ALAMEDA COUNTY MEDICAL CENTER

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

BOARD OF TRUSTEES APRIL RETREAT
Friday, April 27, 2012 & Saturday, April 28, 2012

LOCATION:
Hotel Shattuck Plaza
2086 Allston Way
Berkeley, California 94704

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

DAY 1 – APRIL 27, 2012:

THE MEETING WAS CALLED TO ORDER AT APPROXIMATELY 8:31 AM.

ROLL CALL WAS TAKEN; THE FOLLOWING TRUSTEES WERE PRESENT:

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

Barbara Price, Valerie D. Lewis, Esq., and Ilene Weinreb arrived after roll call.

NON-VOTING MEMBER PRESENT:

Lyn Berry, MD

TAB #1 Agenda Review / Introductions

Wright Lassiter, III, Chief Executive Officer, introduced James Jackson, newly hired Hospital Administrator for Fairmont Hospital. James comes to ACMC from Kaiser Permanente.

Warren Lyons, Chief Strategy & Integration Officer, introduced his team: Patricia Barerra, Director of Legislative Affairs & Community Engagement; Jerri Randrup, Director of Corporate Communications & Marketing, Rohit Sahdev and Alfio Levy, both business development and project managers.

Mr. Lassiter acknowledged Larry Gage with Ropes & Gray and Jeff Hoffman with Kurt Salmon Associates, Jeff's team has been hired to assist ACMC with its strategic plan.

Mr. Lassiter provided an overview of the intent of today's agenda; it will focus on strategy. Presentations will provide the Board with the progress that is being made with regards to strategic planning work as directed by the Board at the last Retreat. The purpose of the Retreat is not to "present" to you but to engage in conversation about the issues.

TAB #2 ACTION: Approval of Minutes

ACTION: A motion was made, seconded, and unanimously approved the Minutes from the October 28 & 29, 2011 Board Retreat as presented.

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

AYES: Daniel Boggan, Jr., Barbara Price, Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Kirk E. Miller, Stanley M. Schiffman, Anthony Slimick, J. Bennett Tate, Ilene Weinreb, and Barry Zorthian, MD
NAYS: None
ABSTAIN: None
ABSENT: None

Trustee Boggan introduced Wilma Chan, Supervisor, 3rd District, Alameda County, and her Chief of Staff, Jeanette Dong.

TAB #3 UPDATE: San Leandro Hospital

Mr. Lassiter shared that the City of San Leandro had extended an invitation to ACMC to attend an Ad Hoc committee meeting to focus on health issues in the City of San Leandro and specifically the future of San Leandro Hospital.

Supervisor Chan shared her perspectives with the Board. She expressed a desire for maximum communication and full community engagement throughout the process.

Discussion ensued with the Board and Supervisor Chan regarding the issue as well as the status of St. Rose Hospital and the Joint Powers Authority (JPA).

Mr. Lassiter added that he and Supervisor Chan have discussed the process of community engagement and that education is critical to the success of the process.

TAB #4 DISCUSSION: St. Rose Hospital Joint Powers Authority

Mr. Lassiter provided an update to the JPA. Last Tuesday, the Alameda County Board of Supervisors approved the JPA agreement; ACMC has been asked to participate in the JPA.

Trustee Boggan asked the Board if there were any questions regarding the issue.

Trustee Nelson asked how ACMC would benefit from participation on the JPA board.

Supervisor Chan expressed that if ACMC was involved in the JPA it would have access to information.

Discussion ensued regarding the advantages and disadvantages of ACMC's involvement with the JPA.

Mr. Lassiter addressed the issue of Washington Hospital and their view on the subject. He also provided an overview of Washington's operating model as a district hospital.

Trustee Boggan explained that TABS #5 & 6 on the original agenda have been switched to provide a broad overview of the strategic plan and then go into specific details of the plan. He stressed that while going through the process the Board keeps in mind the 5 strategic goals that were outline at the October Retreat.

