ALAMEDA COUNTY MEDICAL CENTER

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

FINANCE COMMITTEE MEETING
TUESDAY, July 24, 2012

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

MINUTES

TAB #1 CLOSED SESSION - None

THE MEETING WAS CALLED TO ORDER AT 5:42 PM.

ROLL CALL WAS TAKEN AND THE FOLLOWING TRUSTEES WERE PRESENT:

Kirk E. Miller, Ronald D. Nelson, and Valerie D. Lewis, Esq. were present.

Stanley M. Schiffman was excused.

TAB #2 ACTION: Approval of Minutes

ACTION: A motion was made, seconded, and unanimously passed to approve the Minutes of the March 20, 2012 Finance Committee Meeting as presented.

MOTION: Trustee Nelson
SECOND: Trustee Lewis

Minutes of the June 12, 2012 Finance Committee Meeting will be reviewed at the meeting of September 18, 2012.

TAB #3 Financial Forecasting and Analysis

A. REPORT: MultiCare, Revenue Cycle Assessment

Don Briones, VP Finance, introduced James McHugh, Managing Director of MultiCare Consulting and Nate Myra, Engagement Manager. MultiCare performed a hospital revenue cycle assessment of the ACMC during last spring.

Mr. McHugh briefly described MultiCare's background and expertise, and pointed out that the current engagement was exclusively an analysis of all aspects of

ACMC's Hospital Revenue Cycle. Then the two speakers gave a detailed report on the scope and results of their assessment and proposed improvements and initiatives. The assessment focused on net benefit opportunities, current progress and key recommendations related to organizational changes needed to achieve a full revenue cycle redesign.

The Immediate Net Benefit Opportunities were in vendor management, transfer DRG (capturing reimbursement related to patient discharge), third party liability (active pursuit of alternate payers for Emergency Department patients, typically in relation to automobile accidents), government eligibility screening (more active processing of retro-active eligibility and pursuit of MediCare disability status), and bad debt sale. These improvements would contribute between $1.1M – 2.5M annually. ACMC has already begun implementation on these items.

Implementing the Revenue Cycle Redesign recommendations could contribute $4.7M – $7.9M annually. It was recommended that ACMC establish and fully staff both Denial Management and Revenue Integrity units, and organize all parts of the revenue cycle under one ACMC division.

Mr. McHugh noted that unless corrected, current gaps in ACMC's processes would have higher impacts after full implementation of health reform due to the greater number of patients that will be covered through Medicaid/Medi-Cal. He also noted that the Soarian conversion, by increasing the number of automated edits before a bill is first sent out, will increase the time to initially generate claims, a statistic known as Days Not Final Billed (DNFB). Further along in the process, the resulting reduction in billing errors reduces gross accounts receivable (AR) days by generating fewer and fewer denials, thus reducing the total time between delivering the service and being paid.

Trustee Miller asked about the likely timing of the identified annual cost savings and revenue increases. Mr. Briones said that savings achievable without extensive reorganization would take 9 -12 months to achieve, partly because the billing function is deeply affected by the timing of ACMC's Electronic Health Record (EHR) implementation. Recommendations that require aligning all parts of the revenue cycle, not just the billing office, can take up to 24-36 months before improvements could be generated, because practices need to change in every area. For example, the Revenue Integrity unit may identify a pattern of denials in a specific service based on inappropriate Length of Stay. Correction depends on changes in clinical practice.

Wright Lassiter, Chief Executive Officer (CEO), noted that the recently hired Director of Utilization Management will help address clinical operations issues. He noted that the issue of direct admission to the floors by ACMC physicians without Emergency Department screening, an issue with revenue and patient flow impacts noted by

MultiCare, is both a capacity issue and a sensitive area in terms of physician acceptance.

In addition to the completed hospital revenue cycle assessment, ACMC has engaged MultiCare to perform a Physician Revenue Cycle Assessment. Management plans to bring results from this assessment to the Finance Committee later in the fiscal year. The organization is committed to improving revenue cycle activities in all areas.

