Alameda Hospital
CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE
CITY OF ALAMEDA HEALTH CARE DISTRICT
BOARD OF DIRECTORS
AGENDA

Wednesday, February 3, 2010 – 6:00 p.m.

Location: Alameda Hospital (Dal Cielo Conference Room)

2070 Clinton Avenue, Alameda, CA 94501

Office of the Clerk: (510) 814-4001

Regular Meeting

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

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

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Closed Session Minutes – January 11, 2010

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

C. Board Quality Committee Report (BQC) – November 2009 — H & S Code Sec. 32155

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

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

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

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

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

A. Announcements from Closed Session — Jordan Battani

VI. Consent Agenda

A. Approval of January 11, 2010 Minutes **ACTION ITEM** [enclosure]

B. Acceptance of December 2009 Financial Statements **ACTION ITEM** [enclosure]

C. Acceptance of Departmental Policy and Procedure Manuals **ACTION ITEM** [enclosure]

- Respiratory Therapy
- Rehabilitation Services

VI. Regular Agenda

A. President's Report — Jordan Battani

1. Committee Assignments **ACTION ITEM** [enclosure]

2. Election of Officers **ACTION ITEM**

B. Board Education

1. Results of Tracer Studies Completed for Joint Commission Survey Preparation — Mary Bond, RN

C. Chief Executive Officer's Report — Deborah E. Stebbins

1. Joint Commission Leadership Training Availability

D. Strategic Planning and Community Relations Report

1. Committee Report – January 19, 2010 — Rob Bonta

E. Finance and Management Committee Report

1. Committee Report – January 27, 2010 — Rob Bonta

2. Authorization to Purchase PACS **ACTION ITEM** [enclosure] — Kerry Easthope

F. Medical Staff President Report — Alka Sharma, MD

VIII. General Public Comments

IX. Board Comments

X. Adjournment

The next regularly scheduled board meeting is scheduled for March 1, 2010
Closed Session will begin at 6:00 p.m.
Open Session will follow at approximately 7:30 p.m.

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

January 11, 2010

Directors Present:
Jordan Battani
Robert Bonta
Robert Deutsch, MD
J. Michael McCormick
Leah Williams

Management Present:
Deborah E. Stebbins
Kerry J. Easthope
David A. Neapolitan

Medical Staff Present:

Legal Counsel Present:
Thomas Driscoll, Esq.

Excused:
Alka Sharma, M.D.

Submitted by:
Jaclyn Yuson

Action		
1. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 6:07 p.m.	
2. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
3. Adjourn into Executive Closed Session	At 6:08 p.m. the meeting adjourned to Executive Closed Session.	

4. Reconvene to Public Session	**A. Announcements from Closed Session** Jordan Battani reconvened the meeting into public session at 8:40 p.m. The following closed session announcement was made. [1] Minutes – December 7, 2009 and December 9, 2009 Closed Session minutes were reviewed and approved.	
5. Consent Agenda	[A] Approval of December 7, 2009 and December 9, 2009 Minutes [B] Acceptance of November 2009 Financial Statements [C] Acceptance of the Environment of Care Manual [D] Acceptance of Departmental Policy and Procedure Manuals [E] Approval of Amendment to Medical Staff Bylaws – H&P Privileges for Podiatrists Consent Agenda item [A], December 7th minutes, was pulled for discussion as Directors Williams and McCormick were not present at the December 7th meeting.	Director Deutsch moved to approve the Consent Agenda as presented. Director Bonta seconded the motion. The motion carried unanimously. Director Deutsch moved to approve the December 7, 2009 minutes as presented. Director Bonta seconded the motion. The motion carried with two abstentions, Directors Williams and McCormick.
6. Regular Agenda	**A. President's Report** 1. <u>Update on Committee Assignments and Election of Officers</u> Director Battani stated she would like to offer Director Williams the opportunity to attend a variety of committee meetings this year and also extend the offer to the applicants who applied for the vacant Board position in	

	December 2009. Director Battani would like the Board members to think about what committees they want to be a part of this calendar year. After reviewing the District Bylaws, Director Battani commented on committees not having to be chaired by a Board member. Currently, there are three standing committees: Board Quality, Finance, and a combined committee that addresses Strategic Planning and Community Relations. Director Battani suggested separating the latter committee into two different groups. Ms. Stebbins added that there is a sense of urgency and focus with the Strategic Planning Committee due to the change in the Kaiser contract, thereby agreeing to make the Community Relations a sub-committee to Strategic Planning. Both groups need concentrated attention, thus separating the committee into two groups would be ideal. Other thoughts Ms Stebbins presented is to trim down the number of staff in each committee as the presence of more Board members and community members than staff is beneficial. Director Bonta seconded the idea that creating two groups would be beneficial with the right personnel in both committees. Director Williams commented on the idea of posting and sending out notices throughout the community to invite community members to participate. Director Battani stated that the role of "Treasurer" is currently vacant and has to be filled. Electing a Board member for this position will take place in the February meeting. Practice has been that the person who is Treasurer also chairs the Finance Committee which does not necessarily have to happen this way. In reviewing the District Bylaws, the Treasurers' primary role and responsible is oversight of the Parcel Tax funds which is / can be separate from taking on the leadership role in the Finance Committee. Patterns over the years have been to elect officers annually in January even though this practice is not stated in the Bylaws. Board members have the option to change the terms of office and the length of time members are in those roles. Director Battani proposed the idea to elect officers for two year terms relative to the time the member was elected onto the District Board. 2. <u>2010 District Board Meeting Calendar</u> The District Board Meeting Calendar is an informational item that presents the list of dates when the District Board Meetings will take place in 2010. District Board meetings will begin at 6 p.m. not at 5:30 p.m. as stated on the District Board Meeting Calendar document.	

B. Chief Executive Officers Report

1. Recommendation of Mental Health Parity Implementation

Ms. Stebbins gave a follow up report on the Mental Health Parity Implementation. After consulting with Mercer, the Hospital's benefits broker, Mercer stated that four other governmental agencies they work with on a regular basis have not opted out of the Mental Health Parity option. Ms. Stebbins recommends the Board reconsider the suggestion of opting out of the Mental Health Parity and approve implementation of such services beginning February 1, 2010. Mercer estimates that these benefits would cost $45,000 annually.

Director McCormick moved to approve the Mental Health Parity Implementation. Director Bonta seconded the motion. The motion carried unanimously.

2. General Statistics

Ms. Stebbins reviewed the key statistics listed below noting that there was a 13.3% increase in December (85.3) from November's average daily census, 75.27. There was also a 41.9% and a 9.7% increase from November to December in the Acute and South Shore census, respectively, with a downturn of -4.1% in the subacute census resulting in an average daily census of 31.9. The emergency room visits and total surgeries were above budget by 3.8% and 11.1%, respectively.

Statistics	December (Prelim)	December Budget	November Actual
Average Daily Census	85.3	88.2	75.27
Acute	32.06	33.3	22.6
Subacute	31.9	33.4	33.32
South Shore	21.3	21.52	19.43
Patient Days	2,643	2,735	2,258
ER Visits	1,47283	1,418	1,383
OP Registration	2,343	2,795	2,372
Total Surgeries	470	423	440

3. U

Ms. Stebbins reported to the Board that there will be a Joint Commission Fair on January 26th and 27th, to educate and prepare employees on the Joint Commissions' standards and expectations. A Joint Commission Compass booklet was prepared and published for each member of the Hospital to use as

	a reference tool. Copies of the Compass were distributed to the Board. **C. Strategic Planning and Community Relations Report** Director Bonta reported that the Strategic Planning and Community Relations Committee did not meet in December 2009, however, is scheduled to meet on January 19, 2010 and will update the Board at the February Board meeting. **D. Finance and Management Committee Report** 1. Committee Report – January 6, 2010 Director Battani reported that November was not a profitable month which was actually the first month with a net loss after a long period of positive trends. The low census in November is accounted for this loss which has been confirmed to be a regional trend. Other hospitals around the Bay Area experienced a low census in November as well. **E. Medical Staff President’s Report** Dr. Deutsch reported on Dr. Sharma’s behalf (the Medical Staff President) and informed the Board of Directors that four physicians joined the Alameda Hospital Physician staff: a family practitioner, a general surgeon, plastic surgeon, and an internist. The medical staff has invited a guest speaker who is an expert in stroke management. Dr. Deutsch is welcoming everyone to attend this event on January 5, 2010. An amendment to the medical staff by-laws was added allowing Podiatrist to do pre-operative history and physical examinations on their patients in accordance with state law. Lastly, Dr. Deutsch mentioned that the Annual Holiday and New Year’s event supported by the Medical Staff was successful and thanked everyone who attended.	
8. General Public Comments	None at this time	

9. Board Comments	None at this time	
10. Adjournment		A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 9:18 p.m.

Attest:

____
Jordan Battani
President

____
Robert Bonta
Secretary

THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING DECEMBER 31, 2009

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
December 31, 2009

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
DECEMBER, 2009

The management of the Alameda Hospital (the "Hospital") has prepared this discussion and analysis in order to provide an overview of the Hospital's performance for the period ending December 31, 2009 in accordance with the Governmental Accounting Standards Board Statement No. 34, *Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments.* The intent of this document is to provide additional information on the Hospital's financial performance as a whole.

Financial Overview as of December 31, 2009

- Gross patient revenue was greater than budget by $1,243,000 or 5.3%. Inpatient revenue was greater than budgeted by 3.7% and outpatient revenue was 7.7% greater than budgeted. On an adjusted patient day basis gross patient revenue was $5,610 compared to a budgeted amount of $5,228 or a 7.3% favorable variance.

- Total patient days were 2,643 compared to the prior month's total patient days of 2,258 and the prior year's 2,441 total patient days. The average daily acute care census was 32.1 compared to a budget of 33.3 and an actual average daily census of 22.6 in the prior month; the average daily Sub-Acute census was 31.9 versus a budget of 33.4 and 33.2 in the prior month and the South Shore unit had an average daily census of 21.3 versus a budget of 21.5 and prior month census of 19.4, respectively.

- Emergency Care Center visits were 1,472 or 3.8% greater than the budgeted 1,418 visits and were virtually the same as the prior year's visits of 1,471.

- Total surgery cases were 11.1% greater than budget, with Kaiser surgical cases dropping 60.4% of the 470 total cases. Alameda physician surgical cases were 186 cases in December versus 159 cases in November.

- Outpatient registrations were 16.2% below budgeted targets at 2,343 but were 1.6% better than the prior year's 2,306 registrations.

- Combined excess revenues over expense (profit) for December was $16,000 versus a budgeted excess of expenses over revenue (loss) of $58,000.

- Total assets increased by $197,793 from the prior month as a result of an increase in current assets of $249,358, a decrease in net fixed assets of $68,711 offset by an increase in restricted contributions of $17,146. The following items make up the increase in current assets:

  - Total unrestricted cash and cash equivalents for December increased by $2,878,073. This increase was the result of the December installment of parcel tax funds in the amount of $2,869,239. Day's cash on hand increased to 12.4 at December 31, 2009.

  - Net patient accounts receivable increased in December by $215,609 compared to an increase of $2,231 in November. Day's in outstanding receivables increased slightly to 51.3 as compared to 50.3 in November.

  - Other assets decreased by $2,855,255 as a result of the receipt of the December installment of parcel tax funds of $2,869,239.