TAB #6 DISCUSSION: 2013 – 2015 Strategic Plan Development

Mr. Lyons provided an overview of the presentation that will be made by Kurt Salmon Associates on the 2013 – 2015 Strategic Plan. He then introduced Jeff Hoffman, Managing Director, Kurt Salmon Associates.

Mr. Hoffman provided a brief overview of where ACMC is within the planning process and where ACMC wants to be. He then turned the presentation over to Brian Thygesen.

Mr. Thygesen took the Board through the presentation highlighting the following:

Review of Strategic Core Goals:

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

Key Objectives:

- Understand and incorporate situation assessment work and ISFP completed to date
- Develop strategies and tactics to deliver on goals from ISFP services
- Develop strategies and tactics to expand ambulatory network
- Foster a planning process that adds value to current initiatives
- Create a bold yet achievable plan – continually evaluate ability to implement
- Provide planning tools to monitor / modify execution

Project Participation:

Steering Committee: Convened to meet six times during the course of the engagement
Stakeholder Interviews: 50+ interviews with ACMC key stakeholders completed as part of the current planning engagement
Solutions Work Groups: Interdisciplinary, topic-oriented groups focused on providing specific solutions as to how to achieve major strategic initiatives
Board Meeting: Participation in two Board-level meetings

Mr. Thygesen took the Board through a timeline; currently at the half way point through the process.

Mr. Hoffman continued the presentation focusing on Market Trends and Implications for Safety Net Providers.

Areas of focus discussed:

- Population and Demographics
- Payors / Networks
- Capacity / Supply

Mr. Hoffman addressed challenges that ACMC will face with regards to Access / Capacity and payor mix diversification.

A summary of Overarching Strategy Integration was presented focusing on the following:

- Ability to continually meet current mission
- Achievement of the strategic vision
  - Provider of Choice
  - Preferred Employer
  - Leading integrated healthcare system to all residents of Alameda County
  - Financial sustainability
  - 10 year financial target (Baa) rating
- Advancement of ACMC's Core competencies

Mr. Hoffman went through the 10 Strategic Goals for the organization moving forward:

1. Patient Access / Expansion
2. Enhanced Value
3. Physician Relationships
4. Financial Strength
5. Cost Management
6. Strategic Partnerships
7. Clinical Focus
8. Population Health Management
9. Payor Relationship / Contracts
10. Culture of Excellence

Throughout the presentation the Board engaged KSA with comments and questions pertaining to specifics of the plan and how ACMC would achieve the outlined goals. The Board expressed concern with regards to the cost of the strategic goals. Mr. Hoffman explained that until the strategic plan is determined, the costs are unknown. The plan must be in place before the costs can be determined; there are too many variables otherwise.

After lunch, Mr. Lassiter shared the upcoming screening of The Waiting Room, a documentary film that was made on the Highland campus. The screening will take place in San Francisco on May 1. If any of the Trustees are interested in attending the Clerk of the Board has tickets available.

TAB #5 DISCUSSION: Long-range Integrated Financial Plan Implementation

A. Exploration of Affiliation and Partnership Opportunities

Mr. Lassiter provided an overview of the affiliation and partnerships opportunities that have been considered and an update of the status.

Outreach to the following organizations has occurred to facilitate a network of care:

- St. Rose Hospital
- San Leandro Hospital
- Children's Hospital of Oakland
- Alameda Hospital
- Community Clinics

ACMC is looking to engage organizations that are willing to work with ACMC and there is a strategic overlap in both clinical offerings and geographical coverage, as well as payor mix.

Douglas B. Habig, General Counsel, presented an overview of the Section 14000.2 to the Board. In addition, he explained Health & Safety Code §101850 which is the authorizing statute that established Alameda County Medical Center separate and apart from Alameda County.

Due to many intertwined relationships, it makes it difficult to run totally independent from the County.

