Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

Finance and Management Committee

Wednesday, March 28, 2012

7:30 a.m.

Location: Alameda Hospital (Dal Cielo Conference Room)
2070 Clinton Avenue, Alameda, CA 94501
Office of the Clerk: (510) 814-4001

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.

This is being noticed as a Board Meeting as a quorum of Directors may be present. Ex-officio members and non-committee members cannot vote on any item, whether or not a quorum of the Board is present.

I. Call To Order — Michael McCormick

II. Action Items

A. Acceptance of February 29, 2012 Minutes [enclosure] — Michael McCormick

B. Recommendation to Accept February 2012 Unaudited Financial Statements [enclosure] — Bob Anderson

C. Recommendation to Approve the Establishment of a Comprehensive Orthopedic Program at Alameda Hospital and Approval to Enter into Professional Services Agreements with Two Orthopedic Surgeons [enclosure] — Deborah Stebbins, Mary Bond, RN, Tony Corica

III. Chief Executive Officer Report — Deborah E. Stebbins

A. Revenue Cycle Update [enclosure]

B. Charge Master Description (CDM) Review Update

C. RAC Review Update

D. Rebate on Workers Compensation Reserves

E. Update on Medi-Cal DP/NF Rates

IV. Chief Financial Officer Report

A. FY 2012-2013 Budget – Volume Assumptions [to be distributed] — Bob Anderson, Katy Silverman

V. Board / Committee / Staff Comments

VI. Adjournment

NEXT MEETING SCHEDULED: APRIL 25, 2012

Members Present: (Voting)	Mike McCormick Elliott Gorelick (partial)	Ann Evans Ed Kofman James Oddie	William Sellman, MD (partial) Jim Yeh, DO (partial)
Management Present:	Deborah E. Stebbins Kerry J. Easthope	Bob Anderson Mary Bond, RN	Katy Silverman
Ex Officio/Guests:	Robert Deutsch, MD		
Absent:			
Submitted by:	Kristen Thorson		

TOPIC		DISCUSSION	ACTION | FOLLOW-UP
I. Call to Order	Director McCormick called the meeting to order at 7:35 a.m.		
II. Action Items	A.	Acceptance of January 25, 2012 Minutes	Dr. Yeh made a motion to accept the minutes as presented. Mr. Kofman seconded the motion. The motion carried.
	B.	Recommendation to Accept November 2011 Unaudited Financial Statements Bob Anderson presented the financial statements as presented, noting the following key points. Operating gain for the month of January was $425,000 vs. a budget loss of $206,000. A strong census contributed to gross revenues exceeding budget by $409,000. Deductions from revenue were low due to favorable adjustments to an AB97 accrual along with an increase in the 2011 cost report settlement. Overall case mix index was 1.5350 versus 1.3513 YTD. Operating expenses were above budget due to the higher monthly census. The current ratio was .99 in the month of January. The acute Average Daily Census was 33.10 versus a budgeted 30.39. Subacute was 33.13 versus budgeted 33.0. Skilled Nursing was 18.74 versus budgeted 21.77. ECC visits were slightly above budget at 1,473 versus 1,426. Surgery cases were on virtually on budget or inpatient and outpatient surgeries. Mr. Anderson reviewed the net revenue impact	Mr. Kofman made a motion to recommend approval of the 2011 Unaudited Financial Statements as presented. Mr. Oddie seconded the motion. The motion carried.

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		of the extraordinary items for the month of the AB97 skilled nursing accrual of $237,000 and the 2011 cost report settlement adjustment of $180,000.	
III. Chief Executive Officer Report	A.	Revenue Cycle Update Ms. Stebbins distributed an update on the Revenue Cycle Work plan, highlighting the key areas that are being worked on and a status update on each area.	No action taken.
	B.	Charge Master Description (CDM) Review Ms. Stebbins informed the committee that the company Panacea has been engaged to complete a comprehensive CDM review.	No action taken.
	C.	RAC Review Update Ms. Stebbins updated the committee on the RAC noting that there has been approximately $472,000 taken back by CMS. The Hospital has appealed the take backs but it is uncertain if the monies will be returned. An internal hospital committee has been formed to track and monitor the RAC process.	No action taken.
	D.	Bank of Alameda Wound Care Loan and Line of Credit Update Kerry Easthope updated the committee on discussion with the Bank of Alameda relating to the Line of Credit and the Wound Care Loan. He reviewed that in December the hospital was out of compliance with the loan covenants which could have potentially affected access to the Wound Care Loan. The positive results of January were reported to the Bank and at the February Board meeting the Board approved the reclassification of the long term asset, the Jaber Trust, to a current asset to improve the current ratio. With this authorization, the bank authorized accessing the loan and the hospital officially awarded the contract to Rossi Builders. The Board also authorized management to research the possibility of encumbering the Jaber properties as potential collateral for any future lending from the bank. The Line of Credit is open for renewal while the bank reviews options for renewal and other financing arrangements with the Hospital. The bank has indicated that there are open to discussions.	No action taken.
	E.	Rehabilitation Services Management	No action taken.

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		Outsourcing Analysis Discussion Mr. Easthope informed the committee that management is preparing an analysis, including revenue opportunities and cost savings that could be achieved through a management contract with Select Therapies. A complete analysis will be brought to the committee before being presented for approval by the Board of Directors.	
IV. Chief Financial Officer Report	A.	Discussion of Plan for Incorporation of Waters Edge into Hospital | District Financial Statements Mr. Anderson stated that Waters Edge will be incorporated into the Hospital | District Financial statements but will also have a separate income statement to track progress and profitability.	No action taken.
	B.	FY 2012-2013 Budget Calendar | Key Dates Katy Silverman, Director of Decision Support and Financial Planning presented the FY 2012-2013 Budget calendar as presented in the packet noting the key dates relating to the budget planning and approvals.	No action taken.
V. Board / Committee / Staff Comments	No board, Committee or Staff comments.		
VI. Adjournment	Being no further business, the meeting was adjourned at 9:53 a.m.		

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THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING FEBRUARY 29, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
FEBRUARY 29, 2012

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
FEBRUARY, 2012

The management of 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 February 29, 2012 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.

Highlights

Activity in the month of February made it possible for the hospital to exceed its budget. A negative bottom line of $5,000 was budgeted and a positive $175,000 was realized. Year to date (YTD) the hospital has a loss of ($711,000) versus a budgeted loss of ($6,000).

Activity was strong in February with discharges above budget and patient days just under budget. Discharges were above budget 5.8% and patient days were just 1.9% under budget. For the first time this year the length of stay was above budget. Therefore the hospital had more patients that stayed a longer length of time.

Inpatient surgery cases were 49 which was above the budgeted volume of 44 by 11.4%. As you may recall, inpatient surgery cases had been running below budget for most of the year. Therefore YTD surgery cases are below budget 8.6%. This month's positive surgical volume contributed to higher inpatient revenues. The current months inpatient revenues were above budget $629,000 or 4.2%. This is in contrast to the YTD values where inpatient revenues are down $3.0 million or 2.5%.

Overall outpatient activity was also higher than previous months. This month outpatient volumes were only 1% below budget. This is a significant improvement over prior months as YTD outpatient volumes are about 6% below budget.

Contributing to the positive outpatient volumes, Emergency activity was above budget this month. As well, YTD emergency visits are very close to budget.

Outpatient surgeries were above budget for the month by 4.2%, and, continue above budget YTD by 7.0%.

Gross revenue in February is generally in line with activity. Overall gross revenues were 3.1% above budget, with the inpatient component up 4.2% and outpatient up 0.8%.

The Case Mix Index (CMI) ran above the YTD average. The overall CMI in February was 1.3572; down from last month's high of 1.4123, but still strong compared to earlier months this fiscal year.

The net result of these revenue related influences caused net revenues to be $143,000 or 2.9% above budget. YTD net revenues however are down ($846,000) or 2.1% below budget.

The hospital recently conducted a review of the hospitals charge description master. The purpose of the study was to identify changes in charges and coding which would more appropriately price our services and improve reimbursement. Several of these recommendations have been incorporated into the hospital's charge structure which should improve charges and reimbursement in future months.

Expenses ran slightly under budget this month. Overall expenses were $30,000 or 0.6% below budget. Labor costs continue to track very closely to budget. Increased professional fee costs were offset by savings in supply costs. These trends have continued throughout the year. Our expenses continue to outperform budget as YTD expenses are down $98,000.

Actual cash is up slightly from the prior month. It increased from $2.0M to almost $2.3M. However expressed in days-cash-on-hand, the hospital went from 13.8 days in January to 12.4 days in February. Through the first three weeks in March, daily cash collections have improved significantly. Average daily cash for the year has averaged about $140,000/day. Through the first 21 days of March, collections averaged $158,000. This is a much needed improvement in cash collections.

Net accounts receivable (AR) grew by $678,000 in February. This is due to the higher revenues experienced in February. AR days remained at basically the same level as the previous month. Note that net accounts receivable are only calculated at month end therefore March's figures are not yet available. It is expected that AR will decrease in March for the first time this year.

Accounts payable grew slightly from $8.7M to $8.9M. AP days were 142. This is down slightly from the previous month. Improved collections in March should reduce this further and then the April tax monies will allow for a significant decrease.

Lastly, the current ratio is now 1.03. This is an improvement over the previous month of .99 and now above the 1.0 threshold necessary to meet Bank of Alameda's criteria for funding the Wound Care project and extending the hospitals line of credit. We expect to see this ratio continue to rise above the 1.0 threshold so long as the hospital continues to experience positive operating performance.

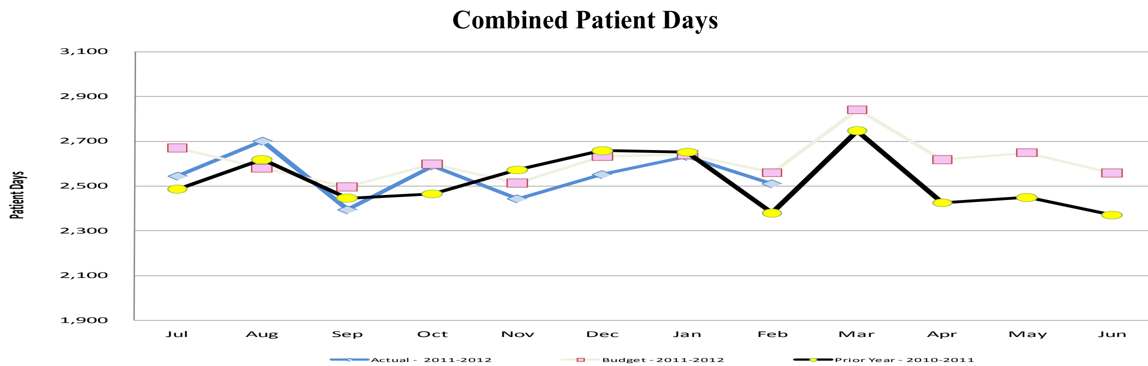
ACTIVITY

ACUTE, SUBACUTE AND SNF SERVICES

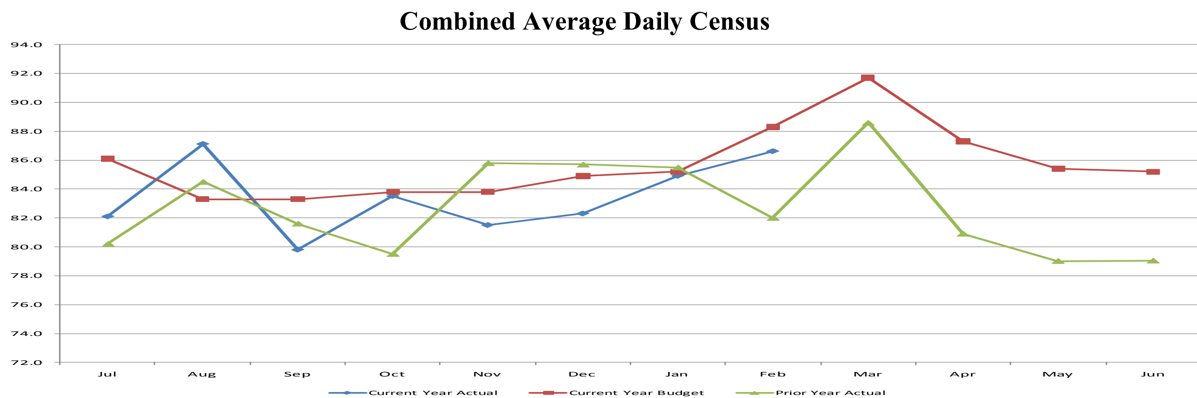
Patient days were slightly below budget for the month but above February of last year. This month's Acute days were up 8.9%, Sub-Acute down .6% and Skilled Nursing down 18.8%. YTD days are now (1.6%) under budget.

February's acute care patient days were 83 days more than budget for the month and 30.7% above the prior year's average daily census of 26.83. The acute care program is comprised of the Critical Care Unit (4.9 ADC, above budget 11.9%), Definitive Observation Unit (12.7 ADC, 5.2% above budget) and Med/Surg Units (17.5 ADC, 10.9% above budget).

