CITY OF ALAMEDA HEALTH CARE DISTRICT

PUBLIC NOTICE

CITY OF ALAMEDA HEALTH CARE DISTRICT BOARD OF DIRECTORS

REGULAR MEETING AGENDA

Monday, May 7, 2012

6:00 p.m. (Closed) | 7:30 p.m. (Open)

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 and present to the District Clerk. This will ensure your opportunity to speak. Please make your comments clear and concise, limiting your remarks to no more than three (3) minutes.

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

II. Roll Call — Kristen Thorson

III. Adjourn into Executive Closed Session

IV. Closed Session Agenda

A. Call to Order

B. Approval of Closed Session Minutes
   1. March 31, 2012 (Special)
   2. April 2, 2012 (Regular)

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

D. Board Quality Committee Report (BQC) — H & S Code Sec. 32155

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

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

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

H. Discussion of Report Involving Trade Secrets — H & S Code Sec. 32106
   1. Discussion of Hospital Trade Secrets applicable to District's Strategy for Delivery of New Programs and Services
      No action will be taken.
      Estimated Date of Public Disclosure: *Not known at this time.*

I. Adjourn into Open Session

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

A. Announcements from Closed Session — Jordan Battani

VI. General Public Comment

VII. Regular Agenda

A. Consent Agenda — **ACTION ITEMS**

✔ 1) Approval of April 2, 2012 Regular Meeting Minutes
[enclosure] (PAGES 3-11)

✔ 2) Approval of March 31, 2012 Special Meeting Minutes
[enclosure] (PAGE 12)

✔ 3) Acceptance of the 2011 Environment of Care Annual Report
[enclosure] (PAGES 13-42)

✔ 4) Approval of Revisions to the City of Alameda Health Care District Policy #2008-0b - Signature Authority
[enclosure] (PAGES 43-45)

✔ 5) Approval to Enter into a Contract with MuirLab for Reference Lab Work
[enclosure] (PAGES 46-47)

✔ 6) Approval of the 2012 Continuing Medical Education Program Mission Statement
[enclosure] (PAGES 48-49)

✔ 7) Approval of Revisions to Medical Staff Rules: Article 2, Anesthesia Service
[enclosure] (PAGES 50-53)

B. Action Items

✔ 1) Acceptance of March 2012 Unaudited Financial Statements and April 25, 2012 Finance and Management Committee Report — J. Michael McCormick
[enclosure] (PAGES 54-74)

✔ 2) Approval to Enter into an Agreement with Select Therapies for Long Term Care Rehabilitation Services Management — Kerry Easthope
[enclosure] (PAGES 75-82)

✔ 3) Approval of Revisions to the Terms and Conditions of the Orthopedic Professional Service Agreements and Authorization to Execute Such Agreements — Tony Corica
[enclosure] (PAGES 83-87)

✔ 4) Approval of Proposed FY 2012 Executive Performance Metrics and Incentive Compensation Plan — Michael McCormick, Elliott Gorelick
[enclosure] (PAGES 88-89)

C. District Board President Report INFORMATIONAL — Jordan Battani

✓Included in the PDF posted May 4, 2012

D. Chief Executive Officer Report **INFORMATIONAL** — Deborah E. Stebbins

✔ 1) Monthly CEO Report

[enclosure] (PAGES 90-94)

- Reports and Updates on Executive Re-Organization, Schedules and Events, Community Outreach, Local Hospitals, Wound Care, Seismic and Other Regulatory Compliance Planning Activities, April Key Stats

2) District Board Meeting Scheduling Discussion

G. Medical Staff President Report **INFORMATIONAL** — James Yeh, DO

F. Community Relations and Outreach Committee Report **INFORMATIONAL** — Stewart Chen, DC

1) April 24, 2012 Committee Meeting

VIII. General Public Comments

IX. Board Comments

X. Adjournment

CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the City of Alameda Health Care District Board of Directors
Open Session
Monday, April 2, 2012 Regular Meeting

Board Members Present	Management Present	Legal Counsel Present	Guests
Jordan Battani Stewart Chen, DC Robert Deutsch, MD Elliott Gorelick J. Michael McCormick	Deborah E. Stebbins Bob Anderson	Thomas Driscoll, Esq.	N/A
		Medical Staff Present	**Excused**
		Jim Yeh, DO	Kerry J. Easthope
Submitted by: Erica Poncé, Administrative Secretary			

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	Topic	Discussion	Action / Follow-Up
I.	Call to Order	The meeting was called to order at 6:07 p.m.	
II.	Roll Call	Ms. Thorson called roll noting a quorum of Directors was present.	
III.	Adjourn into Executive Closed Session	The meeting was adjourned into Executive Closed Session at 6:08 p.m.	
IV.	Closed Session Agenda		
V.	Reconvene to Public Session	The meeting was reconvened into public session at 7:31 p.m.	