- Total liabilities increased by $164,330 compared to a decrease of $1,221,843 in the prior month. This increase was the result of the following:

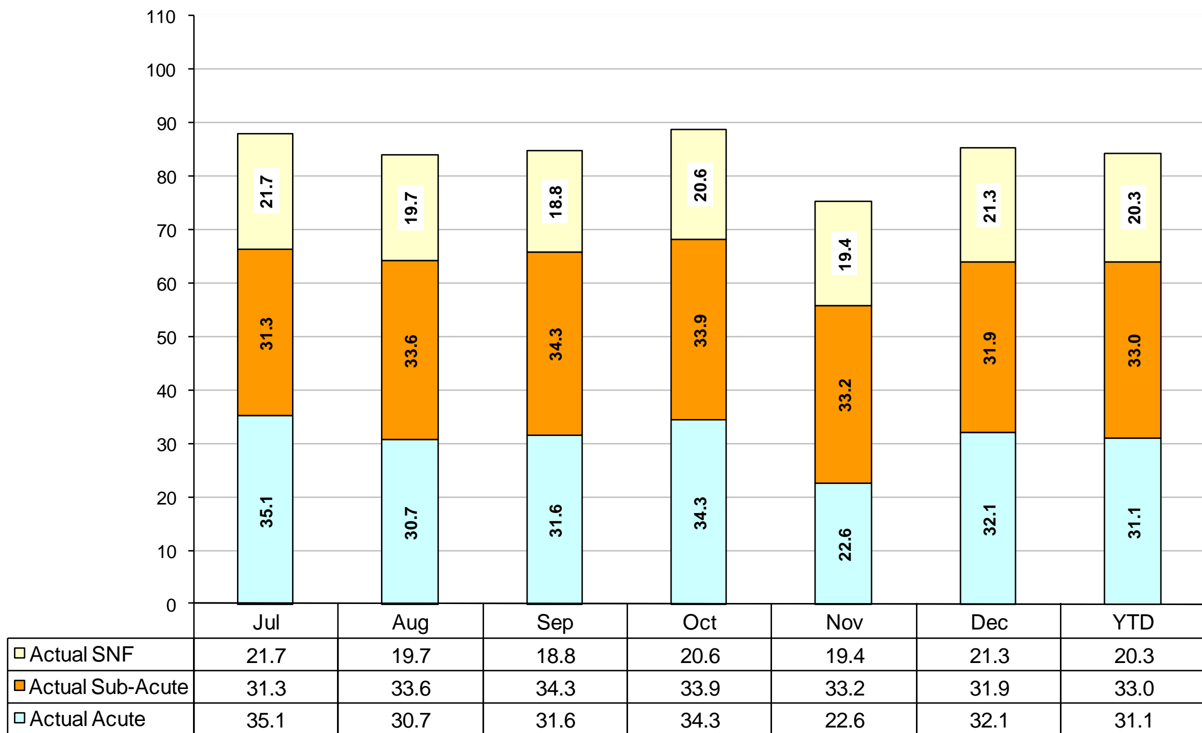
- Accounts payable decreased by $433,895 from the prior month. As a result of this decrease the average accounts payable payment period decreased in December to 56.9 from 57.3 as of November 30, 2009.

- Payroll and benefit related accruals increased by $365,823 from the prior month. This increase was the result of the accrual of twelve (12) days of payroll at December 31st versus the eight (8) days of accrued payroll required at November 30th.

- Other liabilities increased by $268,890 as a result of the amortization of one month's deferred revenue related to the 2009/2010 parcel tax revenues ($477,000) offset by the receipt of the December and January monthly Kaiser prepayment for services ($800,000 per month) under the current services agreement.

Volumes

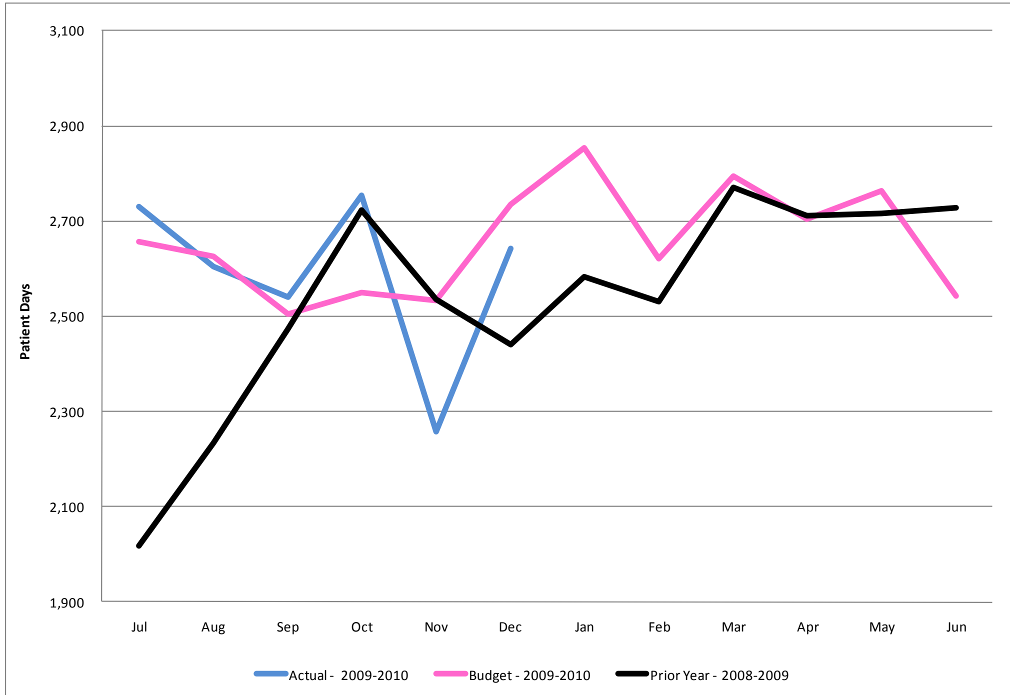
The combined actual daily census was 85.3 versus a budget of 88.2. December saw unfavorable variances in all three inpatient programs for the month. However, the unfavorable variance in the acute care program was only 1.2 unfavorable. Additionally, the sub-acute care program was only 0.2 unfavorable to the budget on an average daily census of 21.3. The unfavorable average daily census variances were 1.2, 1.6 and 0.2 for the acute, sub-acute and skilled nursing programs, respectively.



	Jul	Aug	Sep	Oct	Nov	Dec	YTD
Actual SNF	21.7	19.7	18.8	20.6	19.4	21.3	20.3
Actual Sub-Acute	31.3	33.6	34.3	33.9	33.2	31.9	33.0
Actual Acute	35.1	30.7	31.6	34.3	22.6	32.1	31.1

Total patient days in December were 3.49% less than budgeted and were 8.3% greater prior year volumes. The graph on the following page shows the total patient days by month for fiscal year 2010.

Total Patient Days

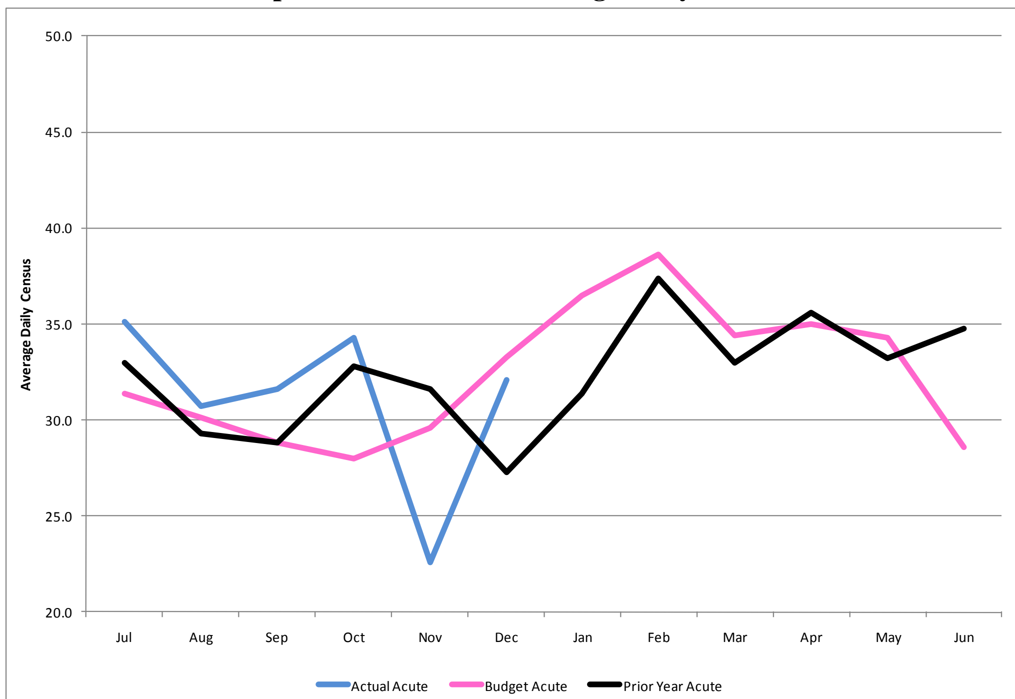


The various inpatient components of our volumes for the month of December are discussed in the following sections.

Acute Care

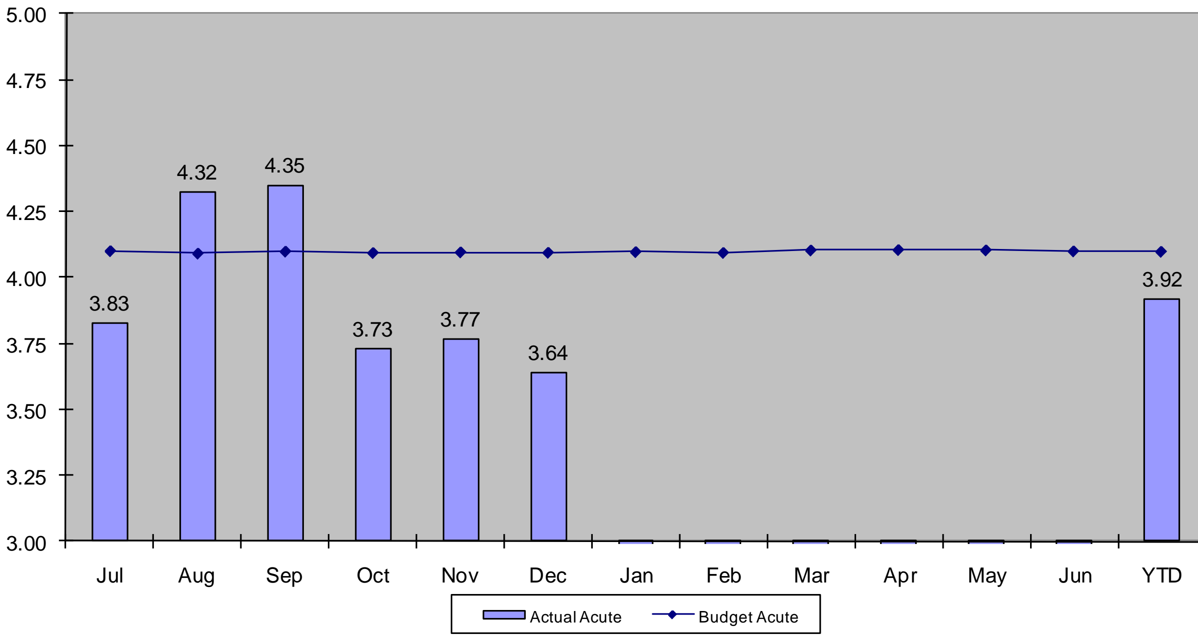
The acute care patient days were 3.7% (38 days) less than budgeted and were 17.4% greater than the prior year's average daily census of 27.3. The acute care program comprised of Critical Care Unit (3.5 ADC), Definitive Observation Unit (10.7 ADC) and Med/Surg Units (17.8 ADC).

Inpatient Acute Care Average Daily Census



The average length of stay (ALOS) decreased slightly to 3.64 days for the month of December versus November's 3.77. This brings the year-to-date ALOS to 3.78 which remains slightly lower than our projected year to date ALOS of 4.10, and is shown in the graph below.

