ALAMEDA COUNTY MEDICAL CENTER

Highland Campus • Fairmont Campus
John George Psychiatric Pavilion • Ambulatory Healthcare Services

BOARD OF TRUSTEES RETREAT

FRIDAY, October 26, 2012
SATURDAY, October 27, 2012

Central Administration Offices located at Highland Hospital
1411 E. 31st Street, Oakland, CA 94602
Barbara L. McElroy, Clerk of the Board
(510) 437-8468

LOCATION:
The Claremont Hotel, Club & Spa
41 Tunnel Road
Berkeley, California 94705
(510) 843-3000

MINUTES

THE MEETING WAS CALLED TO ORDER AT 8:10 AM.

ROLL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Daniel Boggan, Jr., Kirk E. Miller, Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Stanley M. Schiffman, Anthony Slimick, J. Bennett Tate, Ilene Weinreb, and Barry Zorthian, MD.

NON-VOTING MEMBER PRESENT:

Taft Bhuket, MD

DAY 1 – OCTOBER 26, 2012

OPEN SESSION

TAB #1 Welcome, Objectives & April Board Retreat Follow-up

Daniel Boggan, Jr., President welcomed the Trustees, staff, and guests to the October Retreat. He emphasized the use of board etiquette and stressed the importance to the members of the Board to provide their full attention to the agenda items presented.

Wright Lassiter, III, Chief Executive Officer, provided an overview of the day's agenda and follow-up to the April Board Retreat.

The agenda for Friday, October 26, 2012 will be dedicated to review and proposed approval of the strategic plan that will guide ACMC from 2013 to 2015, but more importantly, will lay the foundation for the health system for 2020 and beyond. Dr. Stephen M. Shortell, Dean of the School of Public Health at UC Berkeley, will provide a discussion on contemporary issues related to health care reform. We will end the day reviewing updates on goal attainment for the organization for 2012, and highlighting 2013 goals and scorecard tracking. Saturday will be devoted to board governance, officer nominations and the 2013 Board calendar.

Mr. Lassiter introduced special guests, Melissa Stafford Jones, President & CEO of the California Association of Public Hospitals and Health Systems (CAPH), and Dr. Stephen M. Shortell.

TAB #2 Healthcare Issues Overview

Stephen Mr. Shortell, Ph.D., Dean of the School of Public Health, UC Berkeley, presented: ***Increasing Health Care Value: Issues Facing California and the Nation***

Drivers of U.S. and California Health Care Spending:

- Population aging – multiple chronic illness
- New technologies
- Personal behaviors
- Tax treatment of health insurance
- Fee-for-service reimbursement
- Fragmented delivery system
- High unit prices
- Regulatory/administrative costs
- Lack of transparency of cost, qua

California Spending as Percent of GSP (statistics included in agenda packet)

California insurance premiums now exceed those of U.S. a whole – 22.6% of median household income vs. 20.6%

Population-Based Health Continuum Goal: Creating the Chronically Well

Building Blocks of the Community Health Care Management System

- Community population-based needs assessment
- Identification of community assets, capabilities, and resource requirement
- Alignment of service providers, managers, and governance within and across medical, health, and community sectors

Population Health Data Management

- Collect individual health status data
- Stratify populations based on risk/need for care - predictive modeling
- Tools to engage people in their health and health care
- Health information exchange capabilities – portability of records
- Workflow tools for physicians to use evidence-based protocols

Key Lessons from Public Hospital Systems Study

- Robust IT – disease registries
- Provide the training and tools for team-based care
- Access to QI tools and coaching
- Improvement champions important but not sufficient
- Communication is key to keeping multiple improvement efforts going

Alameda County Scores on Nine Dimensions of Preparedness and Overall Assessment, by Mean (statistics included in agenda packet)

What is Needed? A New Care Management Platform

Promising Approaches

- Increasing Patient Engagement
  - Pre-visit Planning
  - Self-Management Support
  - Between Visit Disease Management and Health Promotion
- Expanding Care Management
  - Tele-monitoring
  - Nurse Telephone Management
  - Patient Education
  - E.g. Heart Failure Case Management
- Improving Care Transitions
  - Care Transition Teams
  - Timely Outpatient Follow-up Care
  - Sharing Data-Interoperable Electronic Records
  - Medication Management System
- Expanding the Roles of Non-Physician Providers
  - Planned Visits
  - Delegating Exams and Tests
  - Patient Education
  - Between Visit Management