TAB #4 REPORT: Financial and Operations Reporting

A. REPORT: Financial Update for Month Ending May 31, 2012

Marion Schales, Chief Financial Officer, explained that due to year-end close, the month of June has not yet closed. Ms. Schales then reported the financial results for the month of May 2012, with and without the effect of Delivery System Reform Incentive Pool (DSRIP) revenues and expenses.

- May Total Income (*without* DSRIP) was $50K resulting in a negative variance of $565K; Total Margin (excluding DSRIP) was 0.1%.
- May Total Income (*with* DSRIP) was $1.3M with a favorable variance of $714K; Total Margin was 2.9%.

May's negative budget variance resulted from unfavorable variances in Patient Revenues and Non-Labor Expenses that were only partially offset by favorable variances in Other Revenue, Salaries and Wages and Other Post-Employment Benefits.

- Net Patient Revenue was **under** budget ($6.8M) due to a shift in payer mix away from MediCal and Commercial Insurance to HealthPac (HPAC), which has a significantly lower level of anticipated cash collections. Service volumes were lower than budget in surgery (-5%), patient days (-2%) and outpatient visits (-6%).
- Other Operating Revenue was **over** budget ($6.4M) primarily due to additional funds from the County for the HPAC program.
- Total Operating Expense was **over** budget ($453K) due to higher use of management consultants to cover open positions, mostly related to strategic initiatives and E.H.R., and higher than budgeted costs in materials and supplies, repairs/maintenance/utilities and general and administrative expense.
- Differences in timing, such as ACMC's on-schedule investment in E.H.R. contrasted to the State of California's delay in paying the associated American Reconstruction and Recovery Act (ARRA) incentives, also affected the income statement.

- YTD Total Income (*without* DSRIP) was $753K resulting in a negative variance of $1.4M; margin was 0.2%.
- YTD Total Income (*with* DSRIP) was 19.1M with a favorable variance of $16.9M; Total Margin was 3.9%.

Bill Manns, Chief Operating Officer (COO), noted that although outpatient visit volumes are under budget, they are higher than prior year at every delivery site except Fairmont. Shortfalls in relation to budget at Eastmont were due to a 7-month delay in planned construction. At Fairmont, new physician leadership has started to expand outpatient rehab clinic services. Psych Day Care has been growing due to patient word of mouth after relocation to avoid construction noise.

As last year, Ms. Schales will send the internal Financial Statement for June 30, 2012 to the Board once completed. Potential adjustments that will not be included in the internal financial statements include adjustments (in late August) to the waiver, OPEB (Other Post Employment Benefits), workers compensation and medical malpractice. ACMC is behind budget year-to-date for the month of May, and Ms. Schales expects that trend to continue for June.

B. REPORT: Status on Electronic Health Record (E.H.R.)

Mark Zielazinski, Chief Information Officer (CIO), reported on the E.H.R. project.

In January 2011 the ACMC Board of Trustees approved the E.H.R. program, consisting of multiple projects to implement Siemens Soarian Clinical and Financials and NextGen Ambulatory electronic health records across the organization. The approved budget was $73.8M over 10 years. In January 2012, an additional $800K ($500K for capital and $300K in additional operating costs) was approved in order to incorporate an Emergency Department module. The adjusted budget is $74.6M.

Status as of June 2012.

Budget

- As of June 2012, Capital Budget expenditures for FY 2012 are $9.8M. The project is expected to meet the adjusted capital budget of $19.2M. Capitalized labor is a new category of cost shown in the status report. It is not an additional cost, but the result of reclassifying existing labor costs for design and build work from operating costs on the Income Statement to capital costs on the Balance Sheet.
- As of June 2012, ACMC received incentive revenues are $3.2M. ACMC expects to receive another $2.8M within the next 60 days, and to come in $812K over the incentive revenue budget of $18M by end of project.
- As of June 2012, expenditures for the Additional Operating Budget and Current Operating Budget are both under budget; they are forecasted to meet the adjusted total budgets of $33.8M and $21.6M respectively.