The graph, below, shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

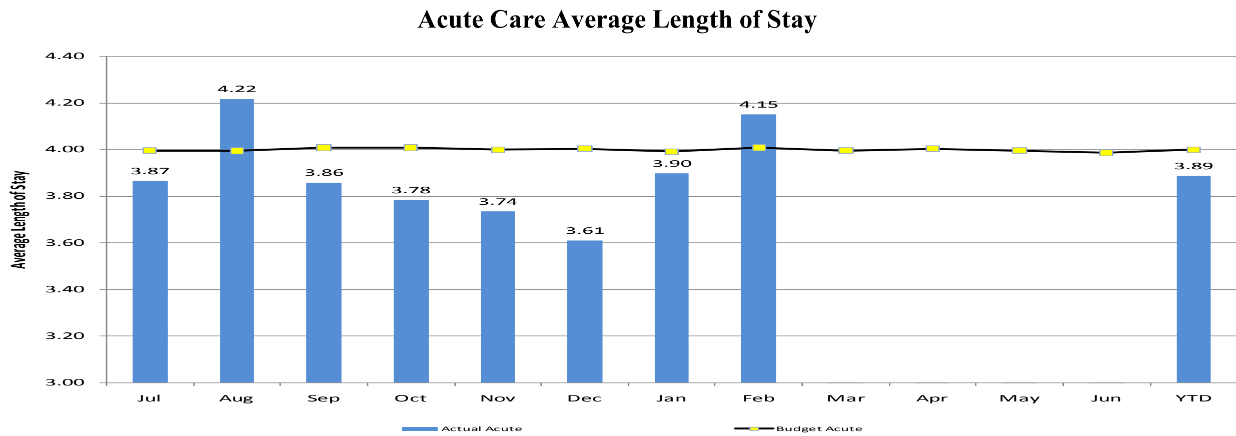


The graph below shows the average daily census for all inpatient services. The actual ADC was 86.59 versus budget of 88.28 an unfavorable variance of 1.9%.

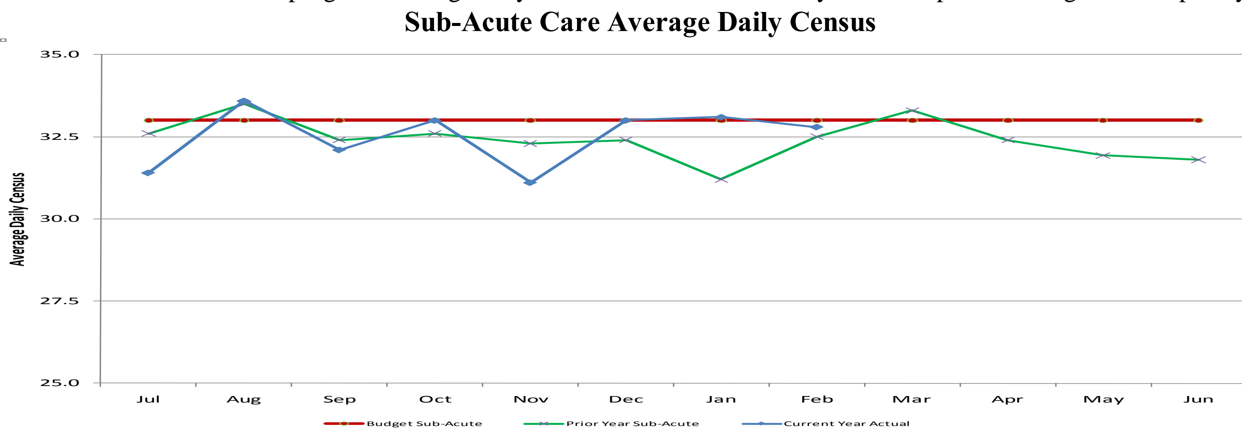


The acute average length of stay (ALOS) increased from the January value of 3.90 to 4.15 in February, just the second time this

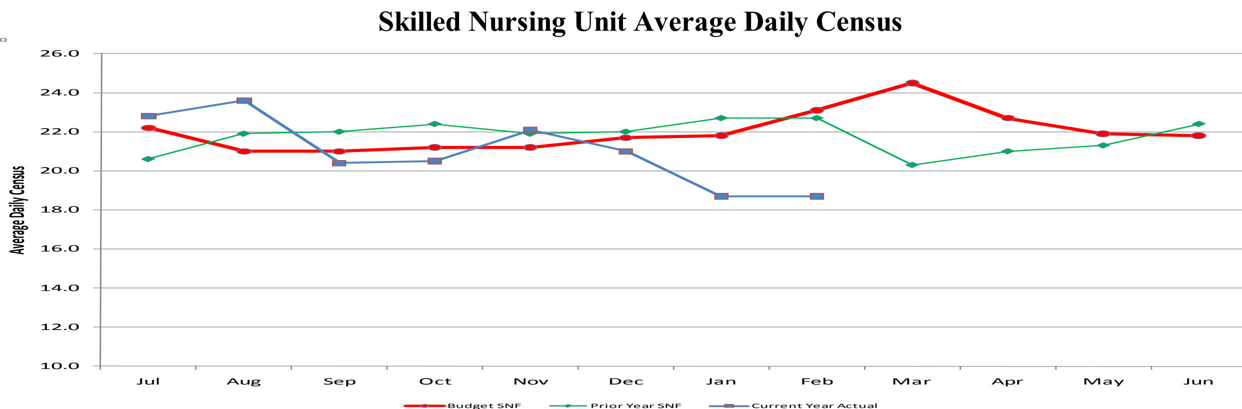
year it has been above 4.0. Budgeted acute ALOS is 4.0, and YTD is still under that target. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month compared to the budget.



The Sub-Acute programs average daily census of 33.13 in February was just above budgeted projections by 0.4%. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.



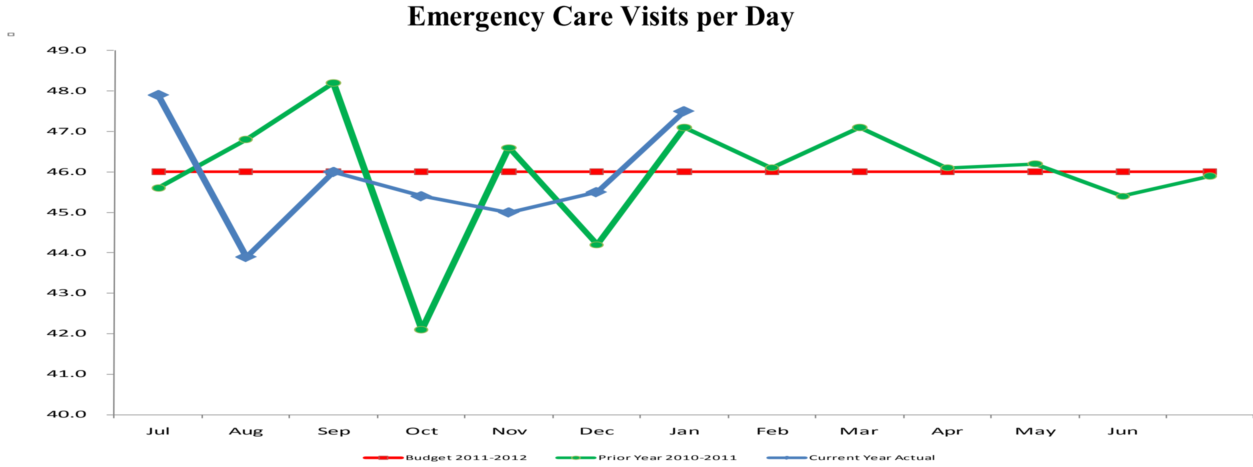
The Skilled Nursing Unit (South Shore) patient days were 18.8% or 126 patient days lower than budgeted for the month of February. YTD days are also down compared to both budget and the prior year. However, efforts to improve census have been fruitful as the March ADC is approximately 22.0. The graph, below, shows the Skilled Nursing Units monthly average daily census as compared to budget and the prior year.



ANCILLARY SERVICES

Outpatient Services

Emergency Care Center visits in February were 1,384. This is 50 visits (3.7%) over the budget of 1,334. 19.2% of ECC visits resulted in inpatient admissions versus 17.9% in January. On a per day basis, the total visits represent an increase of 4.4% from the prior month daily average. In February, there were 267 ambulance arrivals versus 338 in the prior month. Of the 267 ambulance arrivals in the current month, 188 or 70.4% were from Alameda Fire Department (AFD) ambulances.

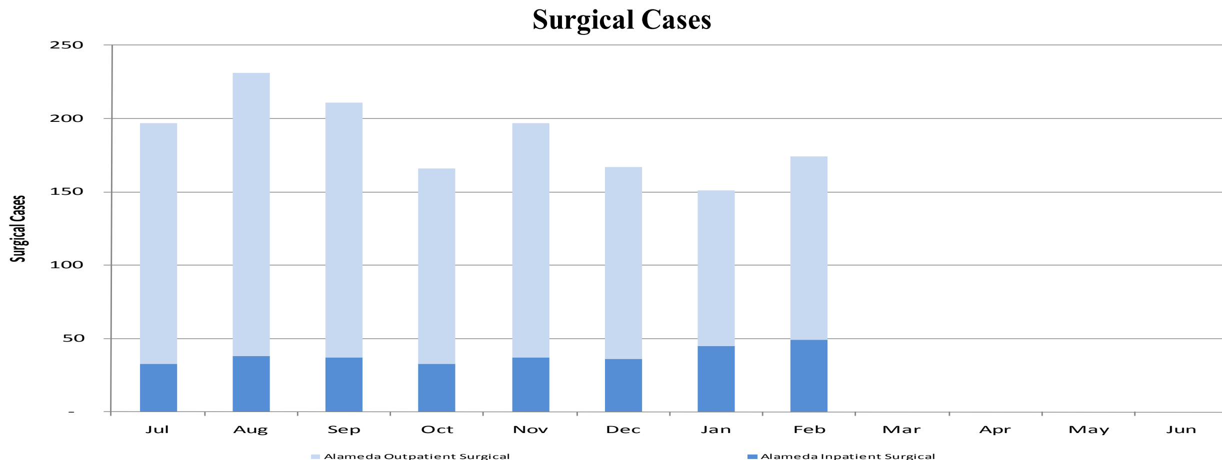


Outpatient registrations were 1,854, or 3.3% below budget. This is less than the prior month primarily due to fewer days in February. February's average daily registrations were 63.9 which was 2.4% higher than the prior month. This is in contrast to YTD outpatient registrations which are below budget by 7.4%. This month IV Therapy was down by 3 patients which equated to 47 visits. Additionally, Laboratory and Occupational Therapy were down 106 and 19 visits respectively. On the other hand visits were up in Radiology (65 visits) and Physical Therapy (28 visits). There were no Wound Care visits but visits were budgeted as the program was expected to start in February.

Surgery

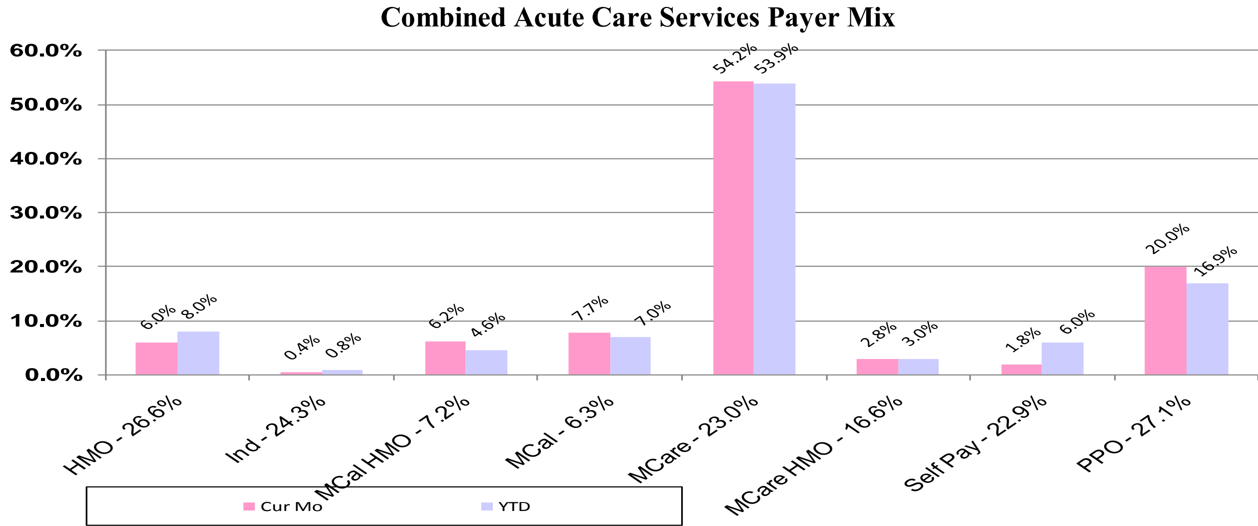
The year-to-date surgery cases were 1,504 or 3.3% above the budget of 1,456 and also above last year. For the month, total surgery cases were above budgeted expectations by 6.1% at 174 cases versus the budget of 164 cases. Inpatient cases were above budget 5 (11.4%) while outpatient cases also 5 (4.2%) above budget. Inpatient and outpatient cases totaled 49 and 125 in February versus 45 and 106 during the prior month. It was a busy inpatient surgery month in February.

The graph below shows the number of inpatient and outpatient surgical cases by month for fiscal year 2012.

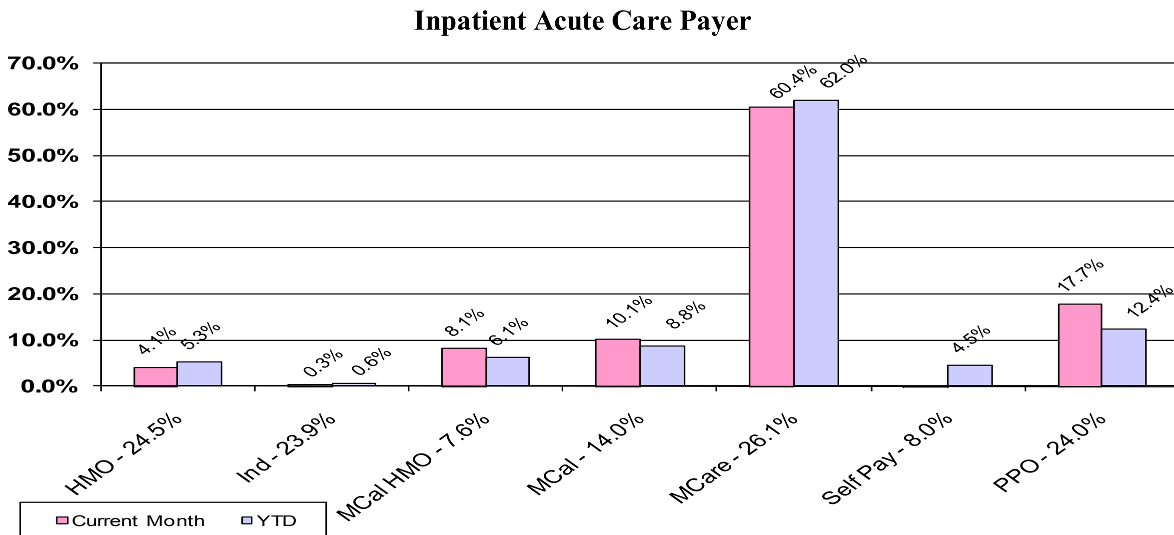


Payer Mix

Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in February made up 57.1% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 26.0%, Medi-Cal Traditional and Medi-Cal HMO utilization at 13.9% and self pay at 6.0%. The graph below shows the percentage of gross revenues generated by each of the major payers for the current month and fiscal year to date as well as the current month's estimated reimbursement for each payer for the combined inpatient and outpatient acute care services.