Early ACO Governance Key Lessons

- Shared goals and incentives
  - Directly linked to performance criteria and individual physician objectives
  - Based on value rather than volume
  - More difficult for hospitals who are not exclusive to specific ACO

- •Governance model should reflect function
  - Long history – more formal and integrated
  - Shorter history – more reliance placed on managerial interaction
  - Need to first establish a culture of trust and supportive decision-making processes
  - Need structures that accommodate flexibility
- Align measures and thresholds across payers
  - Reduce the complexity and costs involved
  - Credibility and transparency of data
  - Risk-modeling tools for presenting comparative data help
  - Promote physician sense of interdependency for achieving ACO goals

Sources of Friction in Strategic Alliances

1. Partners assess situation differently
   - **Problem:** You and your partner agree on ends but not on means
   - **Solution:** Greater communication to ensure common information base, increasing probability of convergence
2. Strongly Self-Interested Partner
   - **Problem:** You and your partner seem to disagree not only on how to get there, but on where you're going
3. Partner has problem with uncertainty
   - **Problem:** Partner seems unwilling to move forward due to risk aversion
   - **Solution:** Offer support, encouragement, and reassurance. Emphasize cost of not moving forward.

Know Your Partner – Five Types

1. Cooperative
   - Maximize joint gains
2. Quasi-Cooperative
   - Make sure you receive enough value so you will not leave
3. Indifferent
   - "I'll get mine, you get yours"
4. Competitive
   - Win/lose. Fixed sum pie.
5. Vengeful
   - Actively work to make sure the other party loses. Erosion of trust.

Why Alliances Fail

1. Environmental reasons
   - Failure to anticipate changing market conditions.
   - Controllable? Predictable? Fundamental or cyclical?
2. Strategic reasons
   - Purpose not clearly articulated or understood
3. Structural reasons
   - Form is ill-suited to strategic purpose

- Too complex, slow or one-sided

4. Behavioral reasons
   - Discomfort with lack of control
   - Individual egos
   - Need to ID relevant stakeholders in advance
5. Startup-Phase: Four Key Questions to Ask
   - Are member strengths complementary?
   - Does the alliance make a financial contribution to both members?
   - Is the leadership of member organizations complementary?
   - Is the strategic intent of member organizations complementary?

Six Requirements for Effective Alliances

1. **Importance**
   Strategic significance to both sides
2. **Investment**
   Approximately equal rewards over the long term
3. **Interdependence**
   Parties must become increasingly interdependent
4. **Integrated**
   Communication and contact must be managed
5. **Informed**
   About each other's plans and directions
6. **Institutionalized**
   Provide supporting mechanisms that enable and facilitate trust among the members

Medicare Physician Group Practice Demonstration

- Annual savings per beneficiary/year were modest overall
- But significant for dual eligible population – over $500 per beneficiary, per year
- Improvement on nearly all of 32 quality of care measures

Preliminary Results of Massachusetts Alternative Quality Contract (AQC)

- 2.8% lower costs ($90 per member, per year)
- Savings much larger among groups with no prior experience with risk sharing
- Savings largely from reduced spending for procedures, imaging, and lab tests
- Greatest savings come from patients with highest health risks
- 10 of 11 participating physician groups spent below their targets, earning a budget surplus payment. All earned a quality bonus.

Comparison of Accountable Physician Practices Versus Other Practices (statistics included in agenda packet)

Early Evidence from Primary Care Medical Home Intervention

- **Group Health Cooperative of Puget Sound (Seattle, Washington)**
  - 29% reduction in ER visits; 11% reduction ambulatory sensitive admissions
- **Health Partners (Minnesota)**
  - 39% decrease ED visits; 24% decrease hospital admissions
- **Geisinger Health System (Pennsylvania)**
  - 18% reduction in all-cause hospital admissions; 36% lower readmissions
  - 7% total medical cost savings
- **Mass General High-Cost Medicare Chronic Care Demo (Massachusetts)**
  - 20% lower hospital admissions; 25% lower ED uses
  - Mortality decline: 16 percent compared to 20% in control group
  - 4.7% net savings annual
- **Intermountain Healthcare (Utah)**
  - Lower mortality; 5% relative reduction in hospitalization
  - Highest $ savings for high-risk patients

The Board discussed the materials presented and inquired about educational opportunities to learn more about the topic. Dr. Shortell indicated there were educational opportunities through UC Berkeley; he will provide the information to Mr. Lassiter to share with the Board.

