (WHERE we want to go)** – This big picture level, defines...
an organization’s core values and establishes a picture of what the organization strives to become or represent over time. This level reflects where an organization is trying to go, often over 10+ years. Typically, there is only one mission and one vision for an organization.

- **LEVEL 2: Goals and Objectives (WHAT we need to achieve)** – The next level of detail, begins to put structure around the direction an organization will take to fulfill its mission and vision by clarifying what must be achieved and by when in order to do so. An organization will typically have several goals, and there can be one or more objective associated with each goal. There should never be an objective that does not directly contribute to a goal. Goals and objectives are often refreshed every 3-5 years.

- **LEVEL 3: Strategies and Tactics (HOW we will accomplish the goals)** – This detailed and tactical level defines how the organization will meet its objectives. Strategies and tactics are the specific programs, projects, initiatives, and associated activities that produce results. These are actively managed and executed on a day-to-day basis and are generally monitored regularly. Annual re-sequencing or reprioritization is common, in particular as resources expand and shrink within the organization and/or as the environment changes.

**STANDARD DEFINITIONS OF STRATEGY COMPONENTS**

- **GOALS** are broad, qualitative statements of what an organization must accomplish to fulfill its mission and vision. They further define the vision and its scope. Goals should be clear and supported by measurable objectives.
  
  **Example:** An Academic Medical Center seeking to become a top ranked center might establish goals to increase research prominence, to increase scale and scope of GME, and to enhance preeminence of highly specialized or cutting edge clinical services.

- **OBJECTIVES** are the only quantitative component of the strategic plan. They bring specification to the goals by answering the questions of ‘how much?’ and ‘by when?’ To be effective, objectives must define BOTH the level of improvement AND the expected timeline. They are arguably the most important part of the strategic plan and serve as the only measurable indicator of the plan’s success.

  **Example:** Our AMC might have a research objective to increase NIH funding to $100M by 2015 or a clinical objective to achieve top 10 national ranking for 3 or more sub-specialties within 5 years.
• **STRATEGIES** define ‘how’ an organization will achieve its objectives and lay out the specific course(s) of action to accomplish them. A strategy may comprise multiple projects and be supported by tactics.  
  
  *Example:* One strategy to gain $100M in NIH funding could be to increase portion of the research portfolio (and PIs) in areas receiving the highest share of NIH funds.

• **TACTICS** are the concrete actions individuals will take to operationalize the strategies. Tactics are always actionable in nature and are often the level used to determine resource requirements and dependencies – they are where the rubber meets the road. Tactics are typically assigned to an individual or team, all or much of an organization often contributes to each goal.  
  
  *Example:* A tactic to increase portfolio prominence in an NIH funded area could be to recruit 3-5 NIH funded researchers with at least $M in funding.

**Common Language for Each Component**  
Verb choice can help distinguish goals, objectives, strategies, and tactics from one another by intuitively differentiating the components. The following table offers a few examples of common verbs used at each level of a strategic framework.

<table>
<thead>
<tr>
<th>AHS must achieve</th>
<th>AHS will accomplish it</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Goals</strong></td>
<td><strong>Objectives</strong></td>
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<tr>
<td>Become</td>
<td>Increase</td>
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<tr>
<td>Represent</td>
<td>Improve</td>
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<tr>
<td>Known as</td>
<td>Gain</td>
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<td></td>
<td>Realize</td>
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<td></td>
<td>Reduce</td>
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<td></td>
<td>Eliminate</td>
</tr>
<tr>
<td></td>
<td>Complete</td>
</tr>
</tbody>
</table>

**Resources/References**  
The Strategy Division serves as an additional resource to help the organization develop strategic plans and set strategic priorities. The resources used to develop this summary included our depth of experience and resources on developing, executing, and evaluating strategy:

Dennis, Pascal, *Getting the Right Things Done*  
Harrison, Ross. *Strategic Thinking in 3D*  
Reagan, Scott. CEO, [www.StrategicplanningMD.com](http://www.StrategicplanningMD.com)  
Studer, Quint. *A Culture of High Performance*
TO: The Honorable Board of Trustees
FROM: Dave Gravender, Chief Information Officer
DATE: January 7, 2014
SUBJECT: Information Systems Strategic Planning

Alameda Health System (AHS) continues to be on the journey of the implementation of the Electronic Health Record (EHR). This journey has many mileposts along the way with many of the most significant having been accomplished. The success of this journey is an extremely important component to become a world-class patient and family centered system of care. The document is laid out in two sections. The first is a description of the Future State Information Systems Environment. This describes what the expected outcomes of the journey will be. Included with this is a vision statement for guiding the decision making process or how things will be done. The remainder of the document reflects the short term projects (one year) and longer term objectives (three years) in moving this initiative forward.

The Information Systems Strategic Planning process is based upon the underlying principle to move towards a consolidation of vendor providers for applications. This direction means working with a single vendor in partnership to deliver, install, and optimize the application to facilitate accomplishing AHS’ goals and objectives. The EHR project has set that process in motion with the Siemens family of products. There are applications specific to business functions that are not provided by Siemens, for example Human Resources (Lawson). Where this the case, Siemens affiliated vendors have been and will continue to be the first choice for consideration.

**Future State Information Systems Environment**
The future state includes nine areas of focus. These nine areas comprise the key components of the furthest advances in the use of electronic health records. This future state will require changes in how work is performed throughout AHS in all care settings. It is accomplished over several years with multiple distinct projects defined and, as of yet, undefined. Some of the technologies needed to produce the stated outcome may not exist today. The Board’s input on these concepts is appreciated and encouraged.
Future State Information Systems Environment.

1. The patient record captures data in a manner that allows for intelligent use of the data eliminating paper scanned documents.

2. The organization is using a healthcare intelligence to analyze “safety patterns”, “patient population related outcomes” “quality issues”, and others to improve quality of care and care delivery efficiency.

3. Patient information flows seamlessly between caregivers and care locations following the patient wherever care is provided or supported.

4. All clinical areas are fully integrated around patient information. Patient information is populated appropriately in the departmental systems without duplication of effort or manual entry.

5. Provide the Patient the ability to view data, download data and participate in the care process.

6. Ongoing submission of electronic syndromic surveillance, immunization and reportable laboratory data.

7. The system is responsive to physician, nurse, and other clinicians’ needs for efficient use of information (the Six Rights).

8. Meet regulatory requirements and maximize return on investment leveraging HITECH funding.

9. Provide high availability, reliability, and resilient application and hardware services.
The Six Rights
The draft Vision for Information Systems is described in the following Six Rights and statements. It is meant to help in the design and selection decision making process to ensure that the outcomes achieved are consistent and focused.

Information Systems and Technology Vision

Building Excellence by making accessible:

- **The right Information** (accurate, complete)
- **To the right Person** (physicians, nurses, clinicians, decision-makers, patients)
- **At the right Place** (office, home, module, unit, room, anywhere)
- **At the right Time** (anytime, always available)
- **In the right Format** (online, pager, smartphone, fax, imaging, paper)
- **At the right Value** (appropriate cost/benefit relationship)

To make better informed decisions to achieve the best outcome and improve patient safety

In a secure manner that supports the privacy of the individual that makes it easy for the right person and impossible for the wrong person to obtain

Through an information technology human interface that is intuitive to all levels of skills

Make it easy to do the “right” thing and hard to do the wrong thing

Provides these services with a sustained dependability in performance that exceeds expectations

When a new application is desired, our first determination will be if our primary vendor has a competent product. If our primary vendor does not have competent product another vendor’s product may be evaluated.

Short Term Projects

The short term plan can be characterized as the “Year of the Three I’s”. Those are Implementation, Integration, and ICD-10. These three activities will consume almost completely the current capacity of the AHS Information Systems resources.