Average Length of Stay



Sub-Acute Care

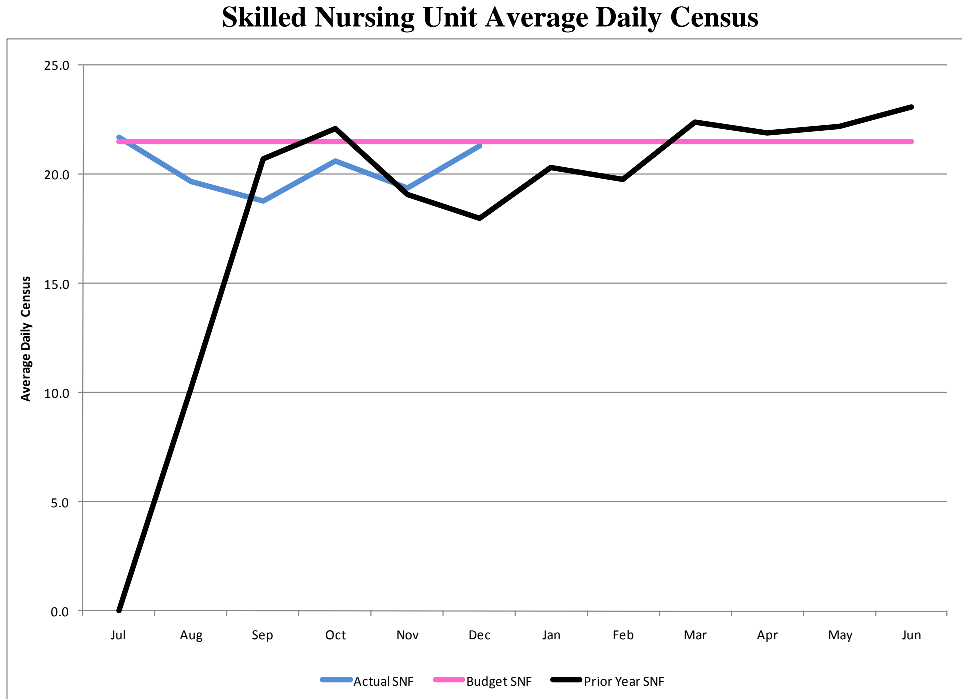
The Sub-Acute program patient days were 4.6% less than budget or 48 patient days. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census

Skilled Nursing Care

The Skilled Nursing Unit (South Shore) patient days were only 0.9% or 5 days less than budgeted for the month of December. Comparing performance to the prior year this program was better than December 2008 with an average daily census of 21.3 versus 18.0. The following graph show the Skilled Nursing Unit average daily census as compared to budget by month.

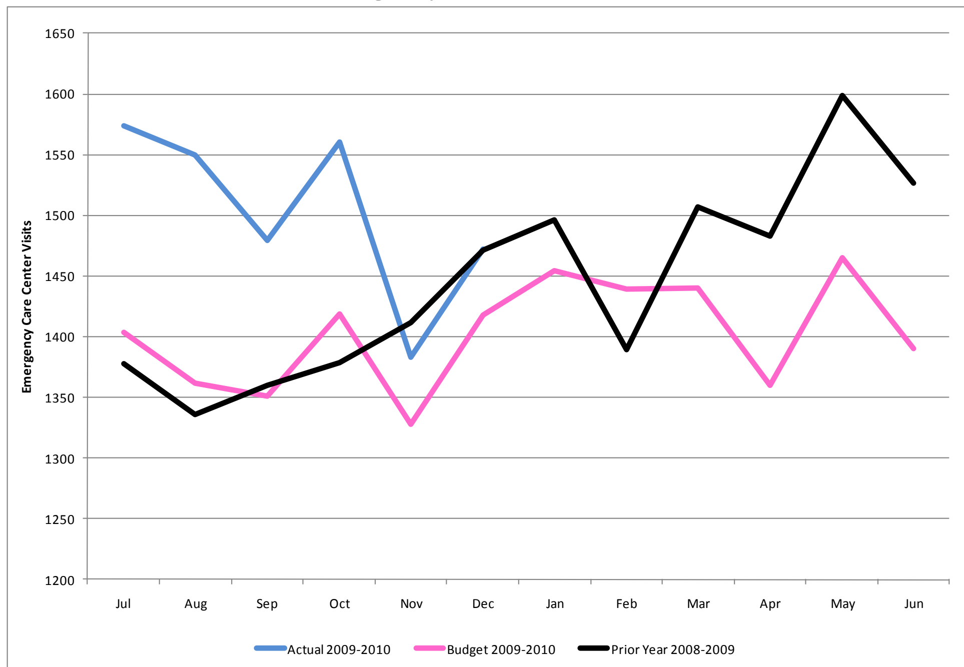
Skilled Nursing Unit Average Daily Census



Emergency Care Center

Emergency Care Center visits at 1,475 were 3.8% greater than budgeted for the month of December and 20% of these visits resulted in inpatient admissions. In December there were 253 ambulance arrivals versus 219 in the month of November, an increase of 15.5% over the prior month. Of the 253 ambulance arrivals 206 or 81.4% were from Alameda Fire Department ambulances. The graph on the following page shows the Emergency Care Centers visits by month for fiscal year 2010 as compared to budget and the prior year.

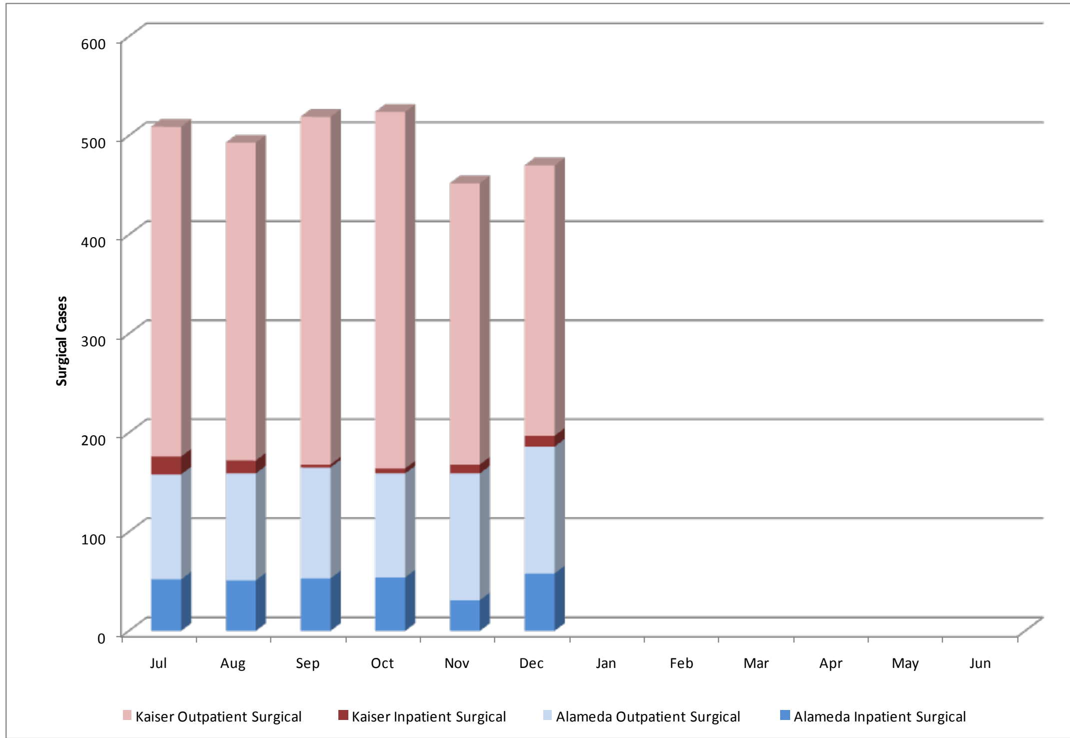
Emergency Care Center Visits



Surgery

Surgery cases were 470 versus the 423 budgeted and 414 in the prior year. In December, Alameda physician cases were 186 cases which were 17% greater than the prior month. The increase was primarily driven by outpatient cases which totaled 128 versus 112 in November. Additionally, inpatient cases were higher than the prior months 32 cases at 58 cases. The largest increase came from GI cases while also seeing an increase in vascular, orthopedic and plastic cases. Kaiser related cases in December decreased to 284 as compared to the 293 cases performed in November. Despite this slight decrease in Kaiser Same Day volume Kaiser Same Day surgery revenue increased by $115,970 from November. As result of the slight increase in Kaiser Same Day Surgery revenue the percentage of net revenues declined to 23.4% from 24.0% in the prior month. The graph on the following page shows the number of surgical cases by month for fiscal year 2010.

Surgical Cases

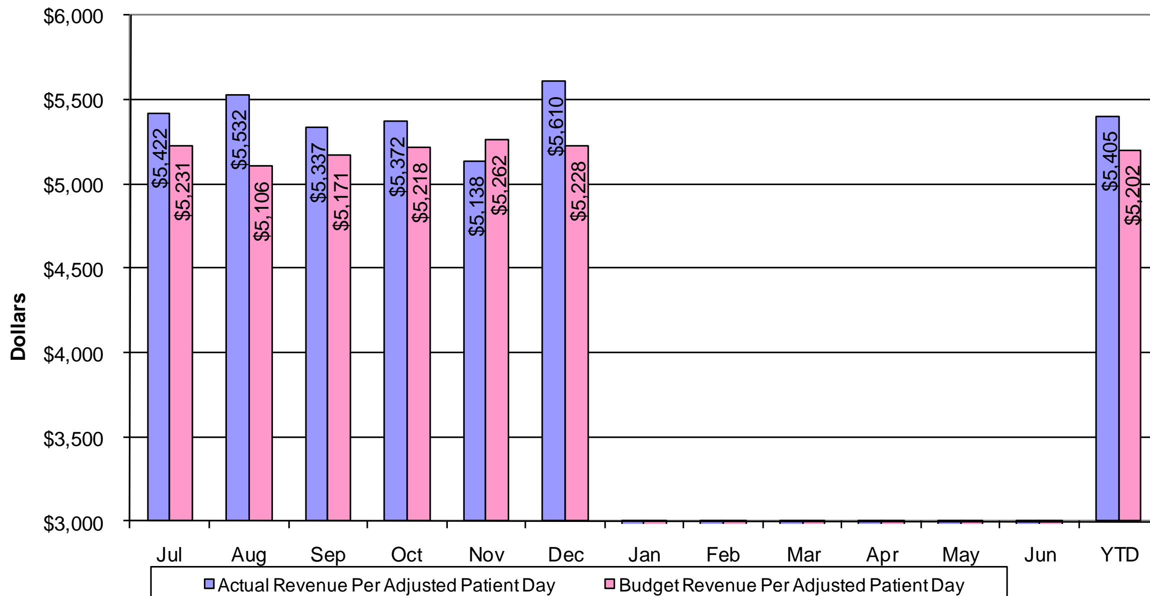


Income Statement

Gross Patient Charges

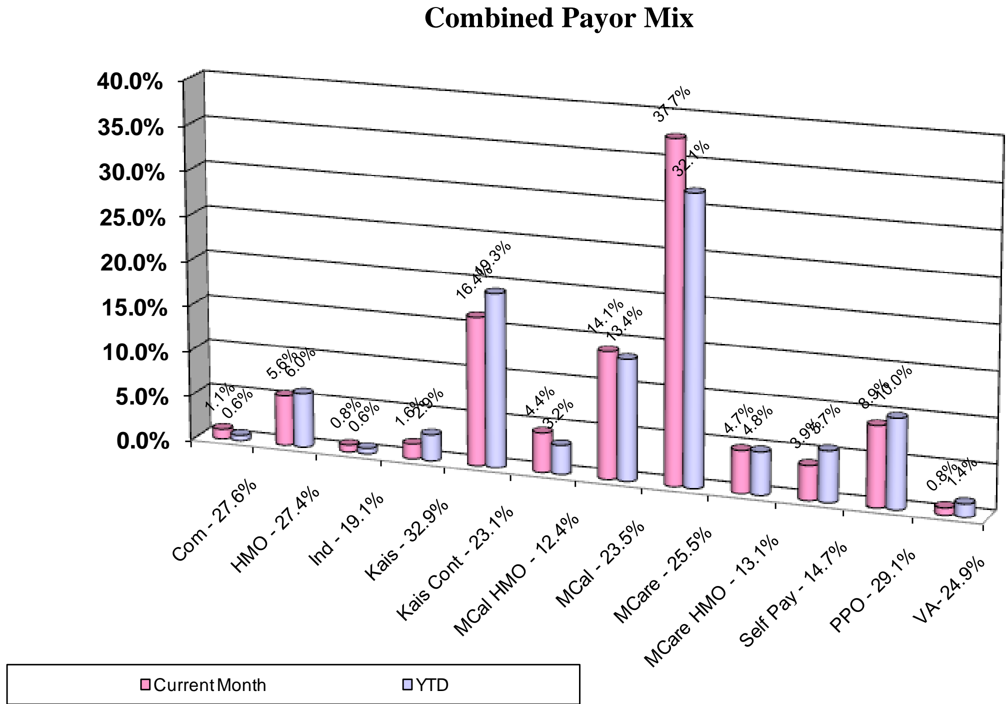
Gross patient charges in December were greater than budgeted by $1,243,000. This favorable variance was comprised of favorable variances of $528,000 and $715,000 in inpatient and outpatient revenues respectively. On an adjusted patient day basis total patient revenue was $5,610 versus the budgeted $5,228 or a 7.3% favorable variance from budget for the month of December.