TAB #3 UPDATE: Our Market Context

Jeff Hoffman, Managing Director, Kurt Salmon Associates presented an overview of the current market place with regards to implementation of the proposed strategic plan. Much of the planning context is predicated on assumptions about what the provider environment will look like in the near future.

Considerations include:

1. Preparing for Increased Demand (specifically ambulatory)
2. Ability to Manage Risk
3. New Reimbursement Models
4. Physician Relationships
5. Significant Management of Clinical Outcomes
6. Partnerships with Other Continuum Providers

Mr. Hoffman emphasized that the U.S. health care industry is in the midst of a massive transition and health care organizations are compelled to respond and organize in order to enhance their missions. The transition focus will be in the following areas: process, focus, value, patient flow, delivery settings, approach, objective, quality, information management, information access, and customer.

The board discussed the issues presented.

Ms. Stafford Jones added her perspective and some clarity to the issue noting there is a shift in the marketplace from vertical to horizontal.

Mr. Hoffman noted that most Bay Area providers are rapidly moving to further integrate with physicians – or take on an increasing role for managing the health of defined populations.

ACMC will be required to compete against increasingly integrated networks focused on growth of patient populations and select highly reimbursed specialty patients. To compete in this competitive landscape, ACMC will need to implement the following:

- Develop multispecialty, clinically integrated group for current safety net population
- Develop capabilities to manage population health
- Create platform to support substantial system growth over coming years
- Create structure to engage community physicians in clinical integrated care delivery.

To help achieve the goals outlined in the ISFP, five core strategic recommendations were set forth for ACMC to pursue in support of a financially sustainable future:

- Increase Access to Primary & Specialty Care Services
- Develop an Effective Physician Operating Model
- Enhance Revenue Opportunities
- Enhanced Cost Effectiveness
- Explore Affiliations & Partnerships

Within ACMC, the organization is approaching capacity for its acute bed types and is at capacity for Rehab, SNF and Psych.

- Inability to quickly admit patients will impact efficient access to other key services
- ACMC will not be adding capacity with ATR project, requiring a re-think about how to maximize current asset base (~170 beds with ATR)

ACMC patient satisfaction ranges from 60% to 86%, but compared to others there is much ground to be covered to compete on patient experience

- ACMC outperforms Kaiser Oakland and Eden MC but trails the Alta Bates campuses

ACMC is in the midst of multiple initiatives driving the transformation of the organization. In addition to the current initiatives underway (acute tower re-build, IT implementation, etc.), several core strategic themes emerged: Access, Financial Sustainability, Integration, Experience, Network Relationships, and Workforce.

TAB #4 REPORT: Strategic Plan FY2013 – FY2015 – A New Vision for ACMC

Mr. Lassiter provided an overview to the process involved to bring a new Mission and Vision Statement forward in conjunction with the proposed strategic plan.

A draft revision of the ACMC Mission and Vision statements were presented to the Strategic Planning Committee in September, 2012.

Additional review and input was solicited from many ACMC stakeholders

- Employees attending Employee Forums
- Medical Executive Committee
- Physician leadership briefing on draft strategic plan
- Department Leader Meetings
- Executive Staff

Overall, reaction from stakeholders was very positive on adopting a shorter, easier to recall mission and vision statement that corresponds to our transformation goals and strategies.

Mr. Lassiter and Mr. Hoffman presented the new Mission and Vision Statements to the Board for adoption.

Mission Statement:

Caring, Healing, Teaching, Serving All

Vision Statement:

To become a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities

The Board took action separately for each statement.

ACTION: A motion was made, seconded, and unanimously approved the revised Mission Statement as presented.

MOTION: Trustee Nelson
SECOND: Trustee Weinreb

AYES: *Trustees Boggan, Miller, Nelson, Huen, Lewis, Schiffman, Slimick, Tate, Weinreb, and Zorthian*
NAYS: *None*
ABSTAIN: *None.*
ABSENT: *None*

A discussion ensued with regards to adding language that specifically states "medical system" to the Vision Statement.

Mr. Hoffman added clarity to the genesis of the Vision Statement and how it was developed to this point.

ACTION: ***A motion was made, seconded, and approved the revised Vision Statement as presented.***

MOTION: ***Trustee Tate***
SECOND: ***Trustee Nelson***

AYES: *Trustees Boggan, Miller, Nelson, Huen, Lewis, Slimick, Tate, Weinreb, and Zorthian*
NAYS: *Trustee Schiffman*
ABSTAIN: *None*
ABSENT: *None*

Trustee Weinreb inquired about ACMC investing in housing adjacent to our facilities to provide transitional housing to our patients. Mr. Lassiter addressed the inquiry acknowledging that new ideas were being explored to address these types of concerns.