Program Accomplishments

- System design and build for Soarian Clinicals was completed on schedule (May 2012). Activation at the John George and Fairmont hospitals is on schedule, planned for September 7, 2012.
- Soarian Financials design and build is approximately 30 days behind schedule but additional resources (included in the forecast) were acquired to get the project back on schedule.
- NextGen E.H.R. was activated at the Eastmont clinic on May 30, 2012, closely followed by Winton and Newark. Interoperability issues between NextGen and Soarian identified during design were resolved by the vendors.
- Infrastructure changes for network cabling, wireless network, end-user devices and servers are on schedule

Program Risks and Issues

- When Eastmont, Winton and Newark activated the NextGen E.H.R., patient appointment slots were halved to accommodate the learning curve for providers and support staff. Ramping back up has been slow. Consequently, the planned August rollout at the Highland clinics has been delayed to October or January to ensure that we do not negatively affect patient care in all parts of the system simultaneously. IT is working with the physician groups and Ambulatory Care leadership on a timeline for the Highland NextGen rollout and will report on the date and impacts at the September Board meetings. The delay has no impact on the ARRA physician incentives; budget impact is expected to be minimal.
- On June 4, 2012, Siemens installed the software version of Soarian Clinicals on which ACMC will be activating. We are now on our fourth round of integration testing. However, the ED module is only now in its first round of integration testing.
- Soarian Clinical and Financial projects are both behind schedule mostly due to delays in staffing ramp-up and availability of ACMC resources during the design and build stages. Project teams are working to make up the time to avoid changing activation dates, which are in 2013. ARRA meaningful use incentive payments will not be impacted by these delays.

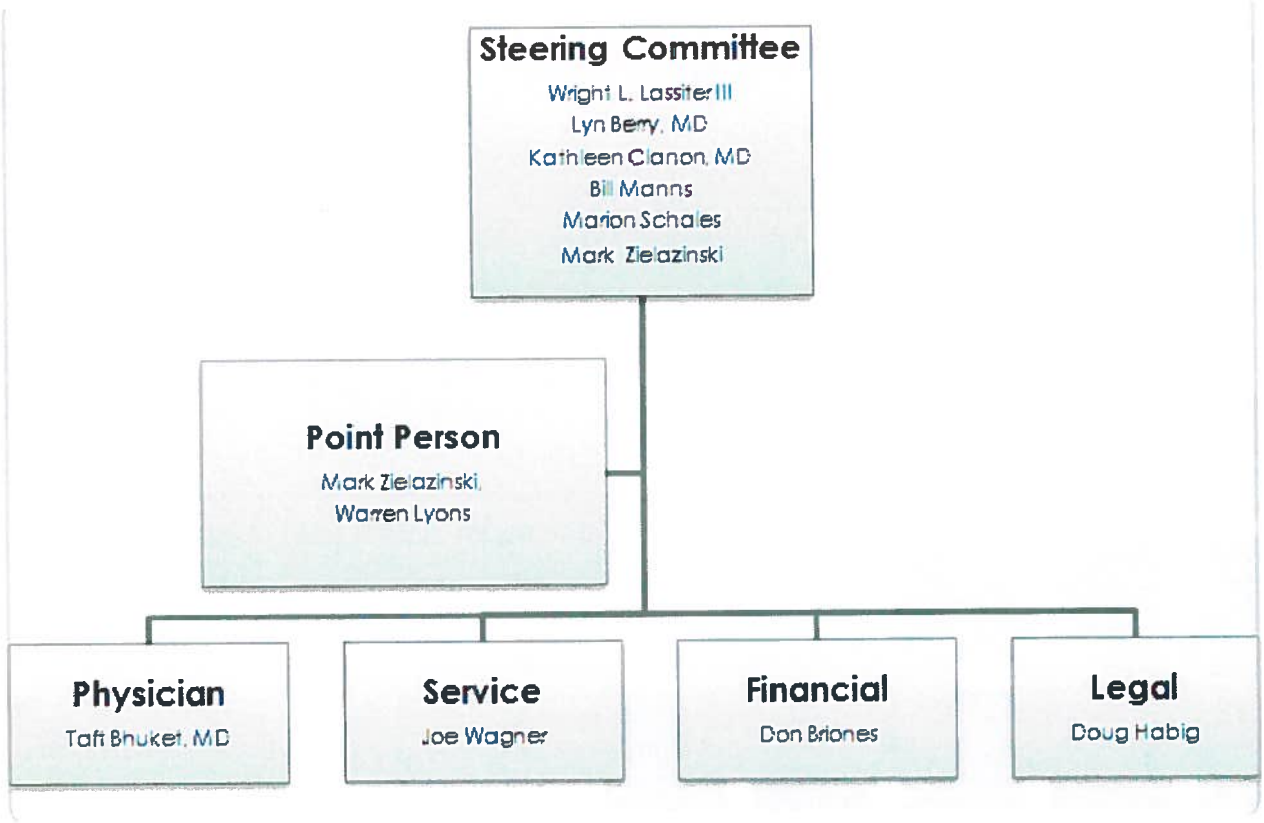
C. REPORT: Status on Managed Equipment Services (MES)