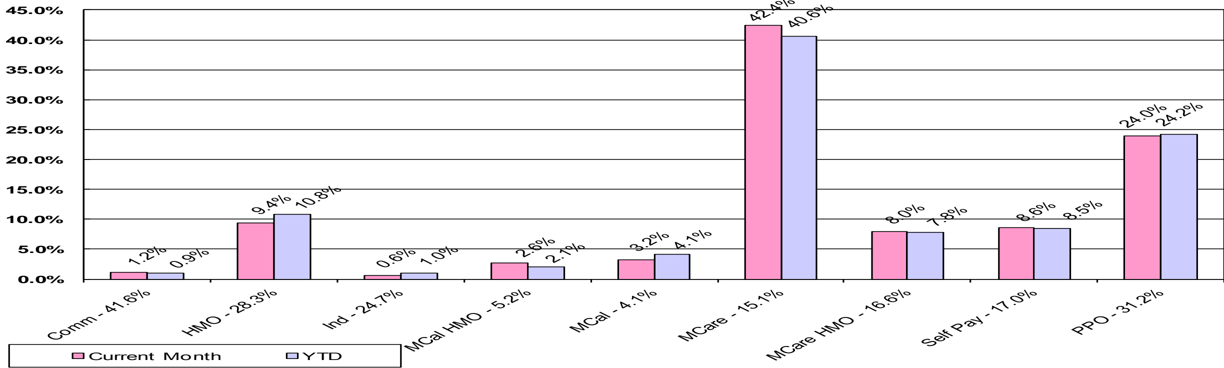
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 60.4% of our total inpatient acute care gross revenues followed by HMO/PPO at 21.8%, Medi-Cal and Medi-Cal HMO at 18.2% and Self Pay at 8.0% of the inpatient acute care revenue. The graph below shows inpatient acute care current month and year to date payer mix and current month estimated net revenue percentages for fiscal year 2012.



The outpatient gross revenue payer mix for February was comprised of 50.4% Medicare and Medicare Advantage, 34.5% HMO/PPO, 5.9% Medi-Cal and Medi-Cal HMO, and 8.6% self pay. The graph below shows the current month and fiscal year

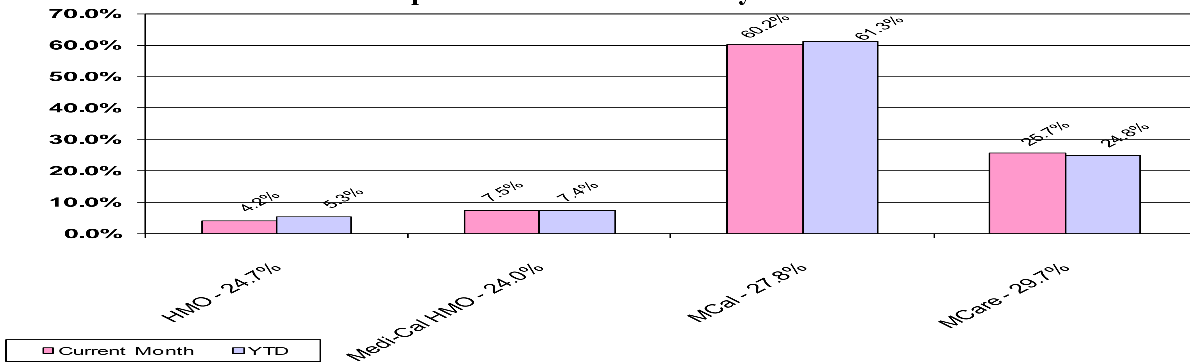
to date outpatient payer mix and the current months estimated level of reimbursement for each payer.

Outpatient Services Payer Mix



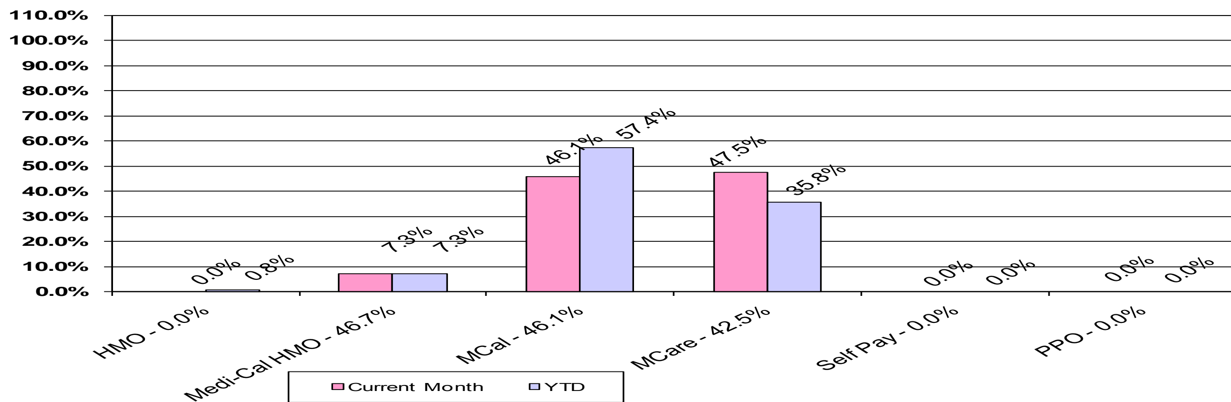
In February, the Sub-Acute care program again was dominated by Medi-Cal utilization of 67.7%, down from a high of 70% in January. Medicare was 25.7% and HMO/PPO rounds out the unit at 4.2%. The graph below shows the payer mix for the current month and fiscal year to date and the current months estimated reimbursement rate for each payer.

Inpatient Sub-Acute Care Payer Mix



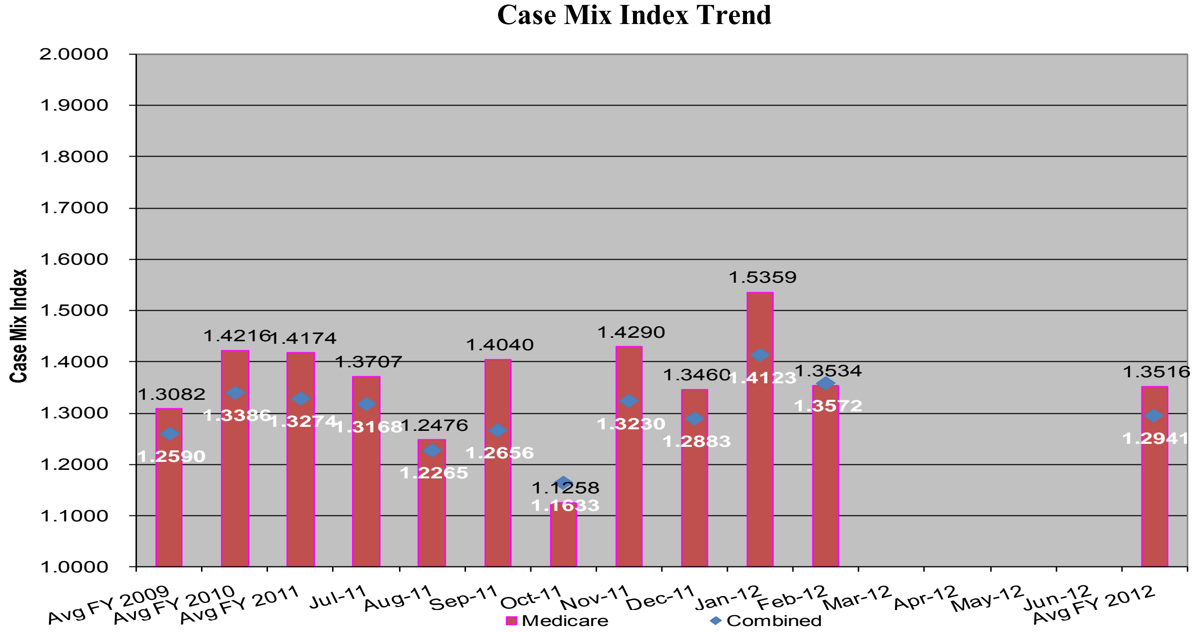
The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. Note the change in volumes between Medicare and Medi-Cal. This reflects the successful placement of an increasing volume of post-acute skilled patients (Medicare).

Inpatient Skilled Nursing Payer Mix



Case Mix Index

The hospital's overall Case Mix Index (CMI) for February was 1.3572, down from the prior months high of 1.4123, and above the February 2011 of 1.3331. The Medicare CMI decreased from 1.5359 in January to 1.3534 in February. The graph below shows the Medicare CMI for the hospital during the current fiscal year as compared to the prior three fiscal years.

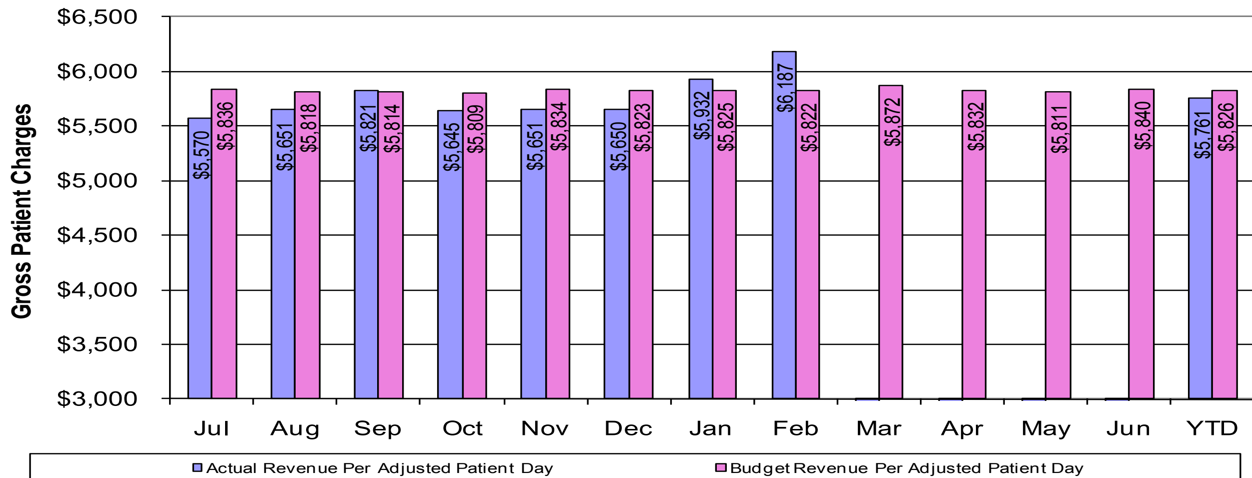


The CMI at the time of forecasting this year's budget was 1.3758. Year-to-date February 2012 the CMI was 1.2998. This represents a 5.3% decline compared to the same time frame last year. However, the month of February 2012 continues the year-to-date average climb. Note that payers with lower volume can have substantial swings in CMI from one period to another. See the table below that compares the CMI by payer for the three periods.

Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Feb 11 YTD	Feb 12 YTD	Feb 12 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.1878	1.0394	6
HMO	1.2522	1.1781	1.3278	79
Industrial	1.8373	1.4212	1.3856	8
Kaiser	1.8412	1.7929	1.9376	9
Medi-Cal HMO	1.0008	1.0026	1.0469	104
Medi-Cal	1.2724	1.2701	1.3066	106
Medicare	1.4724	1.4751	1.3570	997
Medicare HMO	1.3568	1.3580	1.3964	172
Personal Pay	1.0105	1.0247	1.0964	126
Medi-Cal Pending	1.8334	1.8123	2.0751	4
PPO	1.2613	1.3211	1.1187	207
VA	1.4051	1.3213	1.4262	39
Combined	**1.3758**	**1.3719**	**1.2998**	1,857

Gross patient charges in February were above budget by $614,000, or 2.8%. Inpatient revenues were up $629,000 over budget and outpatients were down just $15,000. Most inpatient volumes, surgeries and emergency visits were above or close to budget. Outpatient registrations were just 3.3% under budget. Outpatient revenues were slightly lower than budget as a result of the lower volume. On an adjusted patient day basis, total patient revenue was $6,187, above the budget of $5,822 for the month of February and higher than January gross revenue per APD of $5,932. The following table shows the hospital's monthly gross revenue per adjusted patient day by month and year-to-date for fiscal year 2012 compared to budget.



Contractual Allowances

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 payers such as Blue Cross. As such net revenues as a percentage of gross revenues were very close to budget. A collection ratio of 22.3% was budgeted and 22.2% was realized.