TAB #5 DISCUSSION: Strategic Goals Discussion (Part 1)

Warren Lyons, Chief Strategy & Integration Officer, provided an overview to the presentation of the six ACMC strategic goals to support the new vision.

The goals were developed based on the market and internal planning contexts. Each goal is supported by multiple specific strategies and supporting tactics to provide detail on how to achieve the strategic goals over the next several years. Goals are also supported by specific metrics and required investments to implement the recommended strategies.

1. Access
2. Sustainability
3. Integration
4. Experience
5. Network
6. Workforce

Goal #1 – Access:

Bill Manns, Chief Operating Officer, presented the first Goal – Access; Market competitive standard for access in the communities we serve that supports organizational growth.

Strategies to Achieve this Goal:

- Implement staged specialty recruitment initiative to achieve payor mix market share goals as outlined in 2011 Integrated Strategic and Financial Plan with ACMC and new patient populations
- Focus internal primary care recruitment to develop Institute on Aging and additional primary care providers necessary to fulfill DSRIP primary care expansion plans
- Re-organize ACMC's primary care delivery model to serve as a medical home for patients, but also be able to serve a greater number of patients than seen today through care delivery innovations
- Initiate scheduling initiative to actively block schedules to prioritize referral access to ACMC medical home patients and designated community clinic (e.g., CHCN) referrals
- Create capacity and infrastructure solutions across multiple geographies, focused on meeting the incremental need of recommended specialty and primary care recruitment and improving patient's ability to access / navigate ACMC System
    - Focus on development of 3 to 4 new ambulatory care sites; distributed in community, locations focused on providing access to broader patient base and in conjunction with developing affiliation initiatives
- Support access efforts Institute initiative - prioritize over planning cycle following institutes
    - Orthopedics
    - Surgical Services/Digestive Disease
    - Institute for Aging (Geriatrics)
    - Eye
- Develop relationship with community clinics (e.g., CHCN) to support their specialty referrals to ACMC, focusing on specialty-specific clinic by clinic expansion and in concert with community clinics needs
- Complete tactical implementation plans to improve Access as outlined in DSRIP
- Continue advancement of Behavioral Health Services through continued operational improvement and facility development
- Revise and implement a new rehabilitation services business model and secure new supporting facility to meet current and expected future market expectations

The Board discussed Access as a goal and how to achieve by means of the strategies outlined.

Ms. Jones provided comments with regards to the "all payor" model and the probability was minimal that California would adopt such a model.

Discussion ensued regarding the Quality issue and implementing a behavioral health model system wide.

Goal #2 – Sustainability:

Marion R. Schales, Chief Financial Officer, presented the Goal #2 – Sustainability - Financial sustainability that supports growth and reinvestment to sustain our mission.

Strategic Objective:

1. Achieve financial performance targets outlined under the 2011 ISFP through system improvements and organizational growth
2. Improve ACMC's Revenue Cycle to be superior to national benchmarks (e.g., AR Management)

Strategies to Achieve this Goal:

- Complete implementation of remaining "Net Benefit Opportunity" recommendations (from Multicare Revenue Cycle Assessment)
- Redesign revenue cycle to create best practice organizational structure to support Revenue Cycle enhancements and successful Sorian Conversion (from Multicare Revenue Cycle Assessment)
- Implement recommendations from Med Assets Operational Expense Assessment

A timeline for implementation planning to implement major Sustainability strategies was presented through FY 2015.

Lunch break from 12:00 – 12:30 pm

OPEN SESSION RECONVENED AT 12:30 PM.

Guy Qvistgaard, Hospital Administrator, John George Psychiatric Hospital, announced that the facility had received a grant from the county in the amount of $238,000 from Proposition 63 funding.

The result of the grant provided for the following:

60 patients were paired with recovering mentally ill "mentors". There was a 72% reduction in hospitalizations during the grant period. There was also a return on investment of $800,000 savings against the $238,000 grant.

TAB #5 DISCUSSION: Strategic Goals Discussion (Part 1), continued:

Goal #3 – Integration:

Kathleen Clanon, MD, Interim Chief Medical Officer, presented Goal #3 – Integration - effective physician and hospital partnership that supports clinical integration leading to improved quality and experience for patients.