Gross Charges per Adjusted Patient Day



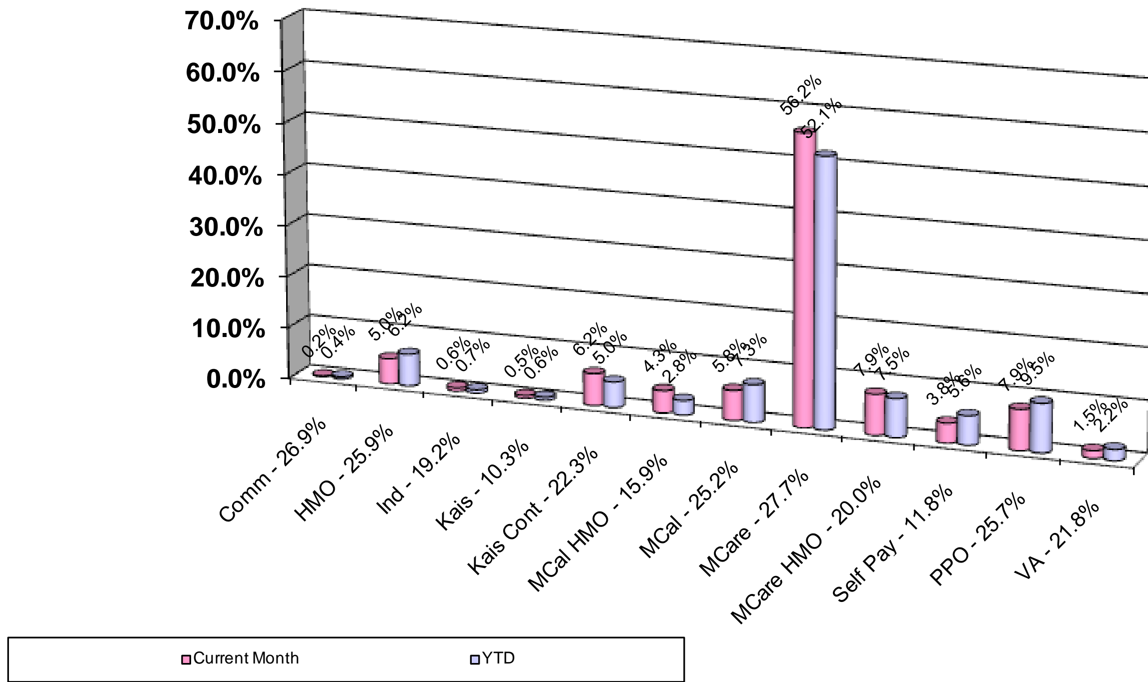
Payor Mix

Medicare total gross revenue in December made up 37.7% our total gross patient charges or 0.5% greater than the 37.2% in the prior month. Kaiser was again the second largest source of gross patient revenues at 18.0% followed by Medi-Cal utilization at 14.1% and the combined HMO / PPO volume at 14.4%. The graph below shows the percentage of revenues generated by each of the major payors for the current month and fiscal year to date as well as the current months estimated reimbursement for each payor.



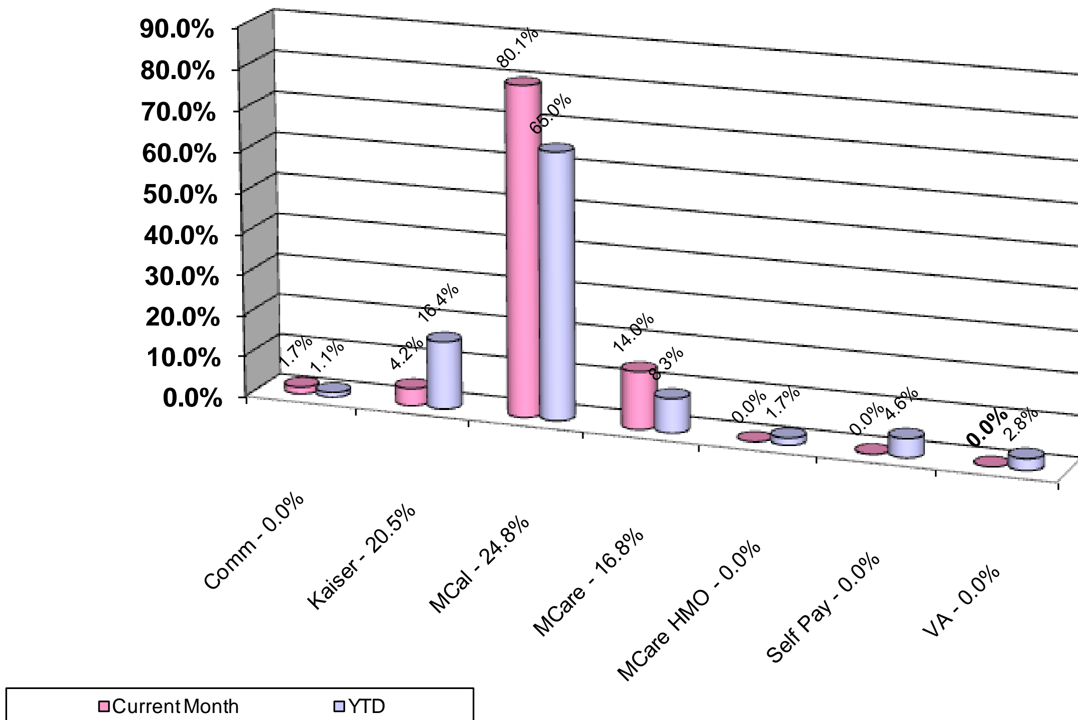
Current month gross Medicare charges made up 56.2% of our total inpatient acute care gross revenues followed by HMO/PPO at 12.9% and Medi-Cal at 5.8%. The hospitals overall Case Mix Index (CMI) decreased to 1.2620 from 1.3094 in the prior month. The Medicare CMI also decreased over the prior month from 1.4981 in November to 1.2832 in December. However, the increased number of Medicare inpatient cases with improved overall reimbursement and one (1) outlier case in the month, the expected reimbursement for Medicare inpatient cases to increased from November's estimate of 24.7% to 27.7% in December. Overall the inpatient acute net patient revenue percentage remained consistent with the prior month at 25.0% in December versus 23.3% in November. The graph on the following page shows the current month and year to date payor mix and current month estimated net revenue percentage for fiscal year 2010.

Inpatient Acute Care Payor Mix



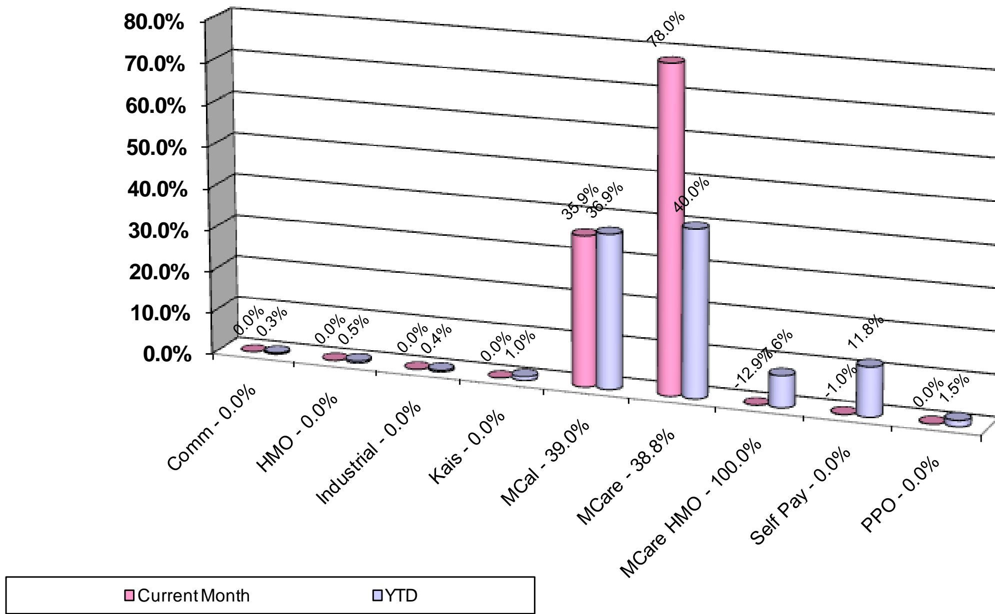
In December the Sub-Acute care program again was dominated by Medi-Cal utilization of 80.1% versus 77.9% in November. The following graph shows the payor mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payor.

Inpatient Sub-Acute Care Payor Mix



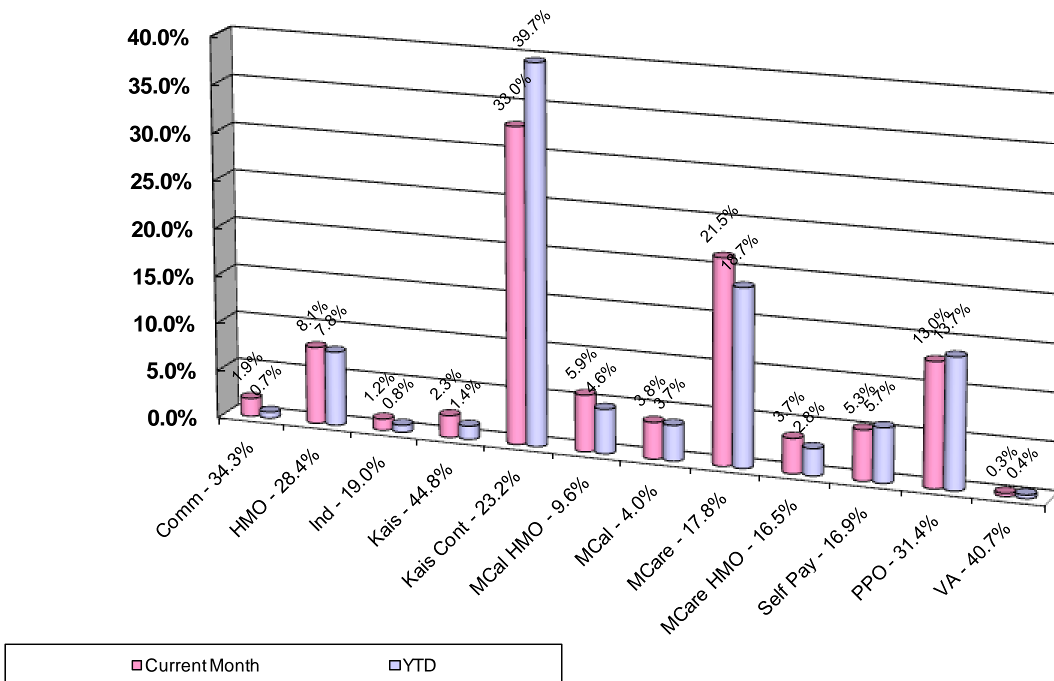
In December the Skilled Nursing program was comprised of Medicare 78.0% and Medi-Cal 35.9%. The graph on the following page shows the current month and fiscal year to date skilled nursing payor mix and the current months estimated level of reimbursement for each payor.