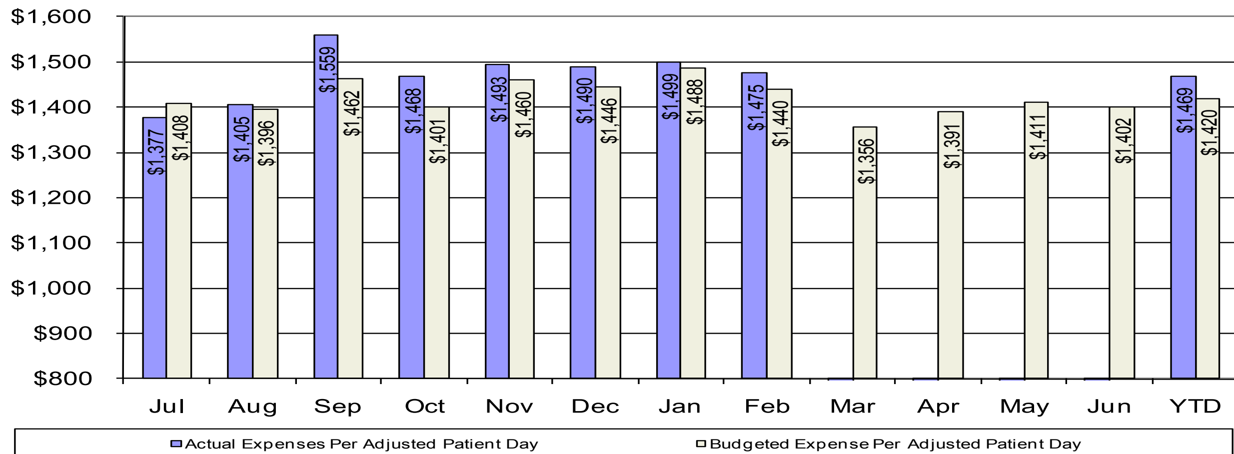
Expenses

Total Operating Expenses

Total operating expenses were lower than the fixed budget by $30,000 or 0.6%. This compares to a gross revenue variance of 5.8%. As such, overall expenses were favorable. Salaries, benefits were up due to high activity in the acute hospital. Non-medical professional fees were up due to consulting fees along with expenses related to Water's Edge.

The graph below shows the actual hospital operating expenses on an adjusted patient day basis for the 2012 fiscal year by month as compared to budget. Note that expenses per patient day were over budget this month. This is a bit of an anomaly because even though revenues were over budget, patient days were below budget. The reason patient days were low was because of patient day activity in the SNF unit. Occasionally some statistics give a false impression of performance. That is the case with expenses per adjusted patient days this month.

Expenses per Adjusted Patient Day



Following are explanations of the significant areas of variance that were experienced in the current month.

Salary and Temporary Agency Expenses

Salary and temporary agency costs combined were unfavorable to the fixed budget by $43,000 and were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $35 or 4.6%. Year to date salaries and agency expenses are running just above budget by 1.9% PAPD.

Benefits

Benefits were favorable to the fixed budget by $64,000 or 17.7%, and right on budget per adjusted patient day. Group Health Insurance – Non Alameda Hospital contributed to this positive variance.

Professional Fees

Professional fees were unfavorable to budget by $67,000 in February due to $11,000 from Medical Professional Fees (ER and Clinic physician expenses) and $30,000 from Non-Medical Professional Fees related to HFS fees for Accounting $13,000, Revenue Cycle $30,000, Pharmacy $15,000 and Administration $11,000.

Supplies

Supplies were favorable to budget by $123,000 (16.8%) or $28 or 14.3% per adjusted patient day in February. As in prior months, this favorable variance was the result of lower than budgeted patient related supplies such as medical supplies expense, pharmacy supplies associated with the IVT program (low IVT program volumes), and prosthetics.

Purchased Services

Purchased services were at the fixed budget and $3 unfavorable PAPD.

Rents and Leases

Rents and leases were above the fixed budget by only $4,000, and above budget $2 PAPD in February at $33 per adjusted patient day versus a budget of $31.

Other Operating Expense

Other operating expenses were $11,000 under the fixed budget and $3 under the budget on a per adjusted patient day basis.

Balance Sheet

Total assets increased almost $400,000 from the prior month, partly because of the increase in accounts receivable as well as the increase in cash. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for February increased by $272,000 and days cash on hand including restricted use funds decreased to 12.4 days on hand in February from 14.6 days on hand in January.

- Net patient accounts receivable increased in February by $678,000 compared to an increase of $304,000 in January. Days in outstanding receivables were 66.5 at February month end, just above the 62.9 days in January. Collections in February were $4.4 million compared to $4.9 million in January. February had 2 less business days than January.

- Other Receivables, Third Party Settlements, Inventories and Prepaids remained fairly constant from one month to the next.

Total liabilities decreased by only $42,000 compared to a decrease of $997,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses increased $147,000. This small increase is an improvement over prior month's accrued expenses.

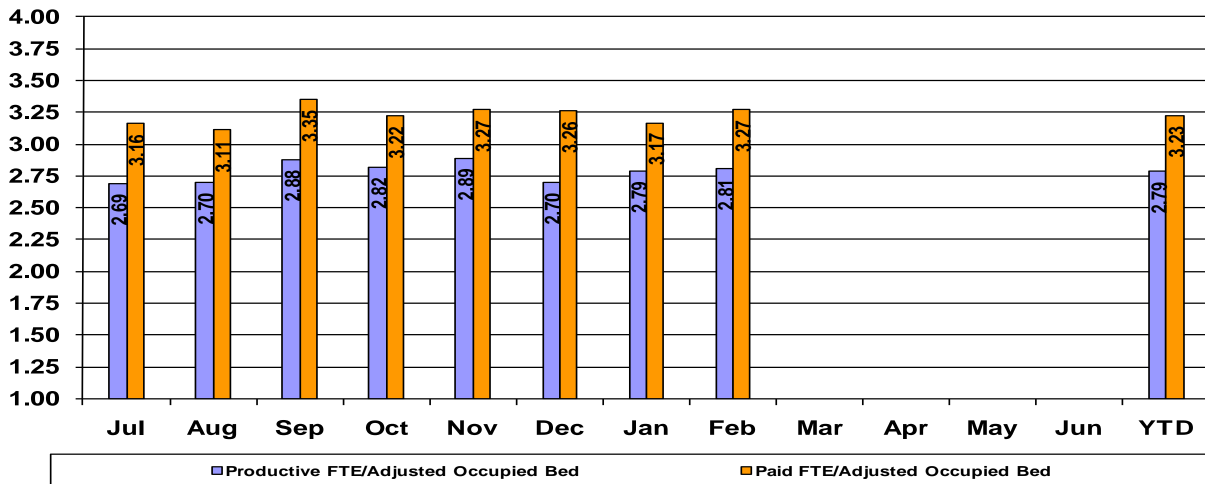
- Payroll related accruals increased by $211,600 as a result of the timing of pay period end in relation to the month end.

- Deferred revenues decreased again by $477,000 due to the recognition of one-twelfth of the 2011/2012 parcel tax revenues of $5.7 million.

Key Statistics

FTE's per Adjusted Occupied Bed

On an adjusted occupied bed basis, productive FTE's were 2.81, above the budget of 2.66 FTE's by 5.3%, and paid FTE's were 3.27 or 5.1% above budget. The graph below shows the productive and paid FTE's per adjusted occupied bed for FY 2012 by month.



Current Ratio

The current ratio for February is 1.03. This has increased above our threshold of 1.0 with the reclassification of the Jabor cash.

A/R days

Net days in Accounts Receivable are currently at 66.5. This is up from prior month. We are working hard to bring this number down to 51, which will help our cash position and current ratio.

Days Cash on Hand

Days cash on hand for February was 12.4. This has decreased slightly from prior month of 13.8 because of increased expenses associated with February activity. We would like this ratio to be closer to the FY 2010 number of 20+ days.

The following pages include the detailed financial statements for the seven (8) months ended February 29, 2012, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
FEBRUARY 2012

	ACTUAL FEBRUARY 2012	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	FEBRUARY 2011	YTD FEBRUARY 2012	YTD FIXED BUDGET	VARIANCE	%	YTD FEBRUARY 2011
Discharges:										
Total Acute	245	233	12	5.2%	197	1,880	1,840	40	2.2%	1,649
Total Sub-Acute	3	1	2	200.0%	1	15	12	3	25.0%	16
Total Skilled Nursing	9	9	-	0.0%	10	69	70	(1)	-1.4%	60
	257	243	14	5.8%	208	1,964	1,922	42	2.2%	1,725
Patient Days:										
Total Acute	1,017	934	83	8.9%	778	7,310	7,363	(53)	-0.7%	6,989
Total Sub-Acute	951	957	(6)	-0.6%	943	7,936	8,052	(116)	-1.4%	7,914
Total Skilled Nursing	543	669	(126)	-18.8%	659	5,125	5,278	(153)	-2.9%	5,375
	2,511	2,560	(49)	-1.9%	2,380	20,371	20,693	(322)	-1.6%	20,278
Average Length of Stay										
Total Acute	4.15	4.01	0.14	3.6%	3.95	3.89	4.00	(0.11)	-2.8%	4.24
Average Daily Census										
Total Acute	35.07	32.21	2.77	8.6%	26.83	29.96	30.18	(0.22)	-0.7%	28.64
Total Sub-Acute	32.79	33.00	(0.20)	-0.6%	32.52	32.52	33.00	(0.48)	-1.4%	32.43
Total Skilled Nursing	18.72	23.07	(4.20)	-18.2%	22.72	21.00	21.63	(0.63)	-2.9%	22.03
	86.59	88.28	(1.63)	-1.9%	82.07	83.49	84.81	(0.69)	-0.8%	83.11
Emergency Room Visits	1,384	1,334	50	3.7%	1,337	11,248	11,224	24	0.2%	11,179
Outpatient Registrations	1,854	1,918	(64)	-3.3%	1,866	14,720	15,897	(1,177)	-7.4%	15,684
Surgery Cases:										
Inpatient	49	44	5	11.4%	48	318	348	(30)	-8.6%	354
Outpatient	125	120	5	4.2%	118	1,186	1,108	78	7.0%	1,105
	174	164	10	6.1%	166	1,504	1,456	48	3.3%	1,459
Adjusted Occupied Bed (AOB)	125.47	129.69	(4.22)	-3.3%	127.30	246.19	125.71	120.48	95.8%	124.08
Productive FTE	352.18	345.53	6.65	1.9%	378.12	341.57	342.55	(0.98)	-0.3%	366.36
Total FTE	410.63	403.84	6.79	1.7%	436.32	395.85	404.98	(9.13)	-2.3%	423.81
Productive FTE/Adj. Occ. Bed	2.81	2.66	0.14	5.3%	2.97	1.39	2.72	(1.34)	-49.1%	2.95
Total FTE/ Adj. Occ. Bed	3.27	3.11	0.16	5.1%	3.43	1.61	3.22	(1.61)	-50.1%	3.42

City of Alameda Health Care District
Statements of Financial Position
February 29, 2012

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 2,253,861	$ 1,981,838	$ 1,784,141
Patient Accounts Receivable, net	10,563,953	9,885,867	7,249,185
Other Receivables	3,674,460	3,616,054	8,090,457
Third-Party Payer Settlement Receivables	661,578	661,578	150,000
Inventories	1,152,120	1,182,028	1,183,358
Prepaids and Other	300,951	324,645	262,359
Total Current Assets	18,606,923	17,652,009	18,719,500
Assets Limited as to Use, net	24,337	558,983	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,397,622	43,397,622	43,383,571
Construction in progress	3,515,044	3,476,290	2,921,048
Depreciation	(39,404,854)	(39,336,772)	(38,862,494)
Property, Plant and Equipment, net	8,385,757	8,415,085	8,320,070
Total Assets	**$ 27,017,018**	**$ 26,626,077**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,583,545	$ 1,606,237	$ 746,074
Accounts Payable and Accrued Expenses	8,881,340	8,734,064	6,987,765
Payroll Related Accruals	4,732,459	4,520,785	3,991,254
Deferred Revenue	1,909,641	2,386,689	5,725,900
Employee Health Related Accruals	629,895	617,641	343,382
Third-Party Payer Settlement Payable	368,344	35,075	(3,930)
Total Current Liabilities	18,105,224	17,900,491	17,790,445
Long Term Debt, net	845,575	845,722	1,142,109
Total Liabilities	18,950,799	18,746,213	18,932,554
Net Assets:			
Unrestricted	7,871,881	7,150,875	8,037,015
Temporarily Restricted	194,337	728,988	553,716
Total Net Assets	8,066,218	7,879,863	8,590,731
Total Liabilities and Net Assets	**$ 27,017,018**	**$ 26,626,077**	**$ 27,523,286**