Strategies to Achieve this Goal:

- Engage medical staff in a process to educate and increase understanding for rationale, vision and structure of new physician operating model
- Finalize structure of physician operating model, including proposed governance, committee structures and responsibilities
- Determine and outline process to obtain core competencies that must be in place to make potential physician partners feel confident about joining model (starting with effective MSO services)
- Create pathways and timeline for integrating physicians into physician operating model
- Develop initial clinical integration efforts upon which the group will focus
- Explore requirements to develop highly effective business intelligence capabilities linking clinical, operational and financial data

Physician organization requires organizational structure to support a high performing model

- Each major director/leader can be supported either through individual or dyad model (clinical leader and administrative leader)
- Goal to provide infrastructure to be self-sustaining operation – some functions can be outsourced to system (compliance, plant, legal, purchasing, etc.)

Day-to-day operations of POM will be mostly coordinated through a Physician-led Operating committee, which will be supported by several subcommittees.

Functions of the subcommittees:

- Advises on strategy, goals, metrics to POM Executive and POM Board of Directors
- Develop and recommend policies and procedures
- Monitor operational, clinical, quality physician performance
- Physician recruitment and retention recommendations

Current process in Physician Model Development will be in 3 Phases: Exploratory Phase, Business Planning Phase, and Implementation Phase.

A timeline through FY2016 was presented.

The Board discussed risks, liabilities and the structure of the model. Mr. Habig provided

clarity on the type of model being presented as well as how modifications/flexibility may occur. Mr. Hoffman emphasized that this goal would change ACMC in a positive way.

TAB #7 DISCUSSION: Strategic Goals Discussion (Part 2)

Goal #4 – Experience / Choice:

Kim Horton, RN, MSN, DHA, Chief Nurse Executive, presented Goal #4 – Experience / Choice - Patients feel valued, cared for and continue to choose us as their medical home/provider of care.

Strategies to Achieve Goal:

Patient Experience:

- Implement organizational-wide initiatives to develop, confirm and reinforce vision for a "Culture of Service"
- Address system-wide structural issues that impede improvement of overall patient experience
- Drive patient experience improvement through individual departmental / unit patient experience improvement plans
- Create and enhance current accountability structure and incentives to reinforce culture and expectations across organization
- Complete implementation of DSRIP initiatives relating to improved patient experience as tactical elements to support improved patient experience and satisfaction scores
- Increase caregiver time in patient care through reductions in non-productive time

Clinical Quality / Performance Improvement:

- Prioritize efforts to improve clinical quality as reported by major reporting agencies
- 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 ACMC physician partners

A timeline was presented through FY2016.

Discussion ensued around a Culture of Quality and the implementation of the LEAN initiative with regards to this goal. The Board inquired as to the status of the new facilities. Mr. Manns confirmed that the Highland Care Pavilion would be completed in May 2013 and the Acute Tower in 2015. Ms. Horton emphasized that the focus was to change the existing culture prior to the moving into the new facilities.

Discussion around the design of nursing stations and how the working environment would be improved through the LEAN process; additional discussion was focused on patient experience.

Goal #5 – Network:

Mr. Lassiter presented Goal #5 – Network - Community engagement and external partnerships that align resources necessary for a sustainable clinically integrated network of care.

Strategies to Achieve this Goal:

- Implement partnership agreements with select health care organizations based on a standardized framework to advance goals 1 through 4
- Develop and execute a plan that clearly communicates ACMC's purpose and vision to internal and external communities
- Leverage revamped Foundation to increase philanthropic giving and community awareness of ACMC and its role in the community
- Explore development of Community Advisory Councils to obtain input on ACMC's role in the community and provide forum for sharing the organization's vision and progress
- Implement partnership agreements with select health care organizations based on a standardized framework to advance goals 1 through 4

  Components Necessary to Advance Strategy:
  - Pursue strategic partnership with area provider to obtain access to inpatient beds and surgical ORs to serve specialty demand in alternate location than Highland
  - Formalize partnership with select CHCN member clinics to increase specialty referrals with broader payor mix
  - Create partnership plan with Alameda Alliance to increase access to ACMC specialists as well as manage care of chronically ill patients
  - Explore expanded partnership opportunity with UCSF (and/or other partner) to improve ACMC patient access to key high complexity services (e.g., rare cancers)

ACMC partnership opportunities and expectations were presented. The strategic vision will be achieved through increased breadth and depth of network relationships with various provider types to develop a county-wide system of care network.