ACMC is not a corporation, it is a public health authority, but we have corporate powers.

- Hospital Authority powers are generally strait forward:
  - Authority is a legal entity separate from the County
  - Power to acquire and possess real and personal property
  - Power to sell property it owns that is not owned by County

Mr. Habig clarified that the power was given to ACMC by the legislature; the County setup the hospital authority and cannot take that power away. The only governing body that can take away the hospital authority is the legislature.

The Board engaged in discussion to clarify the authority that ACMC has in relationship to Alameda County.

Mr. Habig provided case law in support of the argument that ACMC is in competition with private hospitals and has the authority to compete in the marketplace.

B. **Efficient Physician Operating Model**

Mr. Lassiter provided an overview of the presentation as an outcome from the fall Board Retreat to develop an efficient Physician's Operating Model. Dr. Chang and Larry Gage will provide detail to the presentation.

Sang-ick Chang, MD, Chief Medical Officer, began by stating that this issue is a highly sensitive topic within the organization. Currently, 80% of the medical staff have confidence with the executive team; maintaining that confidence is critical.

There is a need for a vehicle to have strategic relationships with external physician entities. Another area that needs to be addressed is organizational effectiveness – currently the medical staff has 3 different overlapping governance structures with approximately 350 physicians.

Dr. Chang shared that management will further explore developing this model with the medical staff and bring back an implementation plan and strategy document in the fall.

Larry Gage with Ropes & Gray provided an update on his research and recommendations regarding the development of a physician integration plan that will serve as a catalyst and structure to foster physician-hospital alignment through employment and contracting arrangements. He shared a case study: Hennepin County (MN) Medical Center Reintegration of Medical Staff as an example for the Board.

Discussion ensued with the Board and staff discussing the model and what the next steps would be.

Trustee Boggan clarified that this was not an action item, staff was looking for direction from the Board (sense of the Board) to pursue the development of a physician operating model and bring back to the Board at a future date.

C. **Improved Organizational Cost Effectiveness / Enhance Revenue Capture Opportunities**

Marion Schales, Chief Financial Officer, provided a status report on the progress made on two of the initiatives that were identified at the 2011 fall Retreat; improve organizational cost effectiveness and enhance revenue capture opportunities.

<u>Scope of the Cost Management/Revenue Cycle Project</u>
Management determined that timely and rapid momentum would be realized by the following approach.

1. Resources: Identify external resources to begin the work of cost management and revenue cycle transformation.
2. Timing: Begin work immediately in January 2012 to perform high-level cost management and revenue cycle assessments to identify quick opportunities that could be implemented before the end of the fiscal year, as well and opportunities that are more difficult where implementation could begin in the current fiscal year with positive outcomes over the next 12 to 18 months. Management targeted the end of March 2012 to complete this rapid cycle assessment.
3. Prioritization: The scope of both of these assessments is quite large and it is expected that there will be many improvements that will rank from easy to very difficult to implement. Therefore, management identified the following prioritization guidelines.
    a. Identify quick "low hanging fruit" improvements from both assessments that can be implemented in the current fiscal year.
    b. Identify and prioritize the more difficult improvements where implementation can be started in the current fiscal year or early in the new fiscal year where improvements can be realized in the next 12 to 18 months. This will likely be improvements that do not require deep cultural and/or process improvement changes.
    c. All other improvements that are more difficult to implement will be tracked and monitored on a longer implementation cycle.

    Management expects that the work in developing/redesigning the revenue cycle will be more difficult to implement and will thus be on a longer implementation cycle. It is likely that there will be higher costs to execute the improvements in one fiscal year, with the realization of the net benefits occurring in the following fiscal year(s).
4. Execution: Results from the assessments would be presented to the Executives for selection and prioritization of the identified opportunities during the month of April 2012. Tactical plans would be developed for the selected opportunities and executed over the next 12 to 18 months (or longer for the more difficult improvements). The resulting near term net benefits would be incorporated in the 2013 budget development.