City of Alameda Health Care District

Statements of Operations

February 29, 2012

$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,511	2,560	(49)	-1.9%	2,380	20,371	20,693	(322)	-1.6%	20,278
Discharges	257	243	14	5.8%	208	1,964	1,922	42	2.2%	1,725
ALOS (Average Length of Stay)	9.77	10.53	(0.76)	-7.3%	11.44	10.37	10.77	(0.39)	-3.7%	11.76
ADC (Average Daily Census)	89.7	91.4	(1.75)	-1.9%	85.0	84	85.2	(1.33)	-1.6%	83.4
CMI (Case Mix Index)	1.3543				1.3331	1.2936				1.3632
Revenues										
Gross Inpatient Revenues	$ 15,535	$ 14,905	$ 629	4.2%	$ 12,579	$ 117,383	$ 120,378	$ (2,995)	-2.5%	$ 110,161
Gross Outpatient Revenues	6,977	6,922	55	0.8%	6,260	54,755	57,694	(2,939)	-5.1%	53,877
Total Gross Revenues	22,512	21,827	684	3.1%	18,839	172,139	178,073	(5,934)	-3.3%	164,037
Contractual Deductions	17,031	16,095	(936)	-5.8%	13,389	128,639	131,169	2,530	1.9%	116,997
Bad Debts	361	695	333	48.0%	690	3,382	5,663	2,281	40.3%	4,954
Charity and Other Adjustments	113	169	56	33.2%	188	1,369	1,365	(4)	-0.3%	1,257
Net Patient Revenues	5,006	4,869	137	2.8%	4,572	38,749	39,876	(1,127)	-2.8%	40,830
Net Patient Revenue %	22.2%	22.3%			24.3%	22.5%	22.4%			24.9%
Net Clinic Revenue	36	28	8	29.4%	50	285	146	138	94.4%	258
Other Operating Revenue	8	10	(2)	-24.7%	12	224	81	143	177.6%	81
Total Revenues	**5,050**	**4,907**	**143**	2.9%	**4,635**	**39,257**	**40,103**	**(846)**	-2.1%	**41,169**
Expenses										
Salaries	2,723	2,713	(10)	-0.4%	2,825	22,745	22,597	(148)	-0.7%	23,708
Temporary Agency	173	140	(33)	-23.3%	216	924	1,179	256	21.7%	1,605
Benefits	765	787	23	2.9%	768	6,770	6,365	(405)	-6.4%	6,306
Professional Fees	379	313	(67)	-21.3%	255	3,051	2,349	(702)	-29.9%	2,373
Supplies	611	734	123	16.8%	731	4,779	6,004	1,225	20.4%	5,845
Purchased Services	366	364	(2)	-0.5%	328	2,883	2,946	63	2.1%	2,961
Rents and Leases	120	116	(4)	-3.7%	68	699	717	18	2.5%	544
Utilities and Telephone	73	65	(8)	-12.6%	70	535	519	(16)	-3.1%	502
Insurance	29	17	(12)	-73.0%	34	221	135	(87)	-64.3%	254
Depreciation and amortization	68	77	9	11.9%	77	579	565	(14)	-2.5%	642
Other Opertaing Expenses	60	71	11	16.1%	68	712	621	(91)	-14.7%	705
Total Expenses	**5,368**	**5,398**	**30**	0.6%	**5,440**	**43,898**	**43,997**	**98**	0.2%	**45,446**
Operating gain (loss)	**(317)**	**(491)**	**174**	35.4%	**(805)**	**(4,641)**	**(3,894)**	**(747)**	19.2%	**(4,277)**
Non-Operating Income / (Expense)										
Parcel Taxes	477	478	(1)	-0.1%	479	3,846	3,824	22	0.6%	3,828
Investment Income	1	0	0	220.6%	0	4	(102)	107	-104.3%	8
Interest Expense	(13)	(15)	2	10.6%	(8)	(127)	(13)	(114)	893.5%	(71)
Other Income / (Expense)	28	23	5	20.5%	22	206	179	28	15.4%	175
Net Non-Operating Income / (Expense)	**492**	**486**	**6**	**1.3%**	**494**	**3,930**	**3,888**	**42**	**1.1%**	**3,941**
Excess of Revenues Over Expenses	**$ 175**	**$ (5)**	**$ 180**	**-3762.3%**	**$ (311)**	**$ (711)**	**$ (6)**	**$ (705)**	**11853.7%**	**$ (337)**

City of Alameda Health Care District
Statements of Operations - Per Adjusted Patient Day
February 29, 2012

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 4,269	$ 3,976	$ 293	7.4%	$ 3,529	$ 3,929	$ 3,933	$ (3)	-0.1%	$ 3,648
Gross Outpatient Revenues	1,917	1,846	71	3.8%	1,756	1,833	1,885	(52)	-2.8%	1,784
Total Gross Revenues	6,187	5,822	364	6.3%	5,285	5,762	5,817	(55)	-0.9%	5,433
Contractual Deductions	4,681	4,293	(387)	-9.0%	3,756	4,306	4,285	(21)	-0.5%	3,875
Bad Debts	99	185	86	46.4%	194	113	185	72	38.8%	164
Charity and Other Adjustments	31	45	14	31.1%	53	46	45	(1)	-2.8%	42
Net Patient Revenues	1,376	1,299	77	5.9%	1,283	1,297	1,303	(6)	-0.4%	1,352
Net Patient Revenue %	22.2%	22.3%			24.3%	22.5%	22.4%			24.9%
Net Clinic Revenue	10	7	2	33.3%	14	10	5	5	99.2%	9
Other Operating Revenue	2	3	(1)	-22.5%	3	8	3	5	184.4%	3
Total Revenues	**1,388**	**1,309**	**79**	6.0%	**1,300**	**1,314**	**1,310**	**4**	0.3%	**1,364**
Expenses										
Salaries	748	724	(25)	-3.4%	792	761	738	(23)	-3.1%	785
Temporary Agency	48	37	(10)	-27.0%	61	31	39	8	19.8%	53
Benefits	210	210	(0)	-0.1%	216	227	208	(19)	-9.0%	209
Professional Fees	104	83	(21)	-25.0%	71	102	77	(25)	-33.1%	79
Supplies	168	196	28	14.3%	205	160	196	36	18.4%	194
Purchased Services	101	97	(3)	-3.5%	92	97	96	(0)	-0.3%	98
Rents and Leases	33	31	(2)	-6.9%	19	23	23	0	0.1%	18
Utilities and Telephone	20	17	(3)	-16.0%	20	18	17	(1)	-5.7%	17
Insurance	8	5	(4)	-78.3%	9	7	4	(3)	-68.4%	8
Depreciation and Amortization	19	21	2	9.2%	22	19	18	(1)	-5.0%	21
Other Operating Expenses	16	19	3	13.6%	19	24	20	(4)	-17.6%	23
Total Expenses	**1,475**	**1,440**	**(35)**	-2.4%	**1,526**	**1,469**	**1,437**	**(32)**	-2.2%	**1,505**
Operating Gain / (Loss)	**(87)**	**(131)**	**44**	33.4%	**(226)**	**(155)**	**(127)**	**(28)**	22.2%	**(141)**
Non-Operating Income / (Expense)										
Parcel Taxes	131	127	4	2.9%	134	129	125	4	3.1%	127
Investment Income	0	0	0	230.4%	0	0	0	0	172.5%	0
Interest Expense	(4)	(4)	0	7.9%	(2)	(4)	(3)	(1)	27.1%	(2)
Other Income / (Expense)	8	6	1	24.2%	6	7	6	1	18.3%	6
Net Non-Operating Income / (Expense)	**135**	**130**	**6**	**4.3%**	**139**	**132**	**127**	**4**	**3.2%**	**131**
Excess of Revenues Over Expenses	**$ 48**	**$ (1)**	**$ 49**	-3873.2%	**$ (87)**	**$ (24)**	**$ 1**	**$ (24)**	-4807.5%	**$ (11)**

City of Alameda Health Care District
Statement of Cash Flows
For Eight Months Ended February 29, 2012

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ 175,005	$ (711,139)
Items not requiring the use of cash:		
Depreciation and amortization	68,082	$ 578,669
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	(678,086)	(3,314,768)
Other Receivables	(58,406)	4,415,997
Third-Party Payer Settlements Receivable	333,269	(139,304)
Inventories	29,908	31,238
Prepaids and Other	23,693	(38,592)
Accounts payable and accrued liabilities	147,276	1,893,575
Payroll Related Accruals	211,674	741,205
Employee Health Plan Accruals	12,254	286,513
Deferred Revenues	(477,048)	(3,816,259)
Cash provided by (used in) operating activities	(212,378)	(72,865)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	534,646	459,379
Additions to Property, Plant and Equipment	(38,755)	(644,356)
Other	546,001	546,005
Cash provided by (used in) investing activities	1,041,891	361,027
Cash flows from financing activities		
Net Change in Long-Term Debt	(22,839)	540,937
Net Change in Restricted Funds	(534,651)	(359,379)
Cash provided by (used in) financing and fundraising activities	(557,490)	181,558
Net increase (decrease) in cash and cash equivalents	272,023	469,720
Cash and cash equivalents at beginning of period	1,981,838	1,784,141
Cash and cash equivalents at end of period	$ 2,253,861	$ 2,253,861

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results			Unaudited Results	
	FY 2008	FY 2009	FY 2010	FY 2011	YTD 2/29/2012
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.51%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-0.01%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-9.81%
Operating Margin	-3.75%	1.03%	2.74%	-2.61%	-1.64%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	1.03
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	66.52
Days cash on hand (with restricted)	30.6	13.6	21.6	14.1	12.4
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	93.79%
Average pay period	58.93	58.03	57.11	62.68	79.99
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.00)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.23
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-8.82%
Debt to number of beds	20,932	13,481	10,482	11,515	15,088

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results FY 2008	Audited Results FY 2009	Audited Results FY 2010	Unaudited Results FY 2011	Unaudited Results YTD 2/29/2012
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	20,371
Patient days (acute only)	11,276	11,787	10,579	10,443	7,310
Discharges(acute only)	2,885	2,812	2,802	2,527	1,964
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.72
Average daily patients (all sources)	61.99	83.46	83.85	82.93	83.49
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.86%
Average length of stay	3.91	4.19	3.78	4.13	3.72
Emergency Visits	17,922	17,337	17,624	16,816	11,248
Emergency visits per day	48.97	47.50	48.28	46.07	46.10
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	60.33
Surgeries per day - Total	14.78	16.12	13.46	6.12	6.16
Surgeries per day - excludes Kaiser	5.54	5.14	5.32	6.12	6.16

Notes:

1. Includes Kaiser Outpatient Sugercial volume in Fiscal Years 2008, 2009 and through March 31, 2010.
2. In addition to these general requirements a feasibility report will be required.
3. Based upon Moody's FY 2008 preliminary single-state provider medians.
4. EBIDA - Earnings before Interest, Depreciation and Amoritzation
5. EBIDAP - Earnings before Interest, Depreciation and Amortization and Parcel Tax Proceeds

Glossary of Financial Ratios

Term	What is it? Why is it Important?	How is it calculated?
EBIDA	A measure of the organization's cash flow	Earnings before interest, depreciation, and amortization (EBIDA)
Operating Margin	Income derived from patient care operations	Total operating revenue less total operating expense divided by total operating revenue
Current Ratio	The number of dollars held in current assets per dollar of liabilities. A widely used measure of liquidity. An increase in this ratio is a positive trend.	Current assets divided by current liabilities
Days cash on hand	Measures the number of days of average cash expenses that the hospital maintains in cash or marketable securities. It is a measure of total liquidity, both short-term and long-term. An increasing trend is positive.	Cash plus short-term investments plus unrestricted long-term investments over total expenses less depreciation divided by 365.
Cash to debt	Measures the amount of cash available to service debt.	Cash plus investments plus limited use investments divided by the current portion and long-term portion of the organization's debt insruments.
Debt service coverage	Measures total debt service coverage (interest plus principal) against annual funds available to pay debt service. Does not take into account positive or negative cash flow associated with balance sheet changes (e.g. work down of accounts receivable). Higher values indicate better debt repayment ability.	Excess of revenues over expenses plus depreciation plus interest expense over principal payments plus interest expense.
Long-term debt to fund balance	Higher values for this ratio imply a greater reliance on debt financing and may imply a reduced ability to carry additional debt. A declining trend is positive.	Long-term debt divided by long-term debt plus unrestricted net assets.

DATE: March 22, 2012

TO: City of Alameda Health Care District, Finance and Management Committee

FOR: March 28, 2012 Finance and Management Committee

FROM: Deborah E. Stebbins, Chief Executive Officer
Mary Bond, RN, Executive Director of Nursing Services
Tony Corica, Director of Physician Relations

SUBJECT: Recommendation to Approve the Establishment of a Comprehensive Orthopedic Program at Alameda Hospital and Approval to Enter into Professional Services Agreements with Two Orthopedic Surgeons

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Hospital Management is recommending that the Finance and Management Committee recommend to the Board of Directors the following two (2) recommendations.

RECOMMENDATION #1:

Approve the establishment of a comprehensive Orthopedic Program at Alameda Hospital as described below in the Background and Discussion.

RECOMMENDATION #2:

Approval to enter into three-year Professional Services Agreements with Nicholas Pirnia, M.D., and James DiStefano, M.D, two orthopedists wishing to establish medical office practices in Alameda.

A copy of the three-year financial analysis and assumptions for the program and the practice will be sent under separate cover prior to the March 28, 2012 Committee meeting.

BACKGROUND:

Orthopedics remains a highly profitable service line for hospitals across the country. A robust orthopedics portfolio can assist the hospital to support less profitable hospital services. The demand for orthopedic care covers the gamut of ages; the need for sports medicine can begin early in life, while spine surgeries peak in middle age and joint replacements occur predominately among the elderly population.

It is estimated that a full-time orthopedist generates combined net inpatient and outpatient revenues to the Hospital of approximately $2M annually. Our experience with our busiest orthopedic surgeon is in line with this estimate. Thus, the opportunity exists to replace some of the surgery volume lost by the April, 2010 departure of the Kaiser surgical volume from our Hospital. Additionally, physical therapy, diagnostic imaging, and laboratory services will increase.

We would like to develop a comprehensive orthopedic program that will focus on the addition of two orthopedic surgeons who would initially combine general orthopedics with their selected specialties in diseases of the spine and sports medicine, respectively. This program would be developed to enhance our existing services, be a resource for the existing medical community, and position us to become a destination hospital for orthopedics.

At a minimum this program would be developed to:

- Increase utilization in the Operating Room—we will offer block surgical time of ½ room (four hours) a minimum of 1 day per week to start with the potential of approximately 5 to 7 procedures beginning the first month. Surgical procedure ramp-up is generally fairly gradual, initially relying on referrals while the basic personal practice builds. This can be accomplished with minimal cost until volume increases are consistently established.
- Increase inpatient volume on the Nursing Units—our medical surgical unit would be reconfigured to include a specific unit dedicated to post-operative care for not only orthopedic but also vascular and some more intensive general surgical patients. We would like to use the wing off of 3-South, 5 rooms with 10 beds that can be initially used as private rooms. Nurses with experience specifically in post-operative orthopedic and vascular care would be hired to staff the unit.
- Provide a mechanism that will not only enhance our existing services but also allow us to plan for the retirement of orthopedic surgeons in the area.
- Provide increased community involvement through activities at the local schools, gyms, health facilities, and the Boys' and Girls' Club.
- Provide patients and the community with programs, events, and seminars on topics such as Sports Medicine, Total Joint Replacement, Minimally Invasive Orthopedic Surgery, and Post-operative Rehabilitation.
- Aggressively market the new orthopedic practice and program. Selecting a practice name larger than "Alameda" may assist in attracting patients from "off-island". Multiple forms of marketing will be used.
- Locate appropriate office space in Alameda and potentially additional office space within the extended service area for the surgeons. There is potential for financing tenant improvements of selected office location(s).