Goal #6 – Workforce:

Jeanette Louden-Corbett, Chief Human Resources Officer, presented Goal #6 – Workforce - Culture of excellence in the workforce that empowers staff to embrace and lead transformation to a high performance health system.

Strategic Objectives:

- Retain a highly committed, empowered workforce
- Improve employee and physician satisfaction
- Advance the level of skill of the staff

Strategies to Achieve Goal:

- Provide education and support for emerging leaders within the organization
- Provide employees with skills necessary for good customer relations
- Align employee incentives with strategic vision and goals; create a system that identifies, incents and rewards highly capable staff
- Implement cross-functional service line structure to advance patient-centered care and align accountability for clinical quality, improved patient experience and financial sustainability
- Recruit and maintain a highly committed, empowered workforce:
    - Establish and maintain market based salary structure
    - Maintain an aggressive staff recruitment operation
    - Implement comprehensive physician/provider recruitment strategy
    - Ensure and incentivize accountability at all levels
    - Reduce first year turnover to 10%
    - Implement cross-functional service line structure to advance patient centered care and align accountability for clinical quality
- Improve employee and physician satisfaction:
    - Redesign orientation and on-boarding programs
    - Increase avenues for communication and collaboration
    - Continue annual satisfaction surveys, develop and monitor effective action plans to address challenges
    - Increase staff and physician involvement through LEAN implementation and other strategies
    - Increase labor management cooperation and collaboration through patient care committees
    - Assure that employees and physicians have competent, committed colleagues to support their work
- Advance the level of skill of the staff:
    - Fully implement evidence-based leadership practices of Studer Group (our partner for 4 years)
    - Identify emerging leaders, provide support and development
    - Implement a customer service education program throughout ACMC
        - Assess skill level post training
        - Create ongoing monitoring system to gauge effectiveness

- Enhance rigor of annual performance review process
- Align staff performance reviews with organization-wide strategic goals

A timeline through FY2016 for implementation planning to advance Workforce strategies was presented.

TAB #6 CLOSED SESSION

THE BOARD CONVENED TO CLOSED SESSION AT 2:30 PM AND RECONVENED TO OPEN SESSION AT 3:53 PM.

TAB #8 DISCUSSION: Strategic Plan Implications / Risks Discussions

Mr. Hoffman, presented implications of implementing the Strategic Plan and risks involved.

The proposed strategic plan contains several major risks for which the organization must be aware:

- Majority of risks outlined are internal (execution) risks
- External (Environmental) risks also exist, but less ability for ACMC to influence those

All six of the goals presented have risk associated. Mr. Hoffman presented the risks, implications of not executing strategies as proposed, and potential mitigation strategies for each strategic initiative.

To be successful, ACMC will need to balance multiple current initiatives with the strategic goals – requiring focus, prioritization and sufficient resources to execute successfully.

Mr. Lassiter added that steps have been taken to mitigate risk; the recommendation is to move forward with the plan.

The Board expressed concerns about approving the plan without clarity. Discussion ensued around approving the plan with the knowledge that concerns/caveats would be addressed and brought back to the Board.

Mr. Lassiter explained that the Board was being asked to endorse the six (6) strategic initiatives as ways to move the organization forward. A deeper level of detail can be provided in the future if the Board is looking for that level of detail.

TAB #9 REPORT: Overall Financial Impact of Three Year Plan

Ms. Schales and Brad Malsed, Kaufman Hall, presented the overall financial impact of the three year Strategic Plan.

Ms. Schales emphasized that the guiding assumptions of the 10 year plan are maintained in the assumptions of the 3 year plan. It is sustainability, not only survivability.

- Adding 50+ new providers and space/locations to accommodate incremental demand
  - Improving access, service
  - Build the health system with additional revenue, new locations, new patient types
  - $120 M of incremental operating revenue for the organization over 5 years
- Moving payor mix toward a more sustainable mix
- Investing in foundation for future of clinically integrated delivery system through new physician model
- Addressing core areas of improved experience / access
  - Call center, pharmacy re-design
  - Investments to continue development of ACMC's workforce

Mr. Malsed discussed the importance of ACMC attaining Moody's Baa2 rating and that this benchmark is attainable for the organization.

Mr. Lassiter clarified that the assumptions presented are conservative. Investments need to be made to create the foundation.