Inpatient Skilled Nursing Payor Mix



The outpatient gross revenue payor mix for December was comprised of 35.3% Kaiser, 21.5% Medicare, 13.0% PPO and 8.1% HMO. The graph below shows the current month and fiscal year to date outpatient payor mix and the current months estimated level of reimbursement for each payor.

Outpatient Services Payor Mix

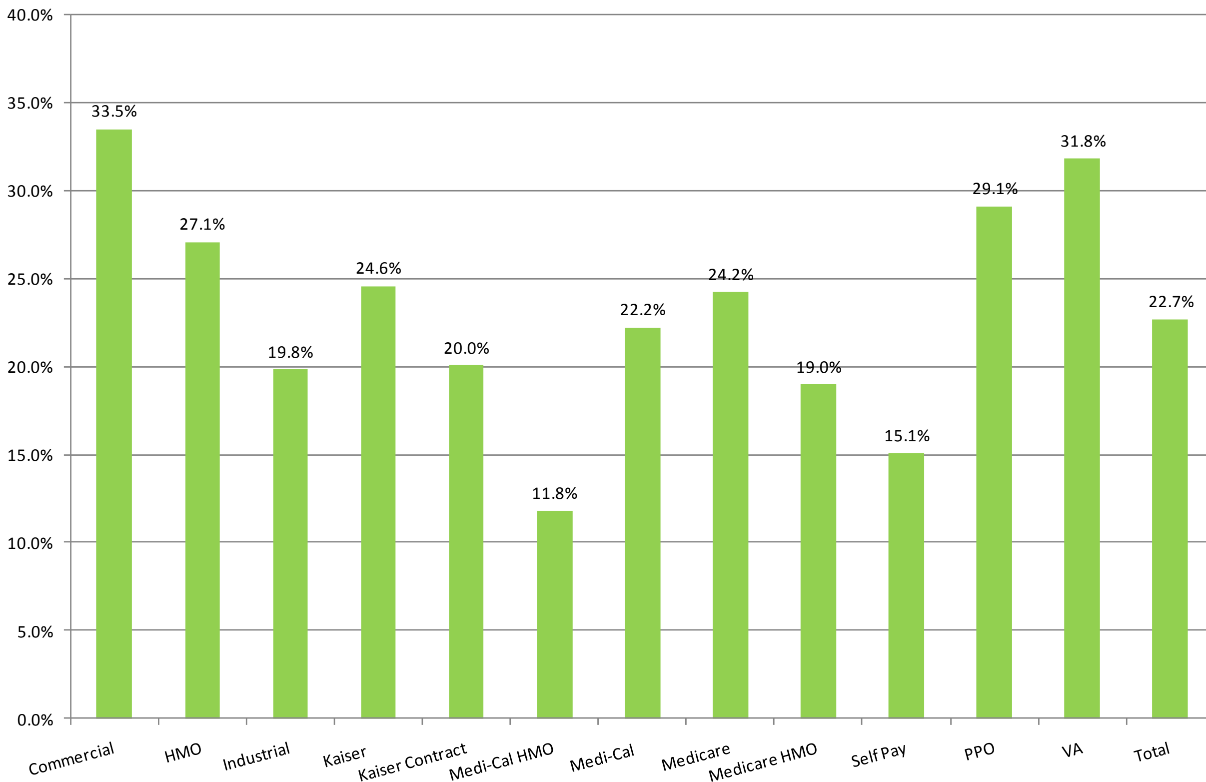


Deductions from Revenue

Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payors such as Blue Cross. In the month of December contractual allowances, bad debt and charity adjustments (as a percentage of gross patient charges) were 77.2% versus the budgeted 76.4%.

Net Patient Service Revenue

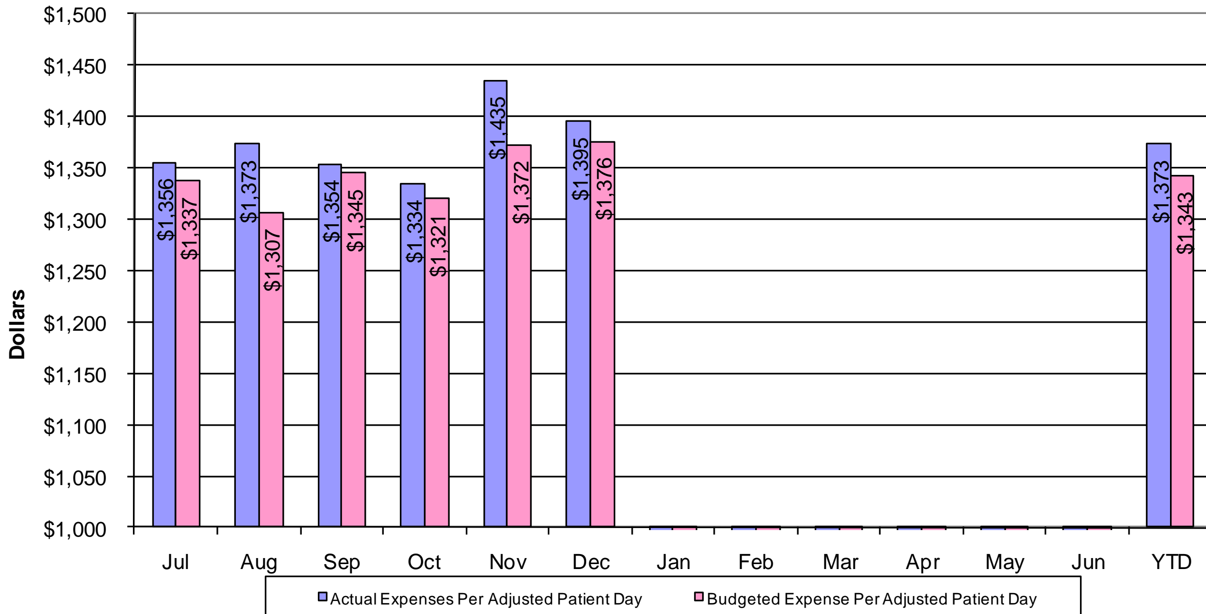
Net patient service revenues are the resulting difference between gross patient charges and the deductions from revenue. This difference reflects what the anticipated cash payments the Hospital is expecting to receive for the services provided. The graph below shows the level of reimbursement that the Hospital has estimated for fiscal year 2010 by major payor category.



Total Operating Expenses

Total operating expenses were less than the fixed budget by $34,000 or 0.5%. On an adjusted patient day basis, our cost per adjusted patient day was $1,395 which was $19 per adjusted patient day unfavorable to budget. This variance in expenses per adjusted patient day was primarily the result of an unfavorable variance in supplies. The graph on the following page shows the hospital operating expenses on an adjusted patient day basis for the 2010 fiscal year by month and is followed by explanations of the significant areas of variance that were experienced in the current month.

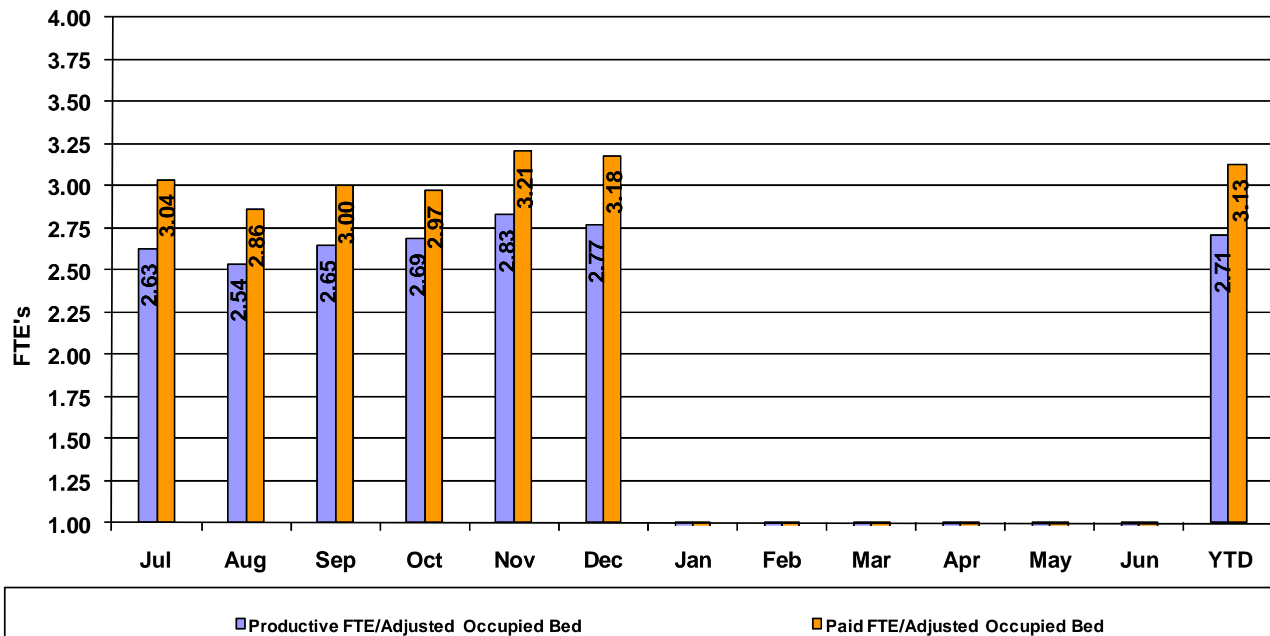
Expenses per Adjusted Patient Day



Salary and Registry Expenses

Salary and registry costs combined were favorable to the fixed budget by $65,000 and were equal to budgeted levels on a per adjusted patient day basis in December. On an adjusted occupied bed basis, productive FTE's were 2.77 in December versus the budgeted 2.66. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2010 by month and year to date.

FTE's per Adjusted Occupied Bed

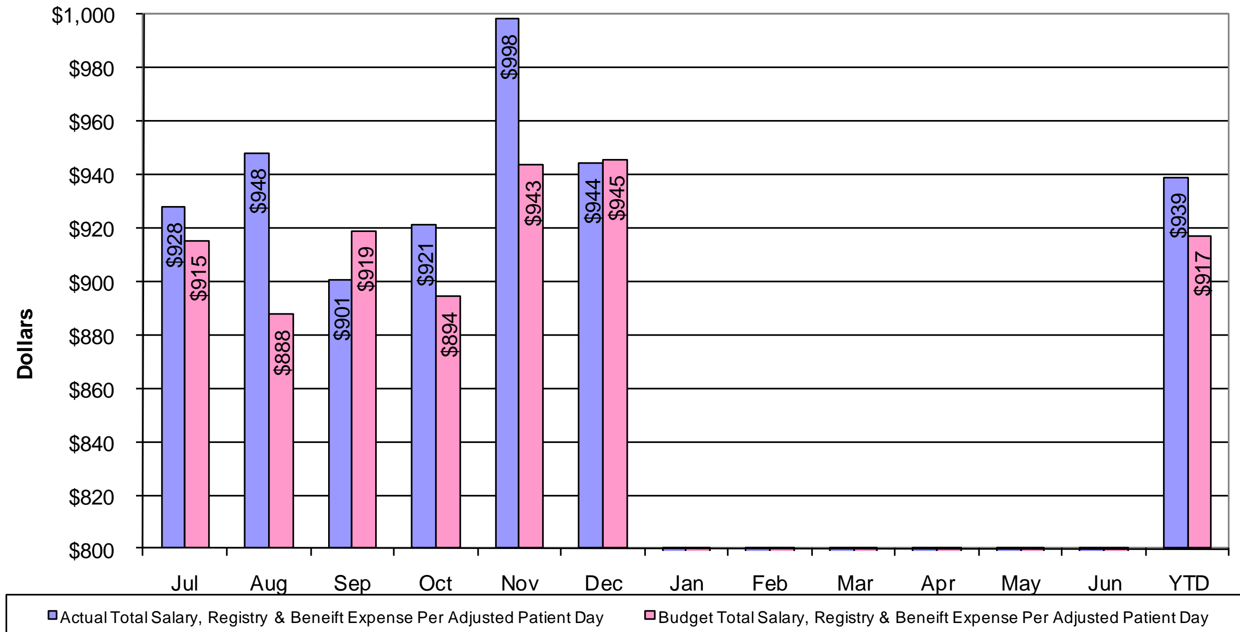


Benefits

Benefit costs were $21,000 favorable to the fixed budget and were $1 favorable to budget on an adjusted patient day basis in December. Benefit costs were favorable to the fixed budget as a result of a reduction in the required incurred but not reported (IBNR) of $54,110.