Progress Report

1. Resources: Two external vendor partners were identified; MedAssets (for cost management) and MultiCare Consulting Services (for revenue cycle). Both vendors were engaged in January 2012. They began their assessments in January 2012.
2. Timing: As of mid-April 2012, most of the cost and revenue cycle assessment work has been completed. There are some additional areas in the cost and revenue cycle assessment scope that are close to completion.
    a. Early MedAssets findings reflect an opportunity range of $19 - $31 million net benefit (per year) in the areas of supply chain, strategic

labor initiatives, strategic sourcing initiatives and process improvement initiatives.

b. Early MultiCare findings reflect initial easy opportunities in the areas of focused process improvement and vendor management of $2.5 million net benefit (per year). There was more difficult organizational and process improvement changes identified, however the net benefits has not been quantified yet.

3. Execution: Preliminary reports were provided to the Executive team on April 16, 2012. Once all of the assessments have been completed, the Executive team will review the list of opportunities for selection and prioritization. Finally, tactical plans will be developed and implemented.

Next Steps

Management intends to provide the complete MedAssets assessment report to the Finance Committee in May 2012 and the Revenue Cycle assessment report will be presented to the Finance Committee in July 2012. The net benefit opportunities that are incorporated into the 2013 budget will be presented as part of the 2013 budget presentation to the Board of Trustees in June 2012.

It is important to note that the assessment work will continue, as more opportunities are uncovered. The process of cost and revenue cycle transformation is iterative and ongoing.

Discussion focused on alignment of strategic priorities across the organization to achieve the goals identified at the 2011 Fall Retreat. The goals are not specific to Finance, they are across the organization.

Mr. Lassiter added that the most recent change the organization has accomplished would be the employment contracts with SEIU which will allow ACMC to achieve some of these goals.

TAB #7 DISCUSSION / ACTION: ACMC Rebranding Initiative

Mr. Lyons provided an overview of the re-branding initiative and introduced Vintage Foster, President, AMF Media Group, to make the formal presentation.

Mr. Foster presented the re-branding initiative as follows:

The Medical Center - County is a bad association. According to the market - it tarnishes the quality aspects of the brand. The consumer and ACMC staff associates it with below standard expectations of care and service.

Behavioral Health - John George is an institution that is highly successfully, yet highly stigmatized by its emergency psychiatric care. Both JG employees and the market see it solely as a place for involuntary mental health services. Its greatest challenge will be leveraging the equity of its talent, staff and institutional capabilities within the John George paradigm.

Ambulatory Services - Despite the limitations of capacity and access, the clinics of ACMC have experienced some success. They solve a service need for those challenged by transportation and cultural boundaries. However, that success and their role within ACMC makes the call to action more urgent. As ACMC upgrades its brand, the clinics will play a key role in diversifying the payer mix / driving new patients to the service brands of ACMC.

Rebranding Objectives:

- Separate the medical center and its service lines from the current negative perception in the marketplace
- Better position the medical center and its service lines for growth and competition

Rebranding Recommendations:

- Rid the organization of "County" moniker.
- Uncouple the brand and create a house of brands.
- Position Ambulatory Services as a key ambassador for the broader organization.
- Halt JG as the marketplace lead for behavioral health services. Instead create a new lead that speaks to the opportunity with the voluntary patient population.

Benefits of a House of Brands Model:

- Better leverages the brand equity of the organization
- Promotes tangible local community interaction and enriches community relationships
- Is expandable - works for additional hospital, ambulatory and affiliate network locations
- Insulates the organization from an underperforming service line

Rebranding Recommendations and Rationale

Ambulatory Division

- Leverage the Ambulatory clinics to grow market share. Adopt a Wellness and location moniker: Newark Wellness, Hayward Wellness [currently named Winton], and Eastmont Wellness.