It should be emphasized that physical and rehabilitative therapy is vital and essential to an active, prosperous orthopedic program. Not only will orthopedic surgeons use physical therapy after surgical procedures, they will also recommend physical therapy on a conservative basis for those patients experiencing any kind of injury or chronic health problem, strength training, continued physical fitness, or pre-surgical treatment. Additionally, it is not infrequent that orthopedic surgeons are asked to recommend a physical therapy department either in social settings or in general conversation.

The development of a comprehensive orthopedic program backed by strong ancillary departments such as physical therapy, diagnostic imaging, and laboratory services addresses a key component of the Hospital's strategic plan to increase procedural/surgical services that will better serve the community and Hospital.

DISCUSSION:

As part of the Hospital strategic plan for growth, management has been investigating new program opportunities that are needed in our primary service area, that coincide with the mission and vision of the district, and that will provide a positive financial contribution to the hospital. One such program is the development of a multi-specialty orthopedic service line.

Recruitment of orthopedic surgeons has become one of the most difficult recruitment efforts among all specialties. The supply of physicians coming out of residency and fellowship programs is not keeping up with the rate of retirement for outgoing physicians. This shortage has driven the income averages for spine and sports medicine orthopedists to over $500,000 per year.

Alameda Hospital has entered into Professional Services Agreements with physicians since it established its 1206(b) clinic in 2009. We are currently negotiating Professional Services Agreements with two new orthopedists to work in our 1206(b) clinic. These Agreements would include a twelve month income guarantee in Year One. After the first year, the physicians would be eligible for production incentives based on work units, atop a smaller guaranteed base. The annual guaranteed incomes are within the Fair Market Values for the specialties of sports orthopedic medicine and spine orthopedic medicine. The development of the orthopedic program at Alameda Hospital is contingent upon the Hospital's successful negotiation of Professional Services Agreements with the two orthopedists.

Orthopedists Nicholas Pirnia, M.D. and James DiStefano, M.D. were contacted by Alameda Hospital in 2011 regarding their interest in establishing an orthopedic practice in Alameda. Over the past five months, management has engaged in discussions with these two orthopedists who will be completing their orthopedic fellowships in spine and sports medicine, respectively, at the end of July, 2012. They both worked at Alameda Hospital in 2010 as residents in the Kaiser Orthopedic Program. Both surgeons valued their time here and are considering establishing a multidisciplinary orthopedic practice that will include general orthopedic surgery, spine surgery, and sports medicine in Alameda. After numerous meeting/interview sessions with these two physicians, it was concluded that assisting them to establish their practices in Alameda would be an essential component of a comprehensive Orthopedic Program.

While their primary orientation will be to the Alameda community, we are excited about their potential to attract patients from off-island. Two new attending orthopedists recently recruited by Highland Hospital, Dr. Swapnil Shah (Chief of Orthopedics) and Dr. Michael Krosin, graduated two years prior to Drs. Pirnia and DiStefano from the same residency program. They are well-known and well-liked by Drs. Pirnia and DiStefano. This has potential to lead to a closer working relationship with the County. Opportunities for these Orthopedists to work with University Healthcare Alliance, Children's Hospital, Oakland and other healthcare network institutions will be facilitated by Alameda Hospital.

There are currently three orthopedists that have practices in Alameda. Two of those offices are part-time practices, and two of the orthopedists have been on the Alameda Hospital Medical

Staff for over 30 years. The Hospital's busiest orthopedist performed 178 cases at Alameda Hospital in 2011, in contrast to the 5 and 6 cases done last year by his colleagues.

In calendar year 2010, approximately 104 Alameda residents (zip codes 94501 and 94502) had orthopedic surgeries at hospitals other than Alameda. Additionally, 494 Oakland residents and 230 San Leandro residents had orthopedic surgery at hospitals other than Alameda. These numbers present additional volume that, with a comprehensive orthopedic program, could be attracted to the Hospital.

Additional statistical data was gathered from a 2010 study completed by the American Academy of Orthopedic Surgeons that supports the importance of recruiting new orthopedists to the community. The report chose to look at surgeon density in the 65 and older population because these are the people most likely to require orthopedic care and numbers and age of surgeons may be linked to access problems for this age group presently and in the future. This study looked at changes in numbers and ages of orthopedic surgeons from 2002 to 2010. From that report findings specific to the state of California include:

- There are approximately 5.25 orthopedic surgeons for every 100,000 patients
  - Alameda has 3 orthopedic surgeons for its population of 75,000 patients
- There are approximately 4.50 orthopedic surgeons for every 10,000 patients over the age of 65
- The mean age of orthopedic surgeons is 52.9 with a 5% increase between 2002 and 2010 in the number of surgeons over age 64.
  - Alameda's 3 orthopedists are 71, 65, and 58, respectively.
- California is one of 6 states with over 13% of orthopedic surgeons aged 65 and older
- California has experienced an increase of more than 675,000 people aged 65 and older between 2002 and 2010
  - The fastest growing segment of the Alameda population is that of people aged 65 and older. It is predicted to increase 23% between 2010 and 2015.

Given the prevalence of musculoskeletal injury, wear, and degeneration as the population grows and ages, the development of a multi specialty orthopedic program at Alameda Hospital will benefit the community and Hospital for decades to come.

City of Alameda Health Care District
Work Plan for Business Office and Revenue Cycle
Updates as of 3/21/12

#	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Status
1	Call Emdeon about the 4 ED levels splitting the gross amount	Becky Pavone	AH IT and Diane are working with Meditech	Continue to work on this issue Meditech was able to resolve this issue on some but not all claims. Continue to look for what the outstanding claims have in common.	Continue to work on this issue Meditech was able to resolve this issue on some but not all claims. Continue to look for what the outstanding claims have in common. The task is with Alameda IT	B.Pavone to review ED charge issues with Queen of the Valley/Napa - they are on Meditech 5.64	In process
2	Review claim scrubber	Teresa Jacques, Gwynn Smith, Becky Pavone	As we gather information on the issues with Emedeon, we will be looking at whether this is the correct system for AH.	Contact has been made with DSG about a demonstration and proposal	Parties decided late last week to set up a demo and ask for a proposal in the 2nd or 3rd week in March. Teresa has left a message with Scott and expects to hear from him early this week to confirm a date.	DSG was at Alameda to Demo on 3/8/12. Not a top priority at this time	In process
3	**Review what Kaiser pays fo**r. Special focus on LTC and ancillary charges.	Diane Gramse				Task deferred to D.Gramse at Fresno Office	Outstanding
4	**Review credit balance reports**. Recommend repayment strategy if necessary.	Teresa Jacques	This task will be assigned to the Financial Counselor and Escheatment laws will be reviewed.	One staff is working some credits and additional staff have been identified and training is expected to start in the next 10 days.	Still looking to train some additional staff to be able to process credit balances. This was given to a returning staff member but more back up is still needed.	No Update	In process
5	**Day-to-day management of the business office**. The goals are to expedite cash collections, correct system problems, and make recommendations for the long term organization and staffing of the department. A time frame and budget needs to be submitted.	Becky Pavone	Review and make changes to current processes from issues sent from the Fresno Billing Office.	In the process of interviewing for a Business Office Manager. An offer for the Financial Counselor will be offered by Feb 1.	The new Financial Counselor started mid-February. As a former employee the transition has been seamless. All candidates for the Business Office Manager have been interviewed no offers were made.	R.Pavone began Interim Director engagement on 3/4/12 .All areas of registration being evaluated: Meeting with HR on 3/26 to review staffing issues to assist in formulating go forward staffing plan. Daily quality checklists have been implemented to review department data integrity. Expectations have been presented regarding POS collections in Admitting and ED. Department Huddles have been established to meet 3 times weekly to discuss department updates/concerns and status. Created a weekly Self Pay Meeting with Case Mgmt/Social Services/Heath Advocates/Financial counselors to discuss uninsured patient status. Met with HFS Billing Office to review daily issues log to insure timely response and resolution to outstanding issues and utilize info obtained as a teaching tool within department.	On-going

City of Alameda Health Care District
Work Plan for Business Office and Revenue Cycle
Updates as of 3/21/12

#	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Status
6	**Assess current functions** including registration, billing, cash posting, and billing follow-up. Provide final recommendations for organization and staffing levels.	Teresa Jacques	Registration has been evaluated and a plan is being developed. Cash posting has been evaluated and will be in place by January 6. Organization and staffing levels are still outstanding. Beginning Tuesday all Registrations/Admissions will be reviewed/audited by a co-worker and	Additional 1 on 1 training will be completed by 2/17/12 to include proper registration of Medicare and Medi-Cal patients vs. Managed Medicare and Medi-Cal. All clerks will be required to sign off that they received and understand the material. Additionally, we are going to review last quarter's registration errors with January's With respect to the organization and staffing plan we are waiting to incorporate the new Business Office Director for support of the reorganization.	Registration remains an area of concern. Starting on March 5th Rebecca Pavone will be onsite to work with the Admissions staff and cover the Business Office Director position.	Refer to Line 9	In process
7	**Redesign the cash posting system**. Incorporate appropriate checks and balances, reassign to staff member who possesses understanding of third party contracts.	Teresa Jacques	Cash posting will remain in Business Office. Accounting will take responsibility for deposit and banking. Other positions will take responsibility for opening checks, balancing cashiering drawers, and mail.	Cash Posting was been addressed in a temporary fashion. Accounting is waiting for an additional staff member that will take on some of the banking and deposit responsibilities, in the interim we have separated the duties amongst the business office staff.	The Business Office is still waiting for Accounting to take over some of the banking and deposit responsibilities.	No Update	In process
8	**Review relationships between business office and operating departments.** Affirm functions are being covered. Evaluate certain registration functions as being more effective if handled by operating departments.	Teresa Jacques	Have met HIM, IT, Quality, ED to evaluate needs and processes	Met with Janet Dike and Julie Green to understand where coding issues are originiating. We are going to develop algorithms for communicating coding issues and quality assurance. Additionally, thus far we have met with the Directors of ED and Medical Imaging meeting to start this process. Alameda will provide the staff to produce the algorithms and we expect that this project will be completed in the next 6 weeks.	This relationship and communication has smoothed out. With staff in the last month working to get the RAC processes defined there has been no update on the meetings with the Department Directors.	Reviewing process for late add on and walk in ancillary services to insure appropriate authorizations obtained	In process

City of Alameda Health Care District
Work Plan for Business Office and Revenue Cycle
Updates as of 3/21/12

#	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Status
9	**Determine the duties of verification clerks**. How does this relate to Health Advocates? How are authorizations and TARs obtained? Does the system work well?	Becky Pavone, Gwynn Smith, Teresa Jacques	Met with all of the verification clerks and developing a work plan. Refining the TAR process and working to electronically submit TARS. In addition to AH staff, the Fresno Office is checking for TAR approval daily.	HFS is working with IP Verification clerks on authorizations and TARS. A new TAR log has been developed and training on maintaining the log. Electronic TARS has been put on hold for now and will be revisited in March.	Our next step with the TAR process is to see how we can incorporate ETAR into the system. The TAR log has been added to again this month and is being used for both tracking and communication now.	No Update	In process
10	**Determine who will assume supervisory business office responsibilities**. AH Administration?	Becky Pavone	Prepared a new Job descriptions for Business Office Supervisor and will be posting the position by Dec 30th.	Interviews are in process	No offers were made to the Business Office Director candidates.	On 3/4/12 R.Pavone began as Interim Business Office Director	In process
11	**Reports.** Which ones will be provided daily to monitor progress? Schedule weekly update meetings.	Gwynn Smith, Teresa Jacques, Diane Gramse	We have weekly meetings with Admin staff, new QM tool for Admitting, Daily billing log, developing cash projection logs, developed improved ATB tools. In process of developing monthly analysis reporting tools.	Cash projection log has been built, reviewing how billing information can be reported in a format that will work for cash projection.	No update	Daily review of Meditech Revenue Generation reports including individual productivity.	In process
12	**Eligibility and authorization process**. Recommendations for improvement. Check Assist being used? TAR process?	Teresa Jacques, Becky Pavone	Feedback received on Check Assist. Not a reliable tool. Individual websites are more up to date. Have emailed accounting to find out what the Check Assist program costs to see if we should keep the program. Evaluation of the responsibilities has been completed plan for correction is pending. TAR process will be addressed in the plan.	HFS will recommend that the Check Assist be turned off do to its unreliable information. HFS will get into place the necessary website access and training in the next month. HFS has developed a new TAR log and trained Alameda IP Intake staff. HFS is evaluating the Intake/Verification clerk duties to determine the needs of the facility.	This task was handed to Alameda staff and there is no update.	Met with Anita Mayo-Green to obtain individual staff sign on to WebSites. Anticipated implementation and training by April 1	In process
13	**Coordination of authorizations**. Surgery, imaging.	Becky Pavone, Teresa Jacques	HFS staff need to meet with authorization clerk and Imaging and Lab Directors.	1/27/12 HFS has will be meeting with Imaging Director the week of Jan 30th to discuss the authorization process. A meeting with the Lab Director has not yet been scheduled.	The meeting with John did not occur due to the RAC issues, contractual allowance reviews and tearing down the AR.	See #13	In process
14	**Workflow for PBX.**	Diane Gramse, Teresa jacques	Working through the process of PBX staff duties and how this will relate to the duties of the Financial Counselor and Cash posting positions.	We have assigned some cash posting duties to this position and are going to evaluate further after the Financial Counselor has been hired.	This will be looked at in March when Teresa is back onsite.	On Teresa Jacques task list for week of 3/26/12	In process