The first “I” is Implementation. There are four major implementation projects that will be completed in this first year. This consists of completing the implementation of the remaining Soarian family of modules yet to be done: Soarian Emergency Department(ED), Soarian Ambulatory, MobileMD and Soarian Plan of Care.

The Soarian ED is planned for a live date of February 4, 2014. All indications are that this project will be on schedule for this date. The Soarian Ambulatory system will have a much more
phased approach. The initial work will be done at the Highland campus based clinics. The system is planned to be implemented in several component stages leveraging the experience that has been gained in the inpatient system environment. One key component of the project will be provider documentation. This will have usefulness in all areas of care. Once the Highland campus clinics are fully engaged and functional, the system will be rolled to the remaining freestanding ambulatory clinics. The Highland campus clinics will begin work following the completion of the Soarian ED live event.

The MobileMD project implements the required functionality necessary for AHS to meet the Meaningful Use Stage 1, Year 2 requirements of patient access to information. The MobileMD system provides services supporting a Health Information Exchange. This can be used to share patient specific health information with other care providers outside of AHS like the Community Health Center Network (CHCN). The MobileMD projects kicks off in January and is scheduled for completion in June 2014. The project includes Alameda Hospital to meet the same Meaningful Use requirements for that facility.

The last major implementation project is the Soarian Plan of Care. This functionality supports the nursing process of planning for the care of a patient. There is a significant configuration activity necessary to implement evidence based care plans. This project is planned to kick off in Q2 and be completed by the end of the calendar year.

The second “I”, Integration, focuses on the conversion of San Leandro Hospital and Alameda Hospital from the systems currently in use to the AHS core systems. There are many systems involved with this transition touching almost every aspect of the operation. This work has already begun in planning for each of these transitions planned to occur in Q3 of calendar 2014. Alameda Hospital has added complexity of coordination of Meaningful Use Stage 1 Year 2 attestation for the July – September quarter and Stage 2 Year 1 beginning on October 1, 2014.

The third “I”, ICD-10, has significance in the scope of effort needed to complete the project. Extensive amounts of education and remediation is necessary for AHS to be successful in this project. Almost every clinical system is effected by the change from ICD-9 to ICD-10. This requires the installation and testing of new version of the software to meet the new requirements for ICD-10. External resources are and will be needed to meet all of the education and application upgrade ad testing processes to ensure that all systems and personnel are prepared for the conversion to ICD-10 beginning on October 1, 2014. The core work efforts to support the conversion are:

- System Upgrades
- Physician & Staff Training
- Provider Documentation
- Support Clinical Documentation Improvement (CDI)
- Healthcare Analytics
If the first year of projects is characterized as the Three “I”s, the next several years could be characterized as “Focus on Optimization”. The big “O” is necessary after the installation process to take advantage of many of the new features and functions that were not possible to implement during the fast-paced initial implementation processes deadlines. Improvements in clinical documentation will support efforts in the development of sophisticated clinical decision support and population health management solutions. These will help drive AHS to be more efficient and effective in caring for those we serve. There will be other smaller projects focused on addressing the areas identified in the future state description. These projects provide tools to take advantage of the preceding work leveraging all of the data collected during the attainment of Meaningful Use Stage 1 and 2. Significant benefits become more visible as the data is used in meaningful ways through healthcare analytics.

Risks and Issues

This document lays out a set of projects and directions that along with the right structure and execution will produce the desired results and success for AHS. It is in the area of structure and execution where the risk exits for this plan. The most significant risk in the execution of these plans is the availability and allocation of scarce human resources in the Information Systems department. Some recent staff turnover in key positions have left gaps in leadership and in the knowledge base necessary to efficiently execute. The plan to address this issue includes a combination of recruitment and engagement of consulting services to fill these gaps. This is a necessary action because these projects have timeframes set by regulatory requirements.