- All future Ambulatory sites should take a geographical ownership. This template puts our service offerings in context and cement our promise and commitment to area patients and perspective patients.
- Bundle the clinics of ACMC into a sophisticated and comprehensive gateway into the new ACMC brand.
- Further diversify service offerings at clinics to include Lighthouse Behavioral Services and other outpatient services.

Highland Hospital Recommendation

- Maintain the Highland Hospital name and reframe it as our flagship and crown jewel, demonstrating excellence in advanced medical care.
- Promote the strengths of Highland. Emphasize its strengths with a regal presentation of color and font.
- In doing so, shift the current perception from violence-related trauma center to a world-class hospital anchored by a world-class trauma center.

John George Psychiatric Pavilion

- Change the name to John George Psychiatric Hospital and it becomes solely an involuntary inpatient and emergency psychiatric care service line.
- Introduce Lighthouse Behavioral Services as the brand for voluntary mental health services. It would be on-site at the John George campus and other ACMC locations.

Lighthouse Behavioral Health

Lighthouse is a beacon for behavioral healthcare. Providing for the community, illuminating a viable and creditable platform for an underserved market. It becomes the behavioral healthcare vision of the Medical Center:

The ACMC Vision

- Providing a safe harbor/sanctuary for patients and families
- Build a reputation for excellent behavioral healthcare
- Instill hope to all seeking care
- Become a preferred place to heal in the Bay Area

Fairmont Hospital

- Maintain current name implementing a facelift. A new color scheme, font and icon will be utilized until the acute rehabilitation hospital relocates to San Leandro Hospital or reconfigures its service offerings.
- Create a brand message that focuses on our skilled nursing facility as a distinct service line.
- Develop rebranding options for San Leandro Hospital when a relocation plan is announced.

A New System Name

- AMF is bringing forth two naming recommendations:
  - Alameda Health System
  - Sovereign Health
- Service lines such as Fairmont, would carry a tag line - "A Member of Alameda Health System" or "A Member of Sovereign Health." Each brand, however, would retain their specific color, font and icon.

Rationale for Alameda Health System

- Rids organization of County moniker
- Speaks to the comprehensive nature of the organization
- Lessens possible political backlash
- Leans toward more progressive signature
- Creates more modern umbrella moniker and integrates the organization's brands

Rationale for Sovereign Health

- Distances the organization from its county roots
- Addresses the employees desire for greater pride of affiliation and a standard of accountability
- Further amplifies the expectations of care internally
- Makes a powerful statement – our mission is noble, we are committed to a higher calling of healthcare
- Supports the notion - we are second to none worthy of consideration for those who have a choice

Current	Proposed	Comment
Highland Hospital	Highland Hospital	Change color/font/icon
Fairmont Hospital	Fairmont Hospital	Change color/font/icon
John George Psychiatric Pavilion	John George Psychiatric Hospital	Change name, color/font-limit to inpatient and emergency psychiatric care
None	Lighthouse Behavioral Health Services	New name applies to voluntary, ambulatory behavioral health services and counseling at all ACMC locations
Newark Wellness	Newark Wellness	Change color/font/icon; Adopt common style of geographic location + Wellness for all current and future ambulatory care locations
Alameda County Medical Center	CHOICE: Alameda Health System OR Sovereign Health	Change color/font/icon; use as tag line below each sub-brand
Enterprise Tag line	"A Member of Alameda Health System" OR	Tag line to appear in smaller font with enterprise ICON

	"An Affiliate of Sovereign Health"	below each of the sub-brands

Jerri Randrup, Director of Corporate Communications & Marketing, presented project research findings based on the re-branding proposal of AMF Media.

The Board discussed the pros and cons of the re-branding proposal presented. The overall sense of the Board was a dislike of the Sovereign Health brand name.

ACTION: A motion was made, seconded, and unanimously approved the House of Brands model to re-brand the organization with the following names and related visual depiction as described in the attached Exhibit.