The following graph shows the combined salary, registry and benefit costs on an adjusted patient basis for FY 2010 by month.

Salary, Registry and Benefit Cost per APD



Professional Fees

Professional fees expense was favorable to budget by $56,000. This favorable variance from fixed budget was the result of lower physician fees ($37,000). This is the result of the treatment of wages paid to the physicians at the Alameda Town Center Clinic which were budgeted as professional fees but are actually being reported as salaries. In addition, in November there was an over accrual of $18,000 for these budgeted salaries.

Supplies

The supplies expense category was unfavorable to budget by $162,000 and $40 per adjusted patient day greater than budget. This unfavorable variance from the fixed budget was primarily the result of higher than budgeted surgical department costs. These included an unfavorable variance from prosthesis supplies of $91,647 and $58,680 in other surgical supplies. The unfavorable prosthesis variance was from four patient accounts that included spinal cord stimulator implants and pain management pump implants.

Purchased Services

Purchased services expenses were greater than budgeted by $12,000 as a result of additional renal dialysis services purchased during December and recruitment costs related to the hiring of the new Environmental Services Director.

Depreciation and Amortization

Depreciation and amortization expense was $29,000 less than budgeted in December as a result of various pieces of equipment that were purchased in 2004 which became fully depreciated in June 2009.

The following pages include the detailed financial statements for the six months ended December 31, 2009.

ALAMEDA HOSPITAL
Balance Sheet
December 31, 2009

	December 31, 2009	November 30, 2009	Audited June 30, 2009
Assets			
Current assets:			
Cash and cash equivalents	$ 2,450,320	$ (427,753)	$ 1,866,540
Net Accounts Receivable	9,794,709	9,579,100	10,069,536
Net Accounts Receivable %	23.74%	23.88%	22.15%
Inventories	1,297,128	1,296,312	1,291,072
Est.Third-party payer settlement receivable	489,183	479,098	351,648
Other assets	4,032,669	6,887,894	6,920,987
Total Current Assets	18,064,009	17,814,651	20,499,783
Restricted by contributors and grantors for capital acquisitions and research-Jaber Estate	531,152	514,006	468,209
Total Non-Current Assets	531,152	514,006	468,209
Fixed Assets:			
Land	877,945	877,945	877,945
Depreciable capital assets, net of accumulated depreciation	5,792,463	5,861,174	6,029,967
Total fixed assets, net of accumulated depreciation	6,670,408	6,739,119	6,907,912
Total Assets	$ 25,265,569	$ 25,067,776	$ 27,875,904
Liabilities and Net Assets			
Current Liabilities:			
Current portion of long term debt	$ 447,215	$ 449,214	$ 436,733
Accounts payable and accrued expenses	6,252,768	6,686,663	6,244,967
Payroll and benefit related accruals	4,344,417	3,978,594	3,765,683
Est.Third-party payer settlement payable	193,412	193,412	306,588
Other liabilities	4,481,421	4,212,531	7,274,242
Total Current Liabilities	15,719,233	15,520,414	18,028,213
Long-Term Liabilities:			
Debt borrowings net of current maturities	1,483,031	1,517,520	1,733,631
Total Long-Term Liabilities	1,483,031	1,517,520	1,733,631
Total Liabilities	17,202,264	17,037,934	19,761,844
Net Assets			
Unrestricted Funds	7,465,478	7,449,161	7,615,851
Restricted Funds	597,827	580,681	498,209
Net Assets	8,063,305	8,029,842	8,114,060
Total Liabilities and Net Assets	$ 25,265,569	$ 25,067,776	$ 27,875,904

City of Alameda Health Care District

Statements of Operations

December 31, 2009

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 14,827	$ 14,299	$ 528	3.7%	$ 12,793	$ 83,991	$ 81,198	$ 2,793	3.4%	$ 76,158
Gross Outpatient Revenues	10,003	9,288	715	7.7%	9,120	63,491	59,824	3,666	6.1%	58,093
Total Gross Revenues	24,830	23,587	1,243	5.3%	21,913	147,481	141,022	6,459	4.6%	134,252
Contractual Deductions	18,438	17,500	(938)	-5.4%	16,132	109,812	104,874	(4,938)	-4.7%	98,915
Bad Debts	738	438	(300)	-68.6%	550	3,336	2,625	(712)	-27.1%	4,072
Charity and Other Adjustments	(1)	85	86	101.0%	(3)	338	508	170	33.5%	478
Net Patient Revenues	5,654	5,564	90	1.6%	5,233	33,995	33,016	979	3.0%	30,787
Net Patient Revenue %	22.8%	23.6%			23.9%	23.1%	23.4%			22.9%
Net Clinic Revenue	14	64	(50)	-77.7%	-	63	321	(258)	-80.3%	-
Other Operating Revenue	16	15	1	6.7%	28	284	91	194	213.8%	94
Total Revenues	**5,685**	**5,644**	**41**	0.7%	**5,261**	**34,343**	**33,428**	**915**	2.7%	**30,881**
Expenses										
Salaries	3,136	3,176	40	1.3%	2,935	19,125	18,481	(644)	-3.5%	17,041
Registry	149	175	25	14.5%	238	1,016	1,002	(14)	-1.4%	1,320
Benefits	894	915	21	2.3%	740	5,479	5,381	(98)	-1.8%	4,817
Professional Fees	293	349	56	15.9%	317	1,820	2,069	250	12.1%	1,850
Supplies	940	777	(162)	-20.9%	780	5,380	4,615	(765)	-16.6%	4,491
Purchased Services	412	400	(12)	-3.0%	342	2,406	2,371	(35)	-1.5%	2,019
Rents and Leases	69	71	2	3.3%	55	414	424	10	2.4%	349
Utilities and Telephone	65	79	15	18.6%	74	423	471	47	10.1%	431
Insurance	44	46	3	5.5%	49	267	274	7	2.4%	240
Depreciation and amortization	104	133	29	21.8%	122	611	788	177	22.5%	737
Other Opertaing Expenses	70	87	18	20.5%	98	526	519	(7)	-1.4%	453
Total Expenses	**6,175**	**6,209**	**34**	0.5%	**5,750**	**37,468**	**36,396**	**(1,072)**	-2.9%	**33,748**
Operating gain (loss)	**(490)**	**(565)**	**75**	13.2%	**(489)**	**(3,125)**	**(2,968)**	**(157)**	5.3%	**(2,867)**
Non-Operating Income / (Expense)										
Net Non-Operating Income / (Expense)	**506**	**507**	**(0)**	**-0.1%**	**509**	**2,974**	**3,041**	**(67)**	**-2.2%**	**2,957**
Excess of Revenues Over Expenses	**$ 16**	**$ (58)**	**$ 74**	**-128.1%**	**$ 20**	**$ (151)**	**$ 74**	**$ (224)**	**-304.8%**	**$ 91**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

December 31, 2009

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,350	$ 3,169	$ 180	5.7%	$ 3,060	$ 3,080	$ 2,996	$ 84	2.8%	$ 2,996
Gross Outpatient Revenues	2,260	2,059	201	9.8%	2,181	2,328	2,207	121	5.5%	2,285
Total Gross Revenues	5,610	5,228	382	7.3%	5,241	5,408	5,203	205	3.9%	5,281
Contractual Deductions	4,166	3,879	(287)	-7.4%	3,858	4,027	3,869	(158)	-4.1%	3,891
Bad Debts	167	97	(70)	-71.8%	132	122	97	(26)	-26.4%	160
Charity and Other Adjustments	(0)	19	19	101.0%	(1)	12	19	6	33.9%	19
Net Patient Revenues	1,277	1,233	44	3.6%	1,252	1,247	1,218	29	2.3%	1,211
Net Patient Revenue %	22.8%	23.6%			23.9%	23.1%	23.4%			22.9%
Net Clinic Revenue	3	14	(11)	-77.3%	-	2	12	(10)	-80.4%	-
Other Operating Revenue	4	3	0	8.8%	7	10	3	7	211.9%	4
Total Revenues	**1,284**	**1,251**	**33**	2.7%	**1,258**	**1,260**	**1,233**	**26**	2.1%	**1,215**
Expenses										
Salaries	709	704	(5)	-0.7%	702	701	682	(19)	-2.9%	670
Registry	34	39	5	12.8%	57	37	37	(0)	-0.8%	52
Benefits	202	203	1	0.4%	177	201	199	(2)	-1.2%	189
Professional Fees	66	77	11	14.3%	76	67	76	10	12.6%	73
Supplies	212	172	(40)	-23.2%	187	197	170	(27)	-15.9%	177
Purchased Services	93	89	(4)	-5.0%	82	88	87	(1)	-0.9%	79
Rents and Leases	16	16	0	1.4%	13	15	16	0	3.0%	14
Utilities and Telephone	15	18	3	17.1%	18	16	17	2	10.6%	17
Insurance	10	10	0	3.7%	12	10	10	0	3.0%	9
Depreciation and Amortization	23	29	6	20.3%	29	22	29	7	23.0%	29
Other Operating Expenses	16	19	4	18.9%	23	19	19	(0)	-0.8%	18
Total Expenses	**1,395**	**1,376**	**(19)**	-1.4%	**1,375**	**1,374**	**1,343**	**(31)**	-2.3%	**1,328**
Operating Gain / (Loss)	**(111)**	**(125)**	**14**	11.6%	**(117)**	**(114)**	**(109)**	**(5)**	4.7%	**(113)**
Net Non-Operating Income / (Expense)	**114**	**112**	**2**	**1.8%**	**122**	**109**	**112**	**(3)**	**-2.8%**	**116**
Excess of Revenues Over Expenses	**$ 4**	**$ (13)**	**$ 17**	-128.7%	**$ 5**	**$ (5)**	**$ 3**	**$ (8)**	-279.6%	**$ 4**

ALAMEDA HOSPITAL
KEY STATISTICS
DECEMBER 2009

	ACTUAL DECEMBER 2009	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	DECEMBER 2008	YTD DECEMBER 2009	YTD FIXED BUDGET	VARIANCE	%	YTD DECEMBER 2008
Discharges:										
Total Acute	273	252	21	8.3%	242	1,460	1,357	103	7.6%	1,395
Total Sub-Acute	1	4	(3)	-75.0%	4	9	23	(14)	-60.9%	22
Total Skilled Nursing	12	13	(1)	-7.7%	12	72	78	(6)	-7.7%	58
	286	269	17	6.3%	258	1,541	1,458	83	5.7%	1,475
Patient Days:										
Total Acute	994	1,032	(38)	-3.7%	847	5,475	5,559	(84)	-1.5%	5,605
Total Sub-Acute	988	1,036	(48)	-4.6%	1,035	6,078	6,090	(12)	-0.2%	6,064
Total Skilled Nursing	661	667	(6)	-0.9%	559	3,732	3,958	(226)	-5.7%	2,751
	2,643	2,735	(92)	-3.4%	2,441	15,285	15,607	(322)	-2.1%	14,420
Average Length of Stay										
Total Acute	3.64	4.10	(0.45)	-11.1%	3.50	3.75	4.10	(0.35)	-8.5%	4.02
Average Daily Census										
Total Acute	32.06	33.29	(1.23)	-3.7%	27.32	29.76	30.21	(0.46)	-1.5%	30.46
Total Sub-Acute	31.87	33.42	(1.55)	-4.6%	33.39	33.03	33.10	(0.07)	-0.2%	32.96
Total Skilled Nursing	21.32	21.52	(0.19)	-0.9%	18.03	20.28	21.51	(1.23)	-5.7%	20.08
	85.26	88.23	(2.97)	-3.4%	78.74	83.07	84.82	(0.52)	-0.6%	83.50
Emergency Room Visits	1,472	1,418	54	3.8%	1,471	9,018	8,282	736	8.9%	8,336
Outpatient Registrations	2,343	2,795	(452)	-16.2%	2,306	15,057	15,354	(297)	-1.9%	14,737
Surgery Cases:										
Inpatient	69	61	8	13.1%	53	358	339	19	5.6%	341
Outpatient	401	362	39	10.8%	361	2,597	2,342	255	10.9%	2,491
	470	423	47	11.1%	414	2,955	2,681	274	10.2%	2,832
Kaiser Inpatient Cases	11	7	4	-	12	59	53	6	-	52
Kaiser Eye Cases	135	131	4	3.1%	115	947	899	48	5.3%	926
Kaiser Outpatient Cases	138	133	5	3.8%	145	975	830	145	17.5%	916
Total Kaiser Cases	284	271	13	4.8%	272	1,981	1,782	199	11.2%	1,894
% Kaiser Cases	60.4%	64.1%			65.7%	67.0%	66.5%			66.9%
Adjusted Occupied Bed	142.36	145.53	3.17	2.2%	136.30	145.83	147.29	(1.46)	-1.0%	138.39
Productive FTE	395.02	386.48	(8.54)	-2.2%	371.28	397.80	382.20	(15.60)	-4.1%	369.30
Total FTE	454.66	445.77	(8.89)	-2.0%	426.89	450.77	439.88	(10.89)	-2.5%	419.66
Productive FTE/Adj. Occ. Bed	2.77	2.66	(0.12)	-4.5%	2.72	2.73	2.59	(0.13)	-5.1%	2.67
Total FTE/ Adj. Occ. Bed	3.19	3.06	(0.13)	-4.3%	3.13	3.09	2.99	(0.10)	-3.5%	3.03