Respectfully,

[Signature]
Dave Gravender
Chief Information Officer
TO:        Members of the Board of Trustees, Strategic Planning Committee
FROM:     William Peruzzi, M.D., Chief Medical Officer
DATE:     January 9, 2014
SUBJECT:  Approach to implement AHS’ Physician Hospital Organization (PHO)

Context
Alameda Health System’s need for an integrated care delivery system in which the interests and incentives of all parties are aligned has never been more urgent. Reform related trends pushing providers to deliver better service, higher quality care, enhanced patient engagement, and care coordination at ever lower costs are the new industry norm. In addition, ongoing reductions in supplemental payments will further compress margins while the transition from FFS to value-based payments is flipping the traditional sustainability model on its head. Health systems that succeed in the current and future environment will be those that are able to achieve close coordination of clinical and administrative activities across the enterprise.

Rationale for the PHO
AHS envisions the establishment of a physician hospital organization (PHO) that will serve as the primary organizing mechanism to coordinate physician issues/activities and to align the health system, medical staff, and affiliated physicians.

Goals for the PHO (in progress)
- Align and accelerate efforts to improve quality, efficiency, and patient experience.
- Enhance physician leadership in organizational planning and foster ownership and commitment to advancing system priorities (e.g., through shared incentives)
- Create a unified organizing model and governance structure that promotes cohesion among AHS’s medical staff and affiliated physicians, simplifies recruitment of new clinicians, facilitates new partnership models and expands our network in the community, and provides a mechanism for overarching governance of clinical practices at AHS.
- Establish a vehicle for clinical integration (single-pen contracts and clinical efficiency) that supports and accelerates AHS’ transition from sickness care to population health.
PHO Design and Development

Establishing an entity to employ and contract with physicians is not difficult, and creating a unifying organization is an important first step. However, to be successful, our model must do much more. Creating a model that also attracts talent, coordinates fragmented clinicians, and provides for meaningful physician participation in system-wide planning, innovation, and leadership is essential to achieving the meaningful collaboration physicians and hospitals need to successfully prepare for and capitalize on the coming changes.

According to industry experts and best practices, to be successful in these goals, the PHO will have to provide for (and hardwire) integration at all requisite levels of health system planning and management. In addition, the PHO development process itself also plays an important role in engendering trust, ownership, and commitment to the new model. Given historical tensions and distrust, this requires nuance and possibly flexibility in the approach.

To realize this vision, a Physician Leadership Task Force (PLTF) was convened in late 2012 to consider and make recommendations for the organization, governance, and capabilities of an AHS physician hospital organization (PHO). Building on the substantial work completed to date, AHS leadership has engaged ECG, an experienced nationally recognized consulting firm to support the implementation of the PHO. Below are the major milestones in the project plan that will be discussed during the January 13, 2014 Strategic Planning Committee meeting.

<table>
<thead>
<tr>
<th>FY 2014 - Major Milestones</th>
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</thead>
<tbody>
<tr>
<td>Finalize future state, goals, and priorities for the PHO</td>
</tr>
<tr>
<td>Finalize corporate structure and legal documentation for the PHO, complete incorporation</td>
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<tr>
<td>Complete operations assessment to inform service model</td>
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<tr>
<td>Develop an organizing model, structure and governance for PHO</td>
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<tr>
<td>Define key roles, responsibilities, and processes for PHO.</td>
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<tr>
<td>Create roadmap to clinical integration, including infrastructure requirements and timeline</td>
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<tr>
<td>Finalize PHO development plan – Operations and Physician Recruitment.</td>
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<tr>
<td>Establish PHO budget, resource model, and funds flow for approval by board.</td>
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<tr>
<td>Initiate PHO implementation – Operational Components.</td>
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<tr>
<td>Open Physician enrollment and begin obtaining physician Letters of Intent (LOI) to participate.</td>
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</tbody>
</table>

The appendix to the memo includes some additional information that will be discussed in detail during the SPC presentation at the January meeting.
Appendix