Mr. Zielazinski, CIO, gave a report on progress on ACMC's MES initiative.

At the Board Retreat in April, ACMC management proposed exploring options for a Managed Equipment Services (MES) arrangement, featuring risk sharing with the vendor, to provide comprehensive long-term (10+ years) equipment procurement, periodic replacement, maintenance, training and installation. The MES program is intended to allow for predictable expenditures and to improve service levels. ACMC's capital assets have been primarily managed on an "as needed" basis. If

ACMC chooses to control costs via MES, it may be the first organization in the United States with a public/private MES partnership.

Mr. Zielazinski reviewed the MES project structure.



Using nine initial criteria developed with input from physicians, finance and administration, Warren Lyons, Chief Strategy and Integration Officer and Mr. Zielazinski, CIO, are working actively with GE and Siemens to investigate possible arrangements with each.

Mr. Zielazinski shared a comparison grid based on vendor responses to ACMC's initial set of questions. Siemens, with existing MES agreements in China, Spain, Australia and the United Kingdom, was stronger in most categories, although GE was markedly stronger in the area of familiarity and experience with internal and external regulatory bodies. Trustee Lewis expressed concern over whether ACMC is scoring responses to questions that one of the vendors helped formulate.

Selection of the MES partner is expected as early as October 2012, but the timeline to develop the final agreement has been extended to December 2013. It requires extensive negotiation and an exhaustive due diligence process to craft the MES agreement. Replacement protocols, service lines, and governance are only a few of the many issues that need to be designed and agreed by both parties.

The project is coordinated with ACMC's broader cost containment efforts with MedAssets, who is providing vital third party insights into our decision process. Their analyst Beth Ritchie has worked repeatedly with these types of service and capital equipment arrangements and will contribute to the detailed financial analysis that is one of the next steps. It will be based on a complete inventory of ACMC's existing service agreements (maintenance, rental, leasing, etc.) and equipment needs.

In response to trustee questions, Ms. Schales, CFO, noted that the ACMC annual capital budget of $20M is small for the size of the organization; a partnership that offers discount pricing and low financing is one way to access funding to meet more of our pent-up and growing capital replacement needs.

Mr. Lassiter, CEO, said that the inspiration for this project had resulted from discussions with Siemens and the realization that the healthcare delivery market structure in the United States is changing. It is becoming more similar to the delivery structures in countries like the U.K., where there is no longer fee-for service reimbursement, but a focus on population health, which requires long-term cost control solutions. He felt that although GE had not been actively pursuing the MES concept, ACMC would benefit from offering GE the chance to work on this proposal. A company other than Siemens might propose a different approach to achieving predictable capital purchase and maintenance expenditure.

TAB #5 REPORT: CFO Update

Ms. Schales, CFO, announced that on June 24 2012, Ann Metzger, MBA, CPA, who had been assistant controller for the previous 18 months, was promoted to the position of controller. Ms. Metzger has an extensive background in healthcare finance and accounting and significant experience in the position of hospital controller. Ms. Schales will introduce her at the September Finance Committee meeting, when she is able to attend.