DATE: February 3, 2010

TO: City of Alameda Health Care District Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval of Departmental Policy and Procedure Manuals

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Recommendation:

Management recommends that the Board of Directors approve the policy and procedure manuals for the following Hospital Departments or Services:

1. Respiratory Therapy
2. Rehabilitation Services

Background:

Title 22 of the California Code of Regulations, and in some cases the Joint Commission, requires some hospital departments or services to have their department specific policies approved by the governing body. In order to comply with this regulation, and assist with the review process, we have attached the table of contents from each department's policy and procedure manual.

Discussion:

Each manual is available for your review at any time through Administration.

Alameda Hospital
Respiratory Care Service
Table of Contents
Volume 1

Administration
Mission Statement
Plan for the Provision of Patient Care
Scope of Service
Organizational Chart
Performance Improvement Program
Job Descriptions
Credentials
Orientation
Rental Equipment Guidelines
Personnel Recall Guidelines
Therapeutic Guidelines

Patient Assessment
Report Procedure
Physician Orders
Adverse Reactions
Reassessment
NeoNatal Assessment
Pediatric Assessment
Age Specific Considerations

Forms

Critical Care Modalities
Bag Mask Ventilation
Adult CPR
NeoNatal CPR
Manual Ventilation of the Intubated Patient
Nasotracheal Suctioning
Nasal Pharyngeal Airway Insertion
Measurement of Cuff Pressures
Securing an Endotracheal Tube
Endotracheal tube Closed System Suctioning
Metered Dose Inhaler Delivery in the Intubated Patient
Remote Ventilator Alarms
Extubation
Sputum Induction
Nosocomial Pneumonia Protocol
Mechanical Ventilation
Monitoring of Mechanically Ventilated Patients
Puritan Bennett 7200 Ventilator Manual
Puritan Bennett 840 Ventilator
Infant Ventilation
Trach Care
BiPap
Apnea Testing
Easy Cap CO2 Monitoring

Positive Pressure Ventilation

Intermittent Positive Pressure Ventilation (IPPB)
Maximum Volume IPPB
IntraPulmonary Percussive Ventilation (IPV)

Alameda Hospital
Respiratory Care Service
Table of Contents
Volume 2

Ambient Therapies

Aerosol Therapy
Incentive Spirometry
Carbogen Therapy
Heliox Therapy
Hand Held Nebulizer

Percussion/Vibration/Drainage (PVD)

Oxygen Therapy

Oxygen Rounds
Nasal Cannula Oxygen Administration
Simple Mask Oxygen Administration
Partial Rebreathing Mask Delivery
Non-Rebreather/Venturi Mask Administration
Aerosol Administration via T-Piece

Medications

Mucomyst
Normal Saline
Vaponefrin
Albuterol
Atrovent
DUONEB

Pulmonary Diagnostics

Peak Expiratory Flow Rate (PEFR)
Inspiratory Force
Arterial Blood Gas
Pulse Oximetry
Pulmonary Function Studies
Oxygen Desaturation Studies

Infection Control

Miscellaneous

Transport of the Mechanically Ventilated Patient
Home Oxygen Co-Ordination
Liquid Oxygen Filling for Discharged patients
Safety Program
Bio Terrorism
Utility Failure

Rehabilitation Services

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Scope of Service

Occupational Therapy
Scope of Service

Speech- Language Pathology Definition
Scope of Service

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Organizational Chart
Request for service
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PERSONNEL:
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Evaluations
Inservice Mandatories
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SAFETY:
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Fire Safety
Utility Failure
Adverse Reaction
Equipment Safety-Medical Device Incident (see Administrative Policy)
Infection Control
Performance Improvement
Volunteer Procedures

PROCEDURES:
Tests and Measurements
Gait Assessment and Training
Crutch Training
Therapeutic Exercise
ADL Assessment
Sensory Testing
Commercial Cold Packs

Commercial Hot Packs
Contrast Baths
Ice Therapy
Iontophoresis
Paraffin Bath
Therapeutic Massage
TENS
Ultrsound-Contact Technique
Ultrasound-Underwater Technique
Electrical Stimulation
Motorized Cervical Traction
Motorized Pelvic Traction
Hydrotherapy
Splint/Splinting
Therapeutic Exercises
Occupational Therapy Evaluation and Testing
Visual Perception
Isotoner Glove
Speech Therapy Evaluation
Bedside Swallow Assessment
Videofluoroscopy Swallow Study
Treatment Approaches
- Aphasia
- Speech Production
- Voice Disorders
- Reading Comprehension
- Written Expression
- Cognitive Linguistic Impairment
- Nonverbal Communication
- Dysphagia
- Severity of Impairment Definitions

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: February 1, 2010

TO: City of Alameda Health Care District Board of Directors

FROM: Deborah E. Stebbins
Chief Executive Officer

SUBJECT: Recommendations to Modify the
City of Alameda Health Care District
Standing Committee Structure

In February 2008, The City of Alameda Health Care District Board adopted a new standing committee structure. Over the last two years, the Strategic Planning/Community Relations Committee oversaw completion of the Hosptal's Strategic Plan. Many of the critical issues associated with implementing key aspects of the plan involve trade secrets and need discussion in closed sessions of the Board prior to open discussion in committees and action at the Board level. I am recommending that at least for the next few the committee structure be modified slightly with the changes indicated in italics.

Standing Committees:

a Article V, Section 1. A. of the City of Alameda Health Care District Bylaws provides: "The Board of Directors may, by resolution, establish one or more committees and delegate to such committees any aspect of the authority of the Board of Directors. Membership and chairmanship of such committees shall be appointed by the Board……."

1. Finance and Management Committee:

   a. Primary Purpose: The primary purpose of the Finance and Management Committee is to review and recommend the annual budget, review performance relative to budget, and review other aspects of the district's financial performance. The Committee shall also serve the function of reviewing the annual report from the Hospital's external auditor, including the annual presentation of audit findings.The committee may also review and advise regarding operational issues, management systems issues, management information systems, and other aspects of the district's overall operational management.

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

i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee. ~~One of these two members also shall be appointed to serve as the committee chair.~~ The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-voting member of the committee.

ii. Two members of the Alameda Hospital Medical Staff both of whom shall be voting members of the committee.

iii. Up to *three* at large members chosen for expertise needed by the district each of whom shall be voting members of the committee.

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

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: *Committee shall meet on a monthly*.

2. Community Relations Committee:

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

~~*and collaborate with Management to formulate the strategic plan for the Hospital.*~~

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

i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee. One of these two members also shall be appointed to serve as the committee chair. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-voting member of the committee.

ii. ~~Two~~ Up to three members of the Alameda Hospital Medical Staff both of whom shall be voting members of the committee.

iii. Up to ~~*five*~~ *seven* at large members chosen for expertise needed by the district ~~both~~ all of whom shall be voting members of the committee. At least one member at large shall also be a member of the Alameda Hospital Foundation Board.

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

~~iv.~~v. The Executive Director of the Alameda Hospital Foundation and the Director of Community Relations shall serve as staff to the Committee and collaborate with the Committee Chair on the preparation of agenda.

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~~b.~~c. Terms: The committee shall be appointed annually.

~~c.~~d. Meeting Frequency: The committee shall meet at least quarterly.

3. Quality Improvement Committee:

a. Primary Purpose: The primary purpose of the Quality Improvement Committee is to assist the Board of Directors in carrying out their responsibility for the measurement, assessment and improvement of quality patient care provided by the Hospital's professional and support staff. The Quality Improvement Committee of the Board reviews summaries of the performance improvement activities conducted by the medical staff and hospital management that assure the coordination of administrative, clinical and support processes. The QIC Committee reports on key findings and issues arising from the performance improvement process to the full Board of Directors.~~to advise the board of quality, risk management review and issues at the Hospital~~.

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

i. Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee. One of these two members also shall be appointed to serve as the committee chair. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-voting member of the committee.

ii. The President of the Medical Staff of Alameda Hospital.

~~ii.~~iii. Two members of the Alameda Hospital Medical Staff both of whom shall be voting members of the committee.

~~iii.~~iv. The City of Alameda Health Care District Chief Executive Officer, Director of Quality Resource Management, Executive Director of Nursing Services and other hospital management as delegated, who shall not be voting members of the committee.

c. Terms: The committee shall be appointed annually.

d. Meeting Frequency: The committee shall meet monthly

~~4.Audit Committee:~~

~~a.Primary Purpose: The primary purpose of the Audit Committee is to advise the board~~

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

~~i.Two members of the City of Alameda Health Care District Board of Directors both of whom shall be voting members of the committee. One of these two members, of which is not a member of the Finance and Management Committee, shall be appointed to serve as the committee chair. The President of the City of Alameda Health Care District Board of Directors shall be an ex-officio, non-voting member of the committee.~~

~~ii.Two members of the Alameda Hospital Medical Staff both of whom shall be voting members of the committee.~~

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

~~c.Terms: The committee shall be appointed annually.~~

~~d.Meeting Frequency: The committee shall meet at least quarterly.~~

~~5.~~4.Additional committees will be recommended for consideration as the City of Alameda Health Care District Board of Directors identifies the need for them.

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Also attached is a list of the current members of the committees described above and a committee meeting schedule for 2010.