- ***Alameda Health System to replace Alameda County Medical Center***
- ***Highland Hospital to replace Highland General Hospital***
- ***John George Psychiatric Hospital to replace John George Psychiatric Pavilion***
- ***Lighthouse Behavioral Services***
- ***Fairmont Hospital***
- ***Eastmont Wellness***
- ***Hayward Wellness to replace Winton Wellness***
- ***Newark Wellness***
- ***Highland Wellness***

MOTION: ***Trustee Price***
SECOND: ***Trustee Huen***

AYES: Daniel Boggan, Jr., Barbara Price, Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Kirk E. Miller, Stanley M. Schiffman, J. Bennett Tate, and Barry Zorthian, MD
NAYS: None
ABSTAIN: None
ABSENT: Anthony Slimick and Ilene Weinreb

ACTION: A motion was made, seconded, and approved the logo with the "Alameda Health System" brand name as presented.

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

AYES: Daniel Boggan, Jr., , Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Kirk E. Miller, Stanley M. Schiffman, J. Bennett Tate, and Barry Zorthian, MD
NAYS: Barbara Price
ABSTAIN: None
ABSENT: Anthony Slimick and Ilene Weinreb

CONVENE TO CLOSED SESSION

TAB #8 **CLOSED SESSION**
Conference with Legal Counsel: Potential Litigation
[Government Code Section 54956.9]
Douglas B. Habig, General Counsel

RECONVENE TO OPEN SESSION

TAB #9 **ACTION: St. Rose Hospital Joint Powers Authority**

ACTION: A motion was made, seconded, and unanimously approved the recommendation that Barbara Price serve on the Joint Powers Authority as Alameda County Medical Center's representative.

MOTION: Trustee Schiffman
SECOND: Trustee Lewis

AYES: Daniel Boggan, Jr., , Barbara Price, Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Kirk E. Miller, Stanley M. Schiffman, J. Bennett Tate, and Barry Zorthian, MD
NAYS: None
ABSTAIN: None
ABSENT: Anthony Slimick and Ilene Weinreb

Public Comments: **None.**

Board of Trustees Remarks: None.

ADJOURNMENT – DAY 1: THE MEETING WAS ADJOURNED AT 5:05 PM.

DAY 2 – APRIL 28, 2012:

THE MEETING WAS CALLED TO ORDER AT APPROXIMATELY 9:10 AM.

CONVENE TO CLOSED SESSION

TAB #10 CLOSED SESSION
Conference with Legal Counsel: Potential Litigation
[Government Code Section 54956.9]
Douglas B. Habig, General Counsel

RECONVENE TO OPEN SESSION

ROLL CALL WAS TAKEN; THE FOLLOWING TRUSTEES WERE PRESENT:

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

Barbara Price and Anthony Slimick were excused.

NON-VOTING MEMBER PRESENT:

Lyn Berry, MD was excused.

TAB #11 DISCUSSION: Business Partnership Program

Mark Zielazinski, Chief Information Officer, presented an overview of the proposed ACMC Diagnostic Imaging and Clinical Equipment Strategic Partnership plan.

Background: ACMC has not had a consistent strategy for diagnostic imaging or clinical equipment and with the coming plans for the Acute Tower Replacement (ATR) and Highland Care Pavilion (HCP) we will need to procure roughly thirty million ($30M) of equipment for use in the new facilities. Historically we have purchased equipment on single needs basis and as a result we have the following situation:

1. We have equipment from multiple vendors; GE, Phillips, Toshiba and Siemens primarily in diagnostic imaging and a host of vendors in clinical equipment. Much of the equipment that is currently in service is in need of replacement and we have struggled to manage a replacement process due to a lack of standardization coupled with our tight fiscal situation.

2. The new building projects will require that we acquire significant new equipment and we are able to use financing that the county is providing as a part of the project.