Gordon McKinney, the former controller, is moving back to the internal audit function at the end of the summer. In the interim, Mr. McKinney continues in the accounting department, working on year-end financials and preparing for the FYE-2012 audit.

The second item in the CFO report was an update on the rollout of ACMC's cost management initiative, named BETTER, for Building Excellence Through Transformation and Expense Reduction, an acronym coined by Kim Horton, Chief Nurse Executive. The work will be accomplished in eleven (11) opportunity workgroups, each with two executive sponsors to provide depth and back-up for each other. The communication roll out has begun with meetings with the physicians and department managers and other stake holders. Mr. Lassiter will send a memo to all staff describing the initiative and its goals and objectives.

The groups will select teams to begin implementation as soon as possible. As structure, governance and reporting tools are put in place, there will be continual and routine updates to the Finance Committee and to the Board. There will also be a progress report at the Board Retreat in October.

TAB #6 **Financial Policy Development** – No report.

TAB #7 **Healthcare Reform and Regulatory Changes** – No report.

TAB #8 **ACTION: Contract and Capital Authorization**

A. ACTION: Authorization for the CEO to Execute Five Operating Contracts:

1. Lease amendment ***Eastmont Oakland Associates, LLC,*** for clinic expansion.
2. Annual renewal with ***State of California, Department of General Services Natural Gas Service Program,*** for natural gas at Fairmont and Highland.
3. Renewal with ***Paragon Pathology Medical Associates, Inc.***, 2 years.
4. Amendment for ***Traditions Behavioral Health,*** to add psychiatric consultation and liaison services for the ACMC outpatient clinics.
5. New contract with ***Microsoft-Dell Marketing,*** for software licensing.

ACTION: A motion was made, seconded and unanimously passed to authorize the CEO to execute the five operating contracts as presented.

MOTION: Trustee Nelson
SECOND: Trustee Lewis

AYES: *Trustees Miller, Lewis, and Nelson*
NAYS: *None*
ABSTAIN: *None*
ABSENT: *Trustee Schiffman*

B. ACTION: Authorization for the CEO to Execute Five Capital Contracts:

1. Contract amendment with **E4 Services, LLC** for E.H.R.
3. Contract amendment for **MaxIT Healthcare** for E.H.R.
4. Contract amendment with **Santa Rosa Consulting** for E.H.R.
5. Contract amendment with **Peer Consulting, LLC,** for E.H.R.
6. Contract amendment with **Vitalize Consulting Solutions, Inc.** for E.H.R.

Mr. Zielazinski noted that these five contracts represent the total not-to-exceed amounts for the remainder and duration of the time that ACMC plans to use these companies in completing the E.H.R. project. The amounts were included in the forecasted capital expenditures shown as not exceeding budget in the E.H.R. status report earlier in the evening. The contracts are all fee-for-service and ACMC has no obligation to spend the full contract amounts.

ACTION: A motion was made and seconded, to authorize the CEO to execute the five capital contracts as presented.

MOTION: ***Trustee Nelson***
SECOND: ***Trustee Miller***

AYES: *Trustees Miller and Nelson*
NAYS: *None*
ABSTAIN: *Trustee Lewis*
ABSENT: *Trustee Schiffman*

C. **INFORMATION:** List of approved contracts $150 K - $500 K (10 contracts) was provided.

D. **INFORMATION:** List of cumulative vendor contracts totaling more than $500,000 (8 vendors) was provided.

TAB #9 Annual Finance Committee Calendar and Follow-up

A. **INFORMATION: Annual Finance Committee Calendar and Follow-up Worksheet** were provided.

TAB #10 REPORT: Legal Counsel's Report on Action Taken in Closed Session

Douglas B. Habig, General Counsel, reported there was no Closed Session.

Board of Trustees Remarks: None.

Public Comments: None.

THE MEETING WAS ADJOURNED AT 7:15 PM.

Respectfully submitted,

Barbara L. McElroy
Clerk of the Board

APPROVED AS TO FORM:

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