Cityof Alameda Health Care District
Revised Meeting Dates
February 2010

	District Board	Finance & Management Committee	Strategic Planning Committee Executive Closed Session (Board Only)	Community Relations Subcommittee	Board Quality Committee
	First Monday of the Month	Last Wednesday of the month	3rd Tuesday of the Month	4th Tuesday of the Month	3rd Wednesday of the month
	Closed Session & Open Session	Open Session	Closed Session & Open Session	Open Session	Closed Session
	5:30 p.m. / 7:30 p.m.	7:30 a.m.	7:30 a.m.	7:30 a.m.	7:30 a.m.
	Dal Cielo Room / Board Room	Dal Cielo Room	Board Room	Dal Cielo Room	Board Room
Jan-10	Monday, January 11, 2010	Wednesday, January 27, 2010	Start Executive Closed Session of Board of Directors in February	Start Subcommittee in February	Wednesday, January 20, 2010
Feb-10	Monday, February 01, 2010	Wednesday, February 24, 2010	Tuesday, February 16, 2010	Tuesday, February 23, 2010	Wednesday, February 17, 2010
Mar-10	Monday, March 01, 2010	Wednesday, March 31, 2010	Tuesday, March 16, 2010	Tuesday, March 23, 2010	Wednesday, March 17, 2010
Apr-10	Monday, April 05, 2010	Wednesday, April 28, 2010	Tuesday, April 20, 2010	Tuesday, April 27, 2010	Wednesday, April 21, 2010
May-10	Monday, May 03, 2010	Wednesday, May 26, 2010	Tuesday, May 18, 2010	Tuesday, May 25, 2010	Wednesday, May 19, 2010
Jun-10	Monday, June 07, 2010	Wednesday, June 30, 2010	Tuesday, June 15, 2010	Tuesday, June 22, 2010	Wednesday, June 16, 2010
Jul-10	Monday, July 05, 2010	Wednesday, July 28, 2010	Tuesday, July 20, 2010	Resume 3rd Tuesday a.m. meetings	Wednesday, July 21, 2010
Aug-10	Monday, August 02, 2010	Wednesday, August 25, 2010	Tuesday, August 17, 2010		Wednesday, August 18, 2010
Sep-10	Monday, September 13, 2010	Wednesday, September 29, 2010	Tuesday, September 21, 2010		Wednesday, September 15, 2010
Oct-10	Monday, October 04, 2010	Wednesday, October 27, 2010	Tuesday, October 19, 2010		Wednesday, October 20, 2010
Nov-10	Monday, November 01, 2010	Wednesday, November 24, 2010	Tuesday, November 16, 2010		Wednesday, November 17, 2010
Dec-10	Monday, December 06, 2010	No Meeting	Tuesday, December 21, 2010		No Meeting

**September Board Meeting will be held on the 2nd Monday due to Labor Day being on the 1st Monday of the month.

City of Alameda Health Care District
Current Committee Roster
February 2010

Community Relations and Outreach Subcommittee

Board	Physician	Community	Management
Mike McCormick	James Kong, MD	Bill Withrow	Deborah Stebbins
Robert Deutsch	Jim Yeh, DO	Tracy Lynn Jensen	Kerry Easthope
Rob Bonta, Chair	Alka Sharma, MD	Brad Shook	David Neapolitan
Leah Williams		Terrie Kurrasch	Kristen Thorson
Thomas Driscoll		Jim Franz	Louise Nakada
Jordan Battani**		Ann Evans	Tony Corica
		Jeptha Boone, MD	Dennis Eloe

Finance and Management Committee[1]

Board	Physician	Community	Management
Robert Bonta, Acting Chair	Alka Sharma, MD	Ann Evans	Deborah Stebbins
Jordan Battani**	Peter Candell, MD	Ed Kofman	Kerry Easthope
		James Oddie	David Neapolitan
			Kristen Thorson
			Leon Dalva
			Janet Dike
			Vandana Behl
			Joyce Walker
			Mary Bond

Board Quality Committee

Board	Physician	Community	Management
Robert Deutsch, MD, Chair	Emmons Collins, MD		Deborah Stebbins
Mike McCormick	Alka Sharma, MD		Kerry Easthope
Jordan Battani**	Joseph Marzouk, MD		Janet Dike
			Mary Bond

[1] All Board members are invited to Finance Committee

**Ex Oficio

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: February 3, 2010

TO: City of Alameda Health Care District Board of Directors

FROM: Kerry Easthope, Associate Administrator

SUBJECT: Approval to Purchase Picture Archiving & Communication System (PACS)

The recommendation brought to the Finance and Management Committee on January 27, 2010 has been modified to reflect the discussion and subsequent recommendation by the committee as outlined in the following memorandum.

Recommendation:

The Finance and Management Committee recommends that the City of Alameda Health Care District Board of Directors authorize management to enter into purchase agreements with Carestream/Trius and General Electric (GE) Medical for the purchase of PACS and the necessary imaging / medical equipment respectively, totaling $1,584,000 (as outlined in table below) pending the identification of an acceptable financing option that will not limit financing options for future capital projects.

Item	Amount	Total
Carestream/Trius PACS System		$ 726,000
GE Medical / Imaging Equipment		
Precision 500D Digital R&F	$ 233,000	
Silhouette VE (basic radiology)	$ 58,000	
Senographe Essential Mammo	$ 328,000	
Subtotal		$ 619,000
Onetime Conversion Costs		
OSHPD/construction estimate	$ 109,000	
Voice recognition dictation system	$ 45,000	
Meditech Interface	$ 65,000	
Misc: cabling, routers, etc.	$ 20,000	
Subtotal		$ 239,000
Total Cost of Project*		$ 1,584,000

*DOES NOT INCLUDE APPLICABLE SALES TAX AND DELIVERY COSTS

Background:

The hospital has been performing due diligence on a PACS system for the past several months. Consideration of the various options, analysis of the hospital's imaging needs and evaluation of the new systems & processes that will need to be implemented have been led by our Director of Radiology, John Ellis. Valuable input, suggestions and recommendations have been provided by the Radiologists associated with Bay Imaging Consultants.

PACS is a system that acquires, archives (stores), and distributes all radiographic images in a digital format. These can be viewed electronically from any secure location and by multiple users. A PACS system is a required component of a certified Electronic Medical Record (EMR) that has "meaningful use" as is required by 2013.

In addition, PACS has become the standard of care in the medical community in the last several years. This technology can greatly improve the quality of care provided through its enhanced features, rapid image distribution and diagnostic capabilities, and has become the expectation of both physicians and patients.

Lastly, a PACS system is an essential capability that is needed as part of the hospital's other strategic plan objectives: specifically, our business development opportunities and physician recruitment efforts.

Discussion:

Much of the hospital's imaging equipment is already digital compatible and ready for a PACS environment. However, some of these items will require upgrades and DICOM (Digital Imaging and Communication in Medicine) conversions. The following items are either digitally ready (only needing an interface connection) or can be made digitally compatible with a software/DICOM upgrade.

- MRI (already digital)
- Ultrasound (already digital)
- CT Scan (already digital)
- C-Arms (2), need DICOM upgrade
- Portable x-ray machines (2), will use Computed Radiography plates (CR plates)

There are equipment items that are very old and/or non functional that will need to be replaced in order to convert into a digital environment. These items include the following.

- X-ray rooms. We currently have three x-ray rooms but are recommending conversion of only two at this time.
- Mammography
- Nuclear Medicine. **By recommendation from the Finance and Management Committee the upgrade of nuclear medicine equipment has been deferred pending further discussion and analysis regarding this service, service volumes and other cost effective alternatives. Follow-up to be provided at the Finance and Management Committee in February 2010.*

The hospital has looked at a number of different PACS vendors including: Fuji, Siemens, Phillips, Rolle Solutions, Konica – Minolta, GE and Carestream / Trius. An important factor that was considered when analyzing the various vendors was to look for a vendor that provided as many components of a complete PACS solution as possible. Many of the vendors only provided the PACS component, but didn't provide the CR (Computed Radiography) or equipment upgrades that would be required. Dealing with multiple independent vendors makes the conversion more prone to miscommunication and implementation mishaps. We would prefer to contract with one or two vendors that we can work with to implement, and later support, the entire system.

The two preferred vendors were GE and Carestream/Trius. Both of these vendors had quality systems and the overall cost of their proposals was similar. However, it was somewhat difficult to compare apples with apples since GE was proposing new equipment and Carestream/Trius was quoting refurbished equipment with the needed accessories to make it fully functional. One of the results of this difference is the amount of OSHPD and construction work required for installation.

Each vendor demonstrated their systems' features and capabilities and our staff and the radiologists had opportunities to participate in these sessions. In addition, Bay Imaging is familiar with the GE PACS system, as it is used at some of the Sutter facilities where they work. Therefore, the real selection determination came down to physician and technician preference. The physicians and technologists were pleased with the Carestream/Trius PACS functionality and features and we are recommending this system for Alameda Hospital. The total cost of the Carestream/Trius PACS is $726,000 (see attached quote for detail).

At first, we felt that the Carestream/Trius equipment solution would also be our best option. This proposal included refurbished, digitally compatible equipment that most likely would require less extensive OSHPD & construction cost. However, after additional consideration of the hospital's long term needs and following further analysis of the long term capabilities and/or limitations of this option, we are recommending the GE equipment solution.

The GE equipment solution would include all new, latest models of imaging equipment. The GE equipment is upgradeable and expandable to allow for additional clinical applications as we move forward. This equipment will have a practical useful life of 12 – 15 years, and will not only provide a better ROI, but will also provide enhanced clinical capabilities now and in the future. Below is the list of the GE equipment recommended for purchase.

• Precision 500D Digital R&F	$233,000
• Silhouette VE (basic radiology)	$58,000
• Senographe Essential Mammo	$328,000
Total	**$619,000**

There are additional onetime costs associated with this digital conversion as listed below.

- OSHPD/construction estimate $109,000
- Voice recognition dictation system $45,000
- Meditech Interface $65,000
- Misc: cabling, routers, etc. $20,000

Total Other Costs: $239,000

GE has an affiliation with a company called Envisions that facilitates all of the OSHPD plan development, construction work, and equipment installations. This firm does a lot of work with OSHPD and is efficient with GE equipment installs. They are a turn-key company (architectural drawings, OSHPD, construction & installation).

Recurring Operating Expenses:

It is anticipated that the annual recurring expense associated with this new system will be about $100,000 in year two and go up to approximately $150,000 per year by year four (see attached Extended Warranty Cost document). Current annual expenditures are approximately $200,000 that will be eliminated by the end of the initial implementation year. These expenses are comprised of current equipment support & maintenance fees, film cost, and processor & film jacket costs.

In addition to these direct operating expenses, there will be additional depreciation and interest expense that will flow through the monthly Income Statement. This amount will vary depending upon the best finance option available to the hospital.

Marketing Efforts:

GE will assist the hospital in actively marketing the capabilities and features of these new technologies to the community and members of the medical staff. They have brochures, pre-printed mail materials and clinical conference demonstrations that will be part of an extensive, all out, marketing effort to increase patient volumes. It is believed that the hospital is currently loosing imaging business because of its limited technological capabilities, especially with mammography; however, this potential opportunity is difficult to define.

We are confident that a proactive marketing campaign that focuses on the hospitals new imaging capabilities, together with enhanced reporting back to the physician's offices, will be something that will eliminate the continued decline in radiology volumes as well as improve the services viability into the future.

PACS System
Extended Warranty Cost & Ongoing Operating costs

Item Description	Included Warranty	Annual Cost after Warranty	Year 1	Year 2	Year 3	Year 4	Year 5	5-Year Total	5-Year Average
PACS - Carestream									
Hardware Components	12 months	11,500	-	11,500	11,500	11,500	11,500	46,000	9,200
Software Components	12 months	34,413	-	34,413	34,413	34,413	34,413	137,652	27,530
Carestream CR plates (4)	12 months	18,868	-	18,868	18,868	18,868	18,868	75,472	15,094
PACS Sub Total			-	64,781	64,781	64,781	64,781	259,124	51,825
GE Equipment									
Precision 500 D Digital R&F	24 months	28,910	-	-	28,910	28,910	28,910	86,730	17,346
Slhouette VR	24 months	6,248	-	-	6,248	6,248	6,248	18,744	3,749
Senographe Essential Mammo	36 mo detector	42,995	-			42,995	42,995	85,990	17,198
	12 mo. Gantry	29,750	-	29,750	29,750			59,500	11,900
Equipment Sub Total			-	29,750	64,908	78,153	78,153	250,964	50,193
Grand Total			**-**	**94,531**	**129,689**	**142,934**	**142,934**	**510,088**	**102,018**

Note: The department will also need a dedicated PACS administrator who is process and IT savy to manage workflow in the PACS system. It is unknown at this time if an existing employee may be capable and with training, able to fill this position.

Existing Expenses that will be eliminated with PACS implementation

	Annual Expense
Film	64,000
Processor solutions, jackets, other	74,000
Radiology equipment maintenance	
Room #4	17,796
Room #3	17,796
Room #2	4,008
Mammography Unit	22,608
Total	200,208