TAB #10 ACTION: Strategic Plan Approval

ACTION: ***A motion was made, seconded, and unanimously approved the Strategic Plan as presented with caveats discussed during the Retreat.***

MOTION: ***Trustee Schiffman***
SECOND: ***Trustee Huen***

AYES: *Trustees Boggan, Miller, Nelson, Huen, Schiffman, Tate, Weinreb, and Zorthian*
NAYS: *None*
ABSTAIN: *None.*
ABSENT: *Trustee Slimick (left at 1:30 pm) and Trustee Lewis (left at 4:45 pm)*

Mr. Lassiter will have staff develop a follow-up document detailing the caveats discussed and bring back to the Board at a regular meeting.

TAB #11 REVIEW: Goal & Balance Scorecard Review

This item was not presented and will be brought back to the Board at a regular meeting.

TAB #12 REVIEW: Saturday, October 27, 2012 Agenda Review

Trustee Boggan and Mr. Lassiter provided an overview of Saturday's agenda.

Public Comments – None.

Board of Trustees Remarks – None.

THE MEETING WAS ADJOURNED AT 5:15 PM.

DAY 2 – OCTOBER 27, 2012

OPEN SESSION / ROLL CALL

ROLL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Daniel Boggan, Jr., Kirk E. Miller, Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Anthony Slimick, J. Bennett Tate, Ilene Weinreb, and Barry Zorthian, MD.

Stanley M. Schiffman was excused.

NON-VOTING MEMBER PRESENT:

Taft Bhuket, MD

TAB #13 ACTION: 2013 Board of Trustees Officers

Valerie D. Lewis, Esq., Chair, Governance Committee, presented the slate of officers for 2013:

Kirk E. Miller – **President**
Valerie D. Lewis, Esq. – **Vice-President**
Ronald D. Nelson – **Secretary**

***ACTION:* A motion was made, seconded, and unanimously approved the 2013 Officers as presented.**

***MOTION:* Trustee Weinreb**
***SECOND:* Trustee Huen**

AYES: *Trustees Boggan, Miller, Nelson, Huen, Lewis, Slimick, Tate, Weinreb, and Zorthian*
NAYS: *None*
ABSTAIN: *None.*
ABSENT: *Trustee Schiffman*

TAB #14 ACTION: 2013 Board of Trustees Meeting Calendar

Mr. Lassiter presented the 2013 Board of Trustees Meeting Calendar with a change to the regular meeting date in March. A request has been made to change the date from Tuesday, March 26, 2013 to Wednesday, March 27, 2013.

Mr. Lassiter announced that the Annual meeting of the Board of Trustees would be on January 22, 2013; the Annual meeting for ACMC would be on January 29, 2013.

Hearing no discussion, a motion was made.

***ACTION:* A motion was made, seconded, and unanimously approved the 2013 Board of Trustees Meeting Calendar as presented with the revision to the March, 2013 meeting date from March 26, 2013 to March 27, 2013.**

***MOTION:* Trustee Huen**
***SECOND:* Trustee Weinreb**

AYES: *Trustees Boggan, Miller, Nelson, Huen, Lewis, Slimick, Tate, Weinreb, and Zorthian*
NAYS: *None*
ABSTAIN: *None.*
ABSENT: *Trustee Schiffman*

TAB #15 UPDATE: Form 700 Compliance

Mr. Habig presented an overview to the Form 700 compliance process. The Board discussed what categories of the Form 700 should be required of the Trustees and staff.

The Board discussed various issues pertaining to ownership of property, gifts, travel and reimbursements. Mr. Habig emphasized that the requirement is to either complete

or not complete the various attachments to Form 700, there is no latitude to wordsmith the documents.

The consensus of the board was to implement a process that is consistent with both the Trustees and ACMC staff that are required to complete Form 700.

The Board asked that reminders be put in place 2 weeks prior and 2 days prior to the deadline for Form 700 once the documents have been sent to staff and Trustees to complete.

Mr. Habig will work with the Governance Committee to refine the Form 700 policy.

TAB #16 DISCUSSION: Board Advocacy

Mr. Habig provided an overview to the legal aspect of Board advocacy.

Under Government Code § 3203:

Except as otherwise provided in this Chapter, or as necessary to meet the requirements of federal law as it pertains to a particular employee or employees, no restriction shall be placed on the political activities of any officer or employee of a state of local agency.

Under Government Code §3207:

Any city, county, or city and county charter, or in the absence of a charter provision, the governing body of any local agency and any agency not subject to Section 19251 by establishing rules and regulations, may prohibit or otherwise restrict the following:

(a) Officers and employees engaging in political activity during working hours;

(b) Political activities on the premises of the local agency.