As part of a new capital expense management process for the current fiscal year, ACMC has developed a CAPEX committee that is reviewing needs and requests for capital items on a regular basis and there are current requests outstanding to replace existing diagnostic imaging equipment that approach five million dollars ($5M). These requests represent equipment needs over and above the ATR project.

Finally, ACMC has a contract for services with GE to provide the majority of biomedical service throughout ACMC and this contract will come to term over the next 6 months. It will be imperative that a structure for this service is put into place that provides a better service level coupled with a better cost structure going forward.

Based on this information, discussions with a number of very large organizations, GE and Siemens in particular, has started and there is great interest in establishing a broad strategic partnership for Diagnostic Imagining (DI) equipment, Clinical Equipment and Biomedical Services for both types of equipment. The timing of the ATR project has accelerated the need to work on this strategy in order for ACMC to reap the benefits of such a relationship, particularly in regards to the large capital needs that exist for the ATR project. As a result of such a partnership ACMC would realize the following benefits:

1. Better cost structure for acquisition of DI and Clinical equipment.
2. The ability to plan in a meaningful way for ATR projects which will expand our equipment needs.
3. A product life cycle program that will reduce the cost of maintenance and set ACMC up to take better advantage of the chosen vendors planning processes.
4. The ability to streamline cash flow based on a unitary pricing model rather than the typical spikes in capital purchases.

There are two potential downsides to formalizing this strategy which are as follows:

1. Potentially limited clinician choice related to changing clinical needs.
2. Potential limit on ACMC's ability to take advantage of future technical enhancements that may present themselves.

Both of these downsides can be mitigated during the contracting process and ACMC will work to ensure that there are limits on exposure to these issues as the final decision on a vendor is made.

Proposal: Based on the current situation and analysis to date, management is recommending that over the next six months ACMC continue on a path towards a broad strategic DI and Clinical Equipment partnership considering both GE and Siemens as options. A final decision and contract will be reached and presented to the Board prior to the end of the year.

Discussion ensued regarding the pros and cons of entering into this type of partnership. Mr. Zielazinski clarified that at this point, staff was not looking for an action item, but rather a "sense of the Board" to move forward with the process of establishing a partnership that will be brought forward to the Board for approval later this fall. Ms. Schales added clarification of the how the partnership will provide a better cost structure and streamline cash flow. Mr. Lassiter added that staff will interface with both the Finance and Strategic Planning Committees regarding the partnership.

The Board requested clarification as to how this partnership might affect the ATR budget. Mr. Lassiter responded that the affect on the budget is unknown until the scope of the partnership is determined.

TAB #12 DISCUSSION: Board Self Assessment Survey Results

Valerie D. Lewis, Esq., Chair, Governance Committee provided an overview of the Board Self-Assessment process and introduced Roger W. Witalis, FACHE, President, Witalis Healthcare Advisors as today's facilitator.

Mr. Witalis took the Board through the results of the self-assessment comparing this year's results with previous results. Many areas were at or above the national average; there were five competencies that fell below the national average:

- Fiduciary Duty of Care
- Fiduciary Duty of Loyalty
- Financial Oversight
- Self-Assessment and Development
- Advocacy

Some of the low scores can be attributed to a high occurrence of "don't know" responses by Board members. This can be resolved through education as well as removing questions that are not applicable to ACMC Board of Trustees.

Discussion around disclosure of conflicts prompted Mr. Witalis to recommend a white paper from The Governance Institute "Institutional Integrity".

Discussion regarding Financial Oversight prompted the Board to refer audit "don't knows" back to the Audit & Compliance committee for review.

The Board discussed the possibility of introducing 360 assessments for individual Board members. Mr. Witalis emphasized this was a valuable and important tool. Mr. Witalis offered to share a template that ACMC could use to modify to develop a 360 assessment for the Trustees.

Advocacy discussion focused on Trustees reaching out to the community to advocate ACMC.