**Illustrative picture of AHS starting point**

- **Private Organization**
  - Multiple practice sites
  - Paragon Pathology
  - East Bay Nephrology
  - East Bay Foundation
  - Diablo Infectious Disease
  - Catholic Healthcare West

- **Private Organization**
  - AHS practice only
  - OakCare

- **FPP and/or resident**
  - UCSF
  - Berkeley Opt.
  - Samuel Merritt
  - East Bay Foundation
  - U. of the Pacific

**Sources:** Summary of select physician contracts
Organizational alignment requires multiple integration at all levels

PHO must establish roles and/or processes that enable comprehensive alignment

<table>
<thead>
<tr>
<th>Shared Goals</th>
<th>Unified Strategy</th>
<th>Aligned Economics</th>
<th>Reliable infrastructure</th>
</tr>
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<tbody>
<tr>
<td>Shared governance and management structures to align boards and sub-committees around collective goals and objectives</td>
<td>Integrated mgmt. processes and mechanisms to align physicians and administrators around operational priorities, activities, and performance</td>
<td>Mechanisms to share &amp; align economics around the integrated strategy and overall performance (with models that reward both clinical productivity and advancement of system priorities)</td>
<td>Trustworthy systems and infrastructure that provide reliable and timely information on productivity and performance</td>
</tr>
</tbody>
</table>

Physician leadership and participation at all levels of health system strategic, financial, and operational planning/reporting

SOURCES: The Chartis Group, The Advisory Board, ECG, Team Expertise
Our considerations in considering A&M versus ECG

Our goals in this effort…

▪ Build an organizing model that can attract, align, and employ physicians
▪ Provide reliable business support and management services for AHS clinicians
▪ Establish an operating model to develop and systematize evidence-based practices and new models of care
▪ Create structures and processes to integrate clinical priorities and performance goals with those of the broader AHS’ system

Our ideal partner would bring…

▪ Understanding of challenges and opportunities distinctive to the safety net
▪ Diverse experiences with practice plans and physician-hospital alignment models
▪ Seasoned team on site day-to-day engaging our physicians and staff
▪ Deep understanding of our local market and the key players within it
▪ Structure and rigorous process management balanced with flexibility for creative, out-of-the-box solutions
▪ Realistic goals, practical recommendations and resources to support execution

Overview of ECG Experience

☑ Broad experience with physicians, hospitals, and AMCs - Significant local and national experience with physician practice formation, physician-hospital alignment, and compensation planning

☑ Tenured consultants on core team – On the ground project team has more than 20 years combined experience serving physicians and health systems across strategy, operations, reform, and compensation planning

☑ Deep local knowledge – Team works extensively throughout the Bay Area and has deep knowledge of the local stakeholders and market dynamics

☑ Serving partners in our continuum of care - ECG is interim director leading development implementation of the physician organization at Children’s Hospital of Oakland

☑ Local to Bay Area – Bay Area team will be present onsite engaging local physicians to develop the solution and build buy-in, no travel fees

☑ Creative and flexible – Team acknowledges there is not a ‘one sized fits all’ solution and demonstrated ability to quickly and creatively address core concerns of the AHS leadership
<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHO</th>
<th>INTERNAL / ASSIGNED TO:</th>
<th>WHEN</th>
<th>STATUS</th>
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<tr>
<td>Matrix to track Progress</td>
<td>Carladenise Edwa</td>
<td>1/13/2014</td>
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<tr>
<td>IT Strategic Goals</td>
<td>Dave Gravender</td>
<td>1/13/2014</td>
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<tr>
<td>Milestones PHO's</td>
<td>Dr. Peruzzi</td>
<td>1/13/2014</td>
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<tr>
<td>Update on Payor Mix Strategy Data</td>
<td>Rich Gianello</td>
<td>Schedule</td>
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<tr>
<td>Track Major Initiatives</td>
<td>Carladenise Edwa</td>
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