#	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Status
	City of Alameda Health Care District Work Plan for Business Office and Revenue Cycle Updates as of 3/21/12						
15	**Interdepartmental Procedures**	Gwynn Smith	HFS staff are reviewing and updating policies for the department		No update this period.	Gwynn Smith working on Policies/Procedures and Flow charts	In process
16	**Develop Cash projection model**	Teresa Jacques		Have built the model no data available to differentiate government billings from commercial to estimate cash.	If Alameda goes to DSG the issue of estimating cash by payor will work since the model is based on reporting from DSG. Otherwise I will need to see if we can get zero balance information in another form and change the model.	No Update	In process
18	**CDM and revenue usage report.**	Teresa Jacques, Gwynn Smith	Reports have been given to an outside vendor. Alameda has run the CDM through code correct 28 invalid codes were identified. HFS will be doing a market pricing survey.	A contract has been signed for an outside vendor to perform a CDM review.	The CDM team will be onsite the first week in March.	Completed March 9,2012. Report from Panacea due April 2012	In process
19	**Bad Debt -** Evaluate BD contracts, review BD contractors collections, choose contracts, evaluate BD write offs, campaign for charity care, campaign for additional one-time discounts starting in Feb 2012. Goal to get self pay to manageable level	Teresa Jacques	Contracts have been evaluated, CFO is going to evaluate all contractual and BD reserves, CFO waiting for AR reports from Teresa. Rash Curtis will be the early out and bad debt provider this process will start the week of Jan 16. Campaign will start in February. Goal for self pay not set yet.	CFO has received requested information and is now looking for additional information from Analyst staff in order to evaluate. We are still waiting for the report to be built on our side, credit card contract to be signed, and Emdeon to make the necessary corrections on the statements.	Work was done on the contractual assesment this last month but no decision has been made. The Early Out program has started. The file was sent mid February over 5,000 claims. The credit card virtual terminal is up and running and the statements have been changed by Emdeon. Teresa reviewed the statements that are now going out and there is still one phone number that was changed correctly by Emdeon. We are also looking to offer "check by phone" for patients.	Contractual assessment was decided to reserve an additional $400,000 for Feb-June 2012. The discount campaign for Bad Debt has begun at Rash Curtis and ARM. We expect to start Early Out in the first week of April. We corrected the phone numbers on the Emdeon Statements and spelling errors were corrected on the Rash Curtis statements.Received access to Check by Phone on 3/21/12 and will begin training and implementing within the next week.	In process
21	**Compliance**	Diane Gramse, Teresa jacques, Gwynn Smith	As we go through the reorganization process we are looking at potential compliance issues and addresssing them as they present. HFS will be instituting Billing compliance policies and procedures.			Complete	On-going

#	Task	Responsibility	Updates as of 12/29/11	Updates as of 1/27/12	Updates as of 2/26/12	Updates as of 3/22/12	Status
	City of Alameda Health Care District Work Plan for Business Office and Revenue Cycle Updates as of 3/21/12						
22	**Review contracts** with outside vendors that provide revenue cycle related functions. Make recommendations for continuation or modification of services.	Teresa Jacques	All bad debt and early out contracts have been reviewed and Rash Curtis is going to provide both services. Still evaluating Health Advocates and will look further into this service as we grow the Financial Counseling position.	Rash Curtis contract has been signed. We are still in the process of developing a report to transmit the self pay accounts on a weekly basis. All self pay will be turned over and worked before going to bad debt. A discount will be offered in late February on all self pay and bad debt balances with Rash Curtis.	The report is complete and has been transmitted. The discount will be offered for accounts in collections in the first part of March and the Early Out will be offered in the end of March. We are also looking at splitting the bad debt between Rash Curtis and a local company.	In process	In process
23	**Contract payments** - assess P & P for identifying 3rd party shortfalls	Mahera	This task has been assinged to Mahera.	The long term solution is to set up and use the proration module in Meditech. This task is assigned to Mahera.	No update	No Update	In process
25	**Unbilled** - research causes for unbilled amounts over goal by $1.5m, reduce unbilled to goal of $3.5 to $4m for all accounts except LTC	Teresa Jacques	Met with HIM about $2m in unidentified accounts that are not the responsibility of HIM. Needs further attention.	We have identified the unbilled accounts and met again with HIM staff. All uncoded/unbilled are listed with issues. We are working to resolve issues ie physician queries, accounts with no charges, accounts with no reports.	No update	Complete (this issue primarily due to LTC patient receivables. We continue to monitor	In process
26	**RAC Monitoring and Medicare takebacks** - In working Medicare claims several accounts were noted where Medicare had taken back their inpatient payment	Alameda Staff and Business Office		The RAC process has been revisited and the staff have worked diligently over the last two weeks to re-address the RAC process. It has now been noted that $457,000 has been taken back on RAC claims. These claims have been sent to E.H.R. to be appealed. There are several claims in the meantime that will be re-billed as outpatient claims. 191 claims have been audited. 40% of the claims were determined to be appropriate.	The RAC process is still in process we have started our processes in the Business Office and our preparing our policies and procedures.	Business RAC Policy and Procedure draft presented to committee for review. Business Office participates in monthly RAC Status Meetings	On-going
	Waters Edge system conversion on Point Click Care.	Teresa Jacques				Attended several meetings over the last two weeks to plan responsibilites for implementing the PCC system and various other tasks that need to be completed for Finance and Bus Ofc for the April 1 start date. Trained on PCC last week and will be updating and/or building the database the week of March 26.	In process

DATE: March 26, 2012

TO: City of Alameda Health Care District, Finance and Management Committee

FOR: March 28, 2012 Finance and Management Committee

FROM: Deborah E. Stebbins, Chief Executive Officer
Mary Bond, RN, Executive Director of Nursing Services
Tony Corica, Director of Physician Relations

SUBJECT: Additional Information – Orthopedic Financial Analysis and Compensation Info

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As stated in the March 22, 2012 memorandum to the Finance and Management Committee, we are sending out under separate cover, the three-year financial analysis and assumptions for the comprehensive orthopedic program and the office practice. In addition, attached is a memorandum with the proposed compensation package for the two orthopedic surgeons.

Alameda Hospital Orthopedic Program Pro Forma 3/28/2012

	FTE	Year 1	FTE	Year 2	FTE	Year 3	Total	Source:
CLINIC								
Volume								
Sports - Office Visits		1,452		3,270		4,067	8,789	
Spine - Office Visits		1,171		2,163		2,756	6,090	
Total		2,623		5,433		6,823	14,879	All volume data for both office visits and procedures taken from physician projections for spine and sports medicine presented to Hospital Management from Practice and Liability Consultants
Sports - Office Procedure/Hospital Surgery		113		230		313	656	
Spine - Office Procedures/Hospital Surgery		104		205		278	587	
Total		217		435		591	1,243	
Physician Office Net Revenue								
Sports - Office Visit Professional Fee		177,144		398,940		508,375	1,084,459	Each physician's volume calculated at MCR rate of the average of the top 10 procedure codes for each specialty or $122 per visit for each physician
Spine - Office Visit Professional Fee		142,862		263,886		336,232	742,980	
Total		320,006		662,826		844,607	1,827,439	
Sports - Hospital Surgery Professional Fee		127,916		260,360		355,255	743,531	Dr. D. revenue calculated at $1132/procedure
Spine - Hospital Surgery Professional Fee		181,584		357,930		485,388	1,024,902	Dr. P. revenue calculated at $1746/procedure
Total		309,500		618,290		840,643	1,768,433	
Total Office Net Revenue		**629,506**		**1,281,116**		**1,685,250**	**3,595,872**	
Clinic Expenses	FTE		FTE		FTE			
Staff Salaries	2.5	95,680	3.5	122,720	4.5	243,360	461,760	YR 2-Add Medical Assistant; YR 3-Add Physician Assistant
Physician Salaries	2.0	600,000	2.0	582,000	2.0	739,000	1,921,000	
Total Salaries		695,680		704,720		982,360	2,382,760	
Benefits		187,834		190,274		265,237	643,345	27% of Total Salaries
Consulting & Legal - Practice Start up		17,000		-		-	17,000	
Supplies		25,000		25,750		26,523	77,273	
Purchased Services-Billing Company		47,213		96,084		126,394	269,690	
Rent		31,200		31,200		31,200	93,600	
Malpractice Insurance		19,000		27,000		40,000	86,000	
Contingency		20,000		20,000		20,000	60,000	
Total Non-Wage		347,247		390,308		509,353	1,246,908	
Total Clinic Expenses		**1,042,927**		**1,095,028**		**1,491,713**	**3,629,668**	
Clinic Direct Margin		**(413,421)**		**186,088**		**193,537**	**(33,796)**	

Alameda Hospital Orthopedic Program Pro Forma 3/28/2012

	Year 1	Year 2	Year 3	Total	Source:
HOSPITAL					
Volume					
Sports - Inpatient Surgery Cases	48	96	131	275	Volume based on a 70/30 split of the procedures predicted for each practice by
Spine - Inpatient Surgery Cases	48	96	131	275	D. Pharis (70% Surgery Cases-30% Office Procedures)
Sports - Outpatient Surgery Cases	28	56	76	160	YR 1-YR 2 volume increase 200%, YR2-YR 3 volume increase 136% as calculated
Spine - Outpatient Surgery Cases	26	52	71	149	by D. Pharis in procedure volume for each practice
Total Hospital Cases	150	300	408	858	
Total Cases Per Month	13	25	34	72	Total Cases per year divided by 12
Total Cases Per Week	3	6	9	18	Total Cases per year divided by 4
Hospital Surgery Case Net Revenue					
Sports - IP	667,200	1,334,400	1,814,784	3,816,384	Based on Alameda Hospital current Orthopedic average net revenue per case
Spine - IP	667,200	1,334,400	1,814,784	3,816,384	including all ancillary revenue directly related to the hospital surgery cases--
Sports - OP	111,776	223,552	304,031	639,359	lab, xray, physical therapy--does not include revenue from ancillary volume
Spine - OP	103,792	207,584	282,314	593,690	generated on an outpatient basis--see below
Total Hospital Surgery Case Net Revenue	**1,549,968**	**3,099,936**	**4,215,913**	**8,865,817**	
Ancillary Outpatient Volume & Revenue					
Total Radiology Exams	2,300	4,765	5,984	13,049	Volume based on 87.7% of office visit volume per CDC publication "National
Net Radiology Revenue	**446,272**	**924,360**	**1,160,852**	**2,531,483**	Health Statistics Report" #27 dated 11/3/2010
(Based on AH current net revenue for Xray)					Not surgical procedure or in-patient related
Physical Therapy Visits	4,142	8,478	10,960	23,580	Volume based on an average of 9 visits per Surgery and 2 visits per remaining
Net Physical Therapy Revenue	**111,834**	**228,906**	**295,920**	**636,660**	Office Visit (9 visits taken from Academy of Orthopedic Surgeons paper
(Based on AH current net revenue for PT)					"Benchmarking Physical Therapy Programs" July 2011 Issue)
Total Hospital Net Revenue	**2,108,074**	**4,253,202**	**5,672,685**	**12,033,960**	
Hospital Expenses					
Direct Variable Surgery Expenses - IP	604,800	1,209,600	1,645,056	3,459,456	Based on Alameda Hospital current average expenses for Orthopedic services
Direct Variable Surgery Expenses - OP	90,666	181,332	246,612	518,610	related to surgical and non-surgical patient encounters
Direct Variable Radiology Expenses	110,418	228,708	287,221	626,346	Based on Alameda Hospital current Imaging Department direct costs
Direct Variable PT Expenses	95,266	194,994	252,080	542,340	Based on Alameda Hospital current Rehab Department direct costs
Total Incremental Hospital Expenses	901,150	1,814,634	2,430,969	5,146,752	
Hospital Direct Margin	1,206,924	2,438,568	3,241,716	6,887,208	
Clinic Direct Margin	**(413,421)**	**186,088**	**193,537**	**(33,796)**	
Hospital Direct Margin	**1,206,924**	**2,438,568**	**3,241,716**	**6,887,208**	
Total Program Direct Margin	**793,504**	**2,624,656**	**3,435,253**	**6,853,412**	

COMPENSATION FOR SPORTS MEDICINE ORTHOPEDIST

1. **Base Compensation**. Physician's Base Compensation in Year One shall be Three Hundred Thousand Dollars ($300,000.00) per year. Physician Base Compensation in Years Two and Three shall be 70% of Year One Base, or Two Hundred Ten Thousand Dollars ($210,000) per year. Payment of Base Compensation shall be bi-weekly in the amount of 1/26 of Base Compensation, less applicable withholding.

2. **Physician Work RVU (WRVU) Threshold**. The WRVU Threshold shall be 7,000 per year.

3. **Incentive Bonus**. Once the Physician reaches the WRVU Threshold beginning in Year Two and years thereafter, Physician shall be paid an Incentive Bonus in the amount of forty-eight dollars ($48.00) for every WRVU over the WRVU Threshold as described in Section 2 above. WRVUs in excess of the WRVU Threshold shall be reviewed quarterly by Alameda Hospital Physicians (AHP) and interim Incentive Bonuses shall be paid to Physician based on progress during the quarter toward meeting the annual WRVU Threshold, reconciled for the full 12 months during the 4th quarter.

4. **Call Pay**. Physician's on-call pay for the days scheduled to provide general orthopedic coverage for patient care in the Emergency Room shall be at the rate established for general orthopedic coverage at Alameda Hospital. Physician's on-call pay for general orthopedic coverage at Alameda Hospital, or elsewhere as permitted hereunder, shall belong to, and be paid directly to, Physician and not to or through the Clinic. On-Call pay is not part of the Physician's Base Salary.

COMPENSATION FOR SPINE MEDICINE ORTHOPEDIST

1. **Base Compensation**. Physician's Base Compensation in Year One shall be Three Hundred Thousand Dollars ($300,000.00) per year. Physician Base Compensation in Years Two and Three shall be70% of Year One Base, or Two Hundred Ten Thousand Dollars ($210,000) per year. Payment of Base Compensation shall be bi-weekly in the amount of 1/26 of Base Compensation, less applicable withholding.

2. **Physician Work RVU (WRVU) Threshold**. The WRVU Threshold shall be 8,000 per year.