Trustee Schiffman requested a PowerPoint presentation be developed for Trustees to take to outside organizations to advocate ACMC.

Mr. Witalis provided a handout of the summary of follow-up items from the February 26, 2010 Retreat. Mr. Lassiter went through the list with the Board to discuss what items had been accomplished and the status of pending items.

Trustee Lewis thanked Mr. Witalis for a wonderful facilitation of the content.

Mr. Lassiter thanked Mr. Witalis for his support of ACMC.

TAB #13 DISCUSSION: Board Succession Planning

Mr. Lassiter provided an overview of the proposed Board succession plan. A formal plan will be developed to ensure smooth transition of the Board.

TAB #14 DISCUSSION: Self-assessment Topic: Duties of Care and Loyalty

Mr. Habig presented an overview of Duties of Care and Loyalty; two topics which scored at or below the national average in the Board of Trustees self-evaluation for 2011. While it is unlikely that the Board believes that it does not act with care and loyalty, the Board most probably feels itself in need of education on these subjects. The Duty of Care sets forth the level of diligence that is expected of the Board in fulfillment of its fiduciary duties. The Duty of Loyalty requires the Board to put the best interests of the organization above their personal interests.

TAB #15 REPORT: Legal Counsel's Report on Action Taken in Closed Session

Douglas B. Habig, General Counsel, reported that no action was taken in Closed Session.

Public Comments: None.

Board of Trustees Remarks:

Trustee Miller discussed the Duty of Care as a fiscal issue, it is a moving target.

ACTION: A motion was made and seconded to recommend that management develop a budget prior to the next Board meeting that specifies the sources of revenue and anticipated uses in connection with restructuring healthcare reform.

MOTION: Trustee Miller
SECOND: Trustee Nelson

Discussion ensued with regards to the cost of restructuring. Ms. Schales provided clarification that some of these costs will be identified in the FY13 budget. In September, the 3 year strategic plan will be presented to the Board for approval; this process will help to address some of the issues that are being raised.

Trustee Miller offered to withdraw the motion or reframe it. Mr. Lassiter requested that the motion not be withdraw, but reframed with a September timeframe for presentation to the Board. This will allow for a one year snapshot to be brought forward in June and the 3 year strategic plan presentation in September.

Trustee Miller modified the motion to state the next fiscal year delivery date would be this June; and the 3 year plan would be developed in conjunction with the strategic plan.

Trustee Boggan called for the question.

AYES: Daniel Boggan, Jr., Ronald D. Nelson, Floyd Huen, MD, Valerie D. Lewis, Esq., Kirk E. Miller, Stanley M. Schiffman, J. Bennett Tate, Ilene Weinreb, and Barry Zorthian, MD.
NAYS: None
ABSTAIN: None
ABSENT: Barbara Price and Anthony Slimick.

Trustee Schiffman requested that the Retreat minutes be completed in a timely fashion; Trustee Boggan confirmed that the issue had been addressed.

Trustee Miller requested clarification of how partnerships are established and how they are going to move ACMC forward. Mr. Lassiter clarified that this issue would be a part of the strategic plan that will be brought to the Board in September.

Ms. Schales shared how the Steering Committee is addressing the issues raised by the Board and the prioritization that occurs with regards to capital planning.

Trustee Weinreb requested that there be reporting on this issue to the Board. Ms. Schales recommended 6 months as an appropriate window for reporting.

Trustee Schiffman thanked Trustee Boggan for orchestrating a successful retreat. He also thanked staff for the implementation of BoardEffect and assisting the Board in moving forward with their fiduciary responsibilities.

ADJOURNMENT – DAY 2: THE MEETING WAS ADJOURNED AT 12:05 PM.

Respectfully Submitted by:

Barbara L. McElroy,
Clerk of the Board

APPROVED AS TO FORM:

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

System Integration Tag:

A member of Alameda Health System