Under Government Code §3205(a):

An officer or employee of a local agency shall not, directly or indirectly, solicit a political contribution from an officer or employee of that agency, or from a person on an employment list of that agency, with knowledge that the person from whom the contribution is solicited is an officer or employee of that agency.

Under Government Code §3205(b):

A candidate for elective office of a local agency shall not, directly or indirectly, solicit a political contribution from an officer or employee of that agency, or from a person on an

employment list of that agency, with knowledge that the person from whom the contribution is solicited is an officer or employee of that agency.

Under Government Code §3205(c)

This section shall not prohibit an officer or employee of a local agency, or a candidate for elective office in a local agency, from requesting political contributions from officers or employees of that agency if the solicitation is part of a solicitation made to a significant segment of the public which may include officers or employees of that local agency.

Under Government Code §3205(d):

Violation of this section is punishable as a misdemeanor. The District Attorney shall have all authority to prosecute under this section.

Under Government Code §3206:

No officer or employee of a local agency shall participate in political activities of any kind while in uniform.

Under Government Code §3205.5:

No one who holds, or who is seeking election or appointment to, any office shall, directly or indirectly, offer or arrange for any increase in compensation or salary for an employee of a state or local agency in exchange for, or a promise of, a contribution or loan to any committee controlled directly or indirectly by the person who holds, or who is seeking election or appointment to, an office. A violation of this section is punishable by imprisonment in a county jail for a period not exceeding one year, a fine not exceeding five thousand dollars ($5,000), or by both that imprisonment and fine.

Under Government Code §3209:

Nothing in this chapter prevents an officer or employee of a state or local agency from soliciting or receiving political funds or contributions to promote the passage or defeat of a ballot measure which would affect the rate of pay, hours of work, retirement, civil service, or other working conditions of officers or employees of such state or local agency, except that a state or local agency may prohibit or limit such activities by its employees during their working hours and may prohibit or limit entry into governmental offices for such purposes during working hours.

Roger W. Witalis, FACHE, President, Witalis Healthcare Advisors, facilitated the discussion with the Board around advocacy and how the Board can serve as ambassadors for the organization.

The Board discussed the need for a communication strategy for the Trustees. Emphasis was placed on developing a professional public relations campaign.

Mr. Lassiter spoke to the issue of a public relations campaign and advised the Board that this issue was being addressed by staff and more details would be presented to the Board in November. The Board would like to see how the communication strategy will utilize the Trustees to promote the organization from an advocacy perspective.

Further discussion focused on what should be accomplished through outreach. Mr. Witalis emphasized that only 2 – 3 issues should be addressed and that the Board should not over-engineer the process.

The Board discussed which Committee should take ownership of the process, no specific committee was designated.

Mr. Lassiter added that the accomplishment should be focused on positive aspects of ACMC, not specifically patient volumes. 2013 should be the year to launch the campaign.

THE BOARD CONVENED TO CLOSED SESSION AT 10:30 AM AND RECONVENED TO OPEN SESSION AT 11:36 AM.

TAB #17 DISCUSSION: Board Evaluation

Discussed in Closed Session.

TAB #18 DISCUSSION: CEO Evaluation

Discussed in Closed Session.

TAB #19 REPORT: Legal Counsel's Report on Action Taken in Closed Session

Mr. Habig reported that during the Closed Sessions of the Retreat the Board discussed matters pertaining to potential litigation. No action was taken.

TAB #20 Closing Remarks

Trustee Boggan provided a wrap-up to the Retreat, thanked the Board members and the organization for a successful Retreat. Noting that Governance issues would be addressed further in the Governance Committee, specifically the CEO Evaluation and Board Self Assessment.

Mr. Lassiter thanked the Board and noted that this Retreat was full of great dialogue and will provide planning for the future of ACMC.

Mr. Lassiter announced that a meeting was scheduled for the following Monday. Mr. Lassiter, Trustee Boggan, Supervisor Chan, and Alex Briscoe will meet to discuss the San Leandro issue. Additionally, Mr. Lassiter will also be meeting with the Mayor of San Leandro on Monday.

Discussion ensued with regards to the San Leandro issue.

Public Comments – None.

Board of Trustees Remarks – None.

THE MEETING WAS ADJOURNED AT 11:46 AM

Respectfully Submitted by:

Barbara L. McElroy,
Clerk of the Board

APPROVED AS TO FORM:

Reviewed by: _____
Douglas B. Habig, Esq.
General Counsel