3. **Incentive Bonus**. Once the Physician reaches the WRVU Threshold beginning in Year Two and years thereafter, Physician shall be paid an Incentive Bonus in the amount of fifty dollars ($50.00) for every WRVU over the WRVU Threshold as described in Section 2 above. WRVUs in excess of the WRVU Threshold shall be reviewed quarterly by Alameda Hospital Physicians (AHP) and interim Incentive Bonuses shall be paid to Physician based on progress during the quarter toward meeting the annual WRVU Threshold, reconciled for the full 12 months during the 4th quarter.

4. **Call Pay**. Physician's on-call pay for the days scheduled to provide general orthopedic coverage for patient care in the Emergency Room shall be at the rate established for general orthopedic coverage at Alameda Hospital. Physician's on-call pay for general orthopedic coverage at Alameda Hospital, or elsewhere as permitted hereunder, shall belong to, and be paid directly to, Physician and not to or through the Clinic. On-Call pay is not part of the Physician's Base Salary.

Materials Distributed at FMC Meeting

March 28, 2012

Demographic Factors Affecting Orthopedics

1990

- 31.1 million Americans were 65 years of age or older
- 1 in 8 Americans was elderly
- 3.6 million people were estimated to be 85 years and over

2020

- 54 million Americans will be 65 years of age or older
- 1 in 6 will be elderly
- 18.2 million are estimated to be 85 years and over
- Arthritis will affect more than 18% of all people in the US (nearly 60 million)
- Demand for hip and knee replacements is expected to increase by 2020

From "Demographics: Shaping the Future of Physical Therapy", PT Magazine

Factors Affecting Orthopedics Going Forward

- Patients with an orthopedic conditions increased from 28% to 30% from 2001 to 2011

- Obesity
  - More than 44 million Americans are obese, an increase of 74% since 1991
  - 1991-- only 4 states had obesity rates of 15% or higher
  - 2001-- every state except Colorado showed obesity rates of 15% or more
  - 2001--29 states reported rates of 20% or greater

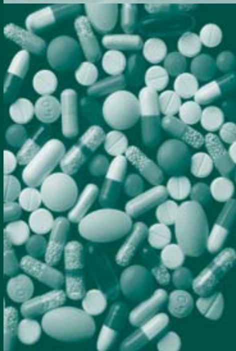
- Patients may also be undergoing joint replacement at a younger age, a trend that is exacerbated by rising obesity rates.

- One in three women and one in eight men aged 50 years and older will experience an osteoporotic related fracture in their lifetimes

National Ambulatory Medical Care Survey

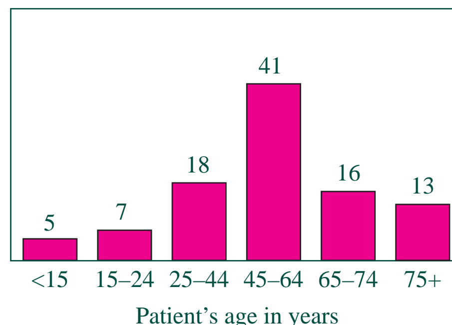
Factsheet

ORTHOPEDIC SURGERY



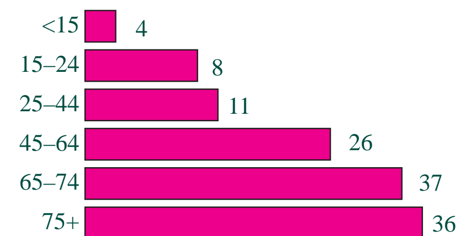
In 2009, there were an estimated 49 million visits to nonfederally employed, office-based physicians specializing in orthopedic surgery in the United States. More than half of the visits were made by persons aged 25–64 years.

Percent distribution of office visits by patient's age: 2009



The annual visit rate increased with age until age 74.

Annual office visit rates by patient's age: 2009



Number of visits per 100 persons per year

Primary expected source of payment included:

- Private insurance — 69%
- Medicare — 26%
- Workers' compensation — 10%
- Medicaid — 6%

The major reason for visit was:

- New problem — 35%
- Pre- or post-surgery/injury follow-up — 28%
- Chronic problem, routine — 20%
- Chronic problem, flare-up — 15%

The top 5 reasons given by patients for visiting orthopedic surgeons were:

- Knee symptoms
- Postoperative visit
- Shoulder symptoms
- Hip symptoms
- Back symptoms

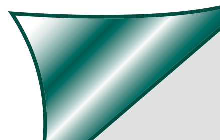
The top 5 diagnoses were:

- Arthropathies and related disorders
- Rheumatisms, excluding back
- Spinal disorders
- Sprains and strains
- Fracture of lower limb

Medications were provided or prescribed at 54 percent of office visits. The top 5 generic substances utilized were:

- Acetaminophen with hydrocodone
- Ibuprofen
- Acetaminophen with oxycodone
- Meloxicam
- Lidocaine

For more information, contact the Ambulatory Care Statistics Branch at 301-458-4600 or visit our Web site at <www.cdc.gov/namcs>.



NAMCS data are widely used in research studies appearing in nationally recognized medical journals, including *JAMA, Journal of Family Practice,* and *Spine*. Here are just a few publications using NAMCS data:

Friedman BW, Chilstrom M, Bijur PE, Gallagher EJ. Diagnostic testing and treatment of low back pain in United States emergency departments: a national perspective. *Spine* (Phila Pa 1976). 35(24):E1406–11. Nov 2010.

Sacks JJ, Luo YH, Helmick CG. Prevalence of specific types of arthritis and other rheumatic conditions in the ambulatory health care system in the United States, 2001–2005. *Arthritis Care Res* (Hoboken). 62(4):460–4. Apr 2010.

Licciardone JC. The epidemiology and medical management of low back pain during ambulatory medical care visits in the United States. *Osteopath Med Prim Care*. 2(1):11. Nov 2008. [Epub ahead of print]

Avasarala J, Odonovan CA, Roach S, Camacho F, Feldman S. Analysis of NAMCS data for Multiple Sclerosis, 1998–2004. *BMC Med*. 5(1):6. Apr 2007. [Epub ahead of print]

Riddle DL, Schappert SM. Volume and characteristics of inpatient and ambulatory medical care for neck pain in the United States: data from three national surveys. *Spine*. 32(1):132–40; discussion 141. Jan 2007.

Deyo RA, Mirza SK, Martin BI. Back pain prevalence and visit rates: estimates from U.S. national surveys, 2002. *Spine*. 31(23):2724–7. Nov 2006.

Federman AD, Litke A, Morrison RS. Association of age with analgesic use for back and joint disorders in outpatient settings. *Am J Geriatr Pharmacother*. 4(4):306–15. Dec 2006.

Wofford JL, Mansfield RJ, Watkins RS. Patient characteristics and clinical management of patients with shoulder pain in U.S. primary care settings: Secondary data analysis of the National Ambulatory Medical Care Survey. *BMC Musculoskelet Disord*. 6(1):4. Feb 2005. [Epub ahead of print]

Caudill-Slosberg MA, Schwartz LM, Woloshin S. Office visits and analgesic prescriptions for musculoskeletal pain in US: 1980 vs. 2000. *Pain*. 109(3):514–9. Jun 2004.

Riddle DL, Schappert SM. Volume of Ambulatory Care Visits and Patterns of Care for Patients Diagnosed With Plantar Fasciitis: A National Study of Medical Doctors. *Foot and Ankle Int'l.* 25(5):303–310. 2004.

Freburger JK, Holmes GM, Carey TS. Physician referrals to physical therapy for the treatment of musculoskeletal conditions. *Arch Phys Med Rehabil*. 84(12):1839–49. Dec 2003.

The complete list of publications using NAMCS data, which includes hundreds of articles and reports, is available on our Web site.

Alameda Hospital

Budget Volume Assumptions

FYE 2013

- FY 2013 Baseline Budget even with FY 2012 Forecast
  - Adjustment to FY 2013 CT Scan and Radiology Visits to account for remodeling downtime in Fall 2011

- Separate 3 West Nursing Unit into 3 Medical and 3 Surgical

- Expansion of Orthopedic Program with two new physicians in the fall
  - Additional 96 surgeries, patient stay average 4.4
  - Outpatient Therapy and Imaging visits

- Implementation of Wound Care Program July 1, 2012
  - Additional 1 inpatient per month
  - Outpatient Wound Clinic visits, plus laboratory, therapy and imaging visits

- Water’s Edge long term care under Hospital umbrella on April 1, 2012
  - Projections based on pro forma as no history under Alameda Hospital yet

Alameda Hospital
Inpatient Acute Volume Summary
FY 2013 Budget

	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments: Ortho Program	Adjustments: Wound Care	Adjusted Budget FY 2013
Discharges - Acute	2,802	2,527	2,787	2,781	96	12	2,889
ALOS - Acute	3.8	4.1	4.0	4.0	4.4	3.0	4.0
Patient Days - Acute							
CCU	1,406	1,552	1,485	1,485	-	-	1,485
DOU	4,445	4,023	4,128	4,128	-	-	4,128
3 West	4,728	4,868	5,534		-	-	-
3 Medical				4,781	-	36	4,817
3 Surgical				730	422	-	1,152
Total Acute	10,579	10,443	11,146	11,124	422	36	11,582
Average Daily Census							
CCU	3.9	4.3	4.1	4.1	-	-	4.1
DOU	12.2	11.0	11.3	11.3	-	-	11.3
3 West	13.0	13.3	15.1		-	-	-
3 Medical				13.1	-	0.1	13.2
3 Surgical				2.0	1.2	-	3.2
Total Acute	29.0	28.6	30.5	30.5	1.2	-	31.7
Available Beds	66	66	66	66	-	-	66
Occupancy Percent	43.9%	43.3%	46.1%	46.2%			48.1%
CMI - Medicare	1.4174	1.4256	1.3594				
CMI - Total	1.3398	1.3332	1.2955				

Notes:

For comparability purposes, Kaiser volume has been excluded from prior years.

Alameda Hospital
Inpatient Long-Term Care Volume Summary
FY 2013 Budget

	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments	Adjusted Budget
Discharges						
Sub-Acute	13	24	52	52		52
South Shore	128	109	74	74		74
Water's Edge	-	-	33	132		132
Total Long Term Care Discharges	141	133	159	258		258
Patient Days						
Sub-Acute	11,977	11,861	11,898	11,898		11,898
South Shore	7,832	7,965	7,882	7,882		7,882
Water's Edge	-	-	8,159	38,774		38,774
Total Long Term Care Days	19,809	19,826	27,939	58,554		58,554
Average Daily Census						
Sub-Acute	32.8	32.5	32.5	32.6		32.6
South Shore	21.5	21.8	21.5	21.6		21.6
Water's Edge (1)	0.0	0.0	89.7	106.2		106.2
Total Average Daily Census	54.3	54.3	143.7	160.4		160.4
Payer Mix						
Sub-Acute						
Medicare	1%	1%	1%	1%		1%
Medi-Cal	94%	94%	96%	96%		96%
Other	5%	5%	3%	3%		3%
South Shore						
Medicare	14%	14%	14%	19%		19%
Medi-Cal	85%	85%	85%	80%		80%
Other	1%	1%	1%	1%		1%
Water's Edge						
Medicare	n/a	n/a	10%	13%		13%
Medi-Cal	n/a	n/a	81%	76%		76%
Other	n/a	n/a	10%	11%		11%
Available Beds (1)	60	60	170	170		170
Occupancy Percent	90.5%	90.5%	84.5%	94.4%		94.4%

1) Water's Edge to begin operation under Alameda Hospital license April 1, 2012, projected at 91 calender days and 110 beds

Alameda Hospital
Surgery & Outpatient
FY 2013 Budget

	Actual FY 2009	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments Ortho Program	Adjustments Wound Care	Adjusted Budget FY 2013
ECC Visits	17,337	17,624	16,816	16,800	16,800	-	-	16,800
Outpatient Registrations	29,948	29,079	23,796	22,950	23,839	5,910	696	30,445
Per Day								
ECC	47.5	48.3	46.1	45.9	46.0	-	-	46.0
Registrations	82.0	79.7	65.2	62.7	65.3	16.2	1.9	83.4
Surgeries								
Inpatient	588	592	502	468	468	96	-	564
Outpatient	1,288	1,351	1,708	1,807	1,807	54	-	1,861
Total	1,876	1,943	2,210	2,274	2,274	150	-	2,424

Alameda Hospital
Five Year Detail Trend of Outpatient Visits + Budget

	Actual FY 2009	Actual FY 2010	Actual FY 2011	Projected FY 2012	Baseline Budget FY 2013	Adjustments: Ortho Program	Adjustments: Wound Care	Adjusted Budget FY 2013
ATC Satellite Lab	167	2,617	3,145	143	-	-		-
Cardio Fit	1,330	1,337	1	-	-	-		-
CT Scan	567	525	483	440	460	787		1,247
EEG	-	-	-	24	24			24
EKG	867	892	865	823	823			823
IV Therapy	2,027	1,676	1,132	891	891			891
IVT Other	-	386	735	772	772			772
Laboratory	9,830	6,560	5,800	7,846	7,846		200	8,046
MRI	479	454	501	545	545	938		1,483
Nutrition	22	12	14	33	33			33
Nuclear Medicine	213	125	161	148	148		38	186
Outpatient - Clinic	22	16	344	631	631			631
Occupational Therapy	472	451	479	301	301			301
Physical Therapy	3,515	3,381	3,046	3,084	3,084	4,142	30	7,256
Respiratory Therapy	80	177	73	79	79			79
Speech	75	20	28	63	63			63
Surgery	5,184	4,182	1,672	1,780	1,780			1,780
Ultrasound	33	1,194	1,200	1,201	1,201			1,201
Radiology	8,565	7,174	7,035	6,207	7,300	575	138	8,013
Wound Care	-	-	-	-	-		2,500	2,500
Other	83	1,587	30	4	4			4
Total Visits	33,531	32,766	26,744	25,011	25,985	6,442	2,906	35,333
O/P Registrations	29,951	29,082	23,796	22,950	23,839	5,910	696	30,445