A. Announcements From Closed Session

Director Battani stated that the Minutes were reviewed and approved from the March 5, 2012 meeting. The Board Quality Committee Report for January 2012 was reviewed and accepted as presented. The Board approved the Credentialing Recommendations of the Medical Staff as outlined below. No other action was taken.

Initial Appointments – Medical Staff

	Name	Specialty	Affiliation	

Topic	Discussion			Action / Follow-Up
	• Susan Cha, MD	Radiology/Teleradiology	Bay Imaging	
	• Henry Turkel, MD	Emergency Medicine	CEP	
Reappointments – Medical Staff				
	Name	Specialty	Staff Status	Appointment Period
	• Darien Behravan, MD	Pain Management	Courtesy	05/01/12 – 04/30/14
	• Eric Dovichi, MD	Radiology	Courtesy	05/01/12 – 04/30/14
	• William Sellman, MD	Family Medicine	Active	05/01/12 – 04/30/14
	• Naini Sharma, MD	Internal Medicine	Courtesy	05/01/12 – 04/30/14
	• Charles Shih, MD	ENT/Plastic Surgery	Courtesy	05/01/12 – 04/30/14
	• Michael Zimmerman, MD	Family Medicine	Active	05/01/12 – 04/30/14
Reappointment - Allied Health Professional There were no applications submitted for reappointment to Allied Professional status.				
Resignations				
	Name	Specialty		
	• Benjamin Hornik, MD	Plastic Surgery (Kaiser)		
	• Jane Kim, MD	Plastic Surgery (Kaiser)		
	• Sophia Kung, MD	Teleradiology		
VI. Regular Agenda				
A. Special Presentation				

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Topic	Discussion	Action / Follow-Up
	1) Annual Auxiliary Report to the Board Linda Lingelser, Auxiliary President, presented the Annual Auxiliary Report. She reported that there are currently 85 members and are beginning a drive to increase membership. In response to President Battani's question regarding the Tele-Chat program, Ms. Lingelser stated that "Tele-Chat" is a new program being initiated. Volunteers will make friendly calls to people free of charge. The program will focus on persons living alone and with health concerns. The auxiliary team is also planning on assessing needs for volunteers at Waters Edge. Ms. Lingelser presented Ms. Stebbins with a check in the amount of $40,000 as a donation to Alameda Hospital from the Alameda Hospital Auxiliary.	
B. Consent Agenda		
	1) Acceptance of March 5, 2012 Regular Meeting Minutes	Director Deutsch made a motion to approve the Consent Agenda as presented. Director McCormick seconded the motion. The motion carried.
	2) Approval of Annual Appointment of Committee Membership of the Community Relations and Outreach Committee	
	3) Approval of Amendments to the Medical Staff Rules and Regulations, Article I-A, Section B.1 and Article 16, Section H	
	4) Ratification of Appointment of District Board Member Elliott Gorelick to ACHD 2012-2013 Education Committee	
C. Action Items		
	1) Acceptance of February 2012 Unaudited Financial Statements and March 28, 2012 Finance and Management Committee Report Director McCormick reviewed his notes from the March 28th committee meeting noting the following: The February 2012 Unaudited Financial Statements were reviewed for discussion and analysis at the Finance and Management committee meeting of March 28, 2012. The positive impact of higher activity made it possible to exceed February's budget by $169,000. A negative $6,000 was budgeted and a positive $175,000 was realized. Gross revenues were above budget for the second month in a row with inpatient	Director Chen made a motion to accept the February 2012 Unaudited Financial Statements as presented. Director Deutsch seconded the motion. The motion carried.

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Topic	Discussion	Action / Follow-Up
	revenue up 4.2% and outpatient revenue up 0.8%. Inpatient surgeries were above budget by 11.4%. YDT is below budget by 8.6%. Emergency revenues were above budget and contributed to a rise of outpatient volumes (which had been showing a below budget YTD of 6%) rising to below budget of 1% for the month. Case Mix Index rose above budget for the second month in a row to 1.3572%. Expenses continue to outperform budget. YTD expenses are down $98,000. Days-cash-on-hand went from 13.8 days to 12.4 days. However, March daily collections are expected to be up considerably partly due to a change in the charge master to more appropriately price our services which will improve reimbursements and lead to an increase in days-cash-on-hand in the next quarter. Current Ratio (current assets divided by short term liabilities) moved upward from an unhealthy 0.99 to a slightly less unhealthy 1.03. Therefore, we have met the bank's benchmark of 1.0 which enables us to continue the Wound Care project with funding on track. At the end of February 2011, the District's YTD was at a loss of $337,000. At the end of February 2012, the District's YTD loss is at $711,000. This time next year, with the addition of both Water's Edge and the Wound Care Center in a maturing operational mode, it is reasonable that the revenue generated should offset today's YTD budget loss. It should also move us closer to a conservatively projected financial position at the breakeven point and a more balanced projected financial position of almost safely in the black. There was a short discussion with clarification given by management regarding information found in the report.	
2)	Approval to Establish a Comprehensive Orthopedic Program at Alameda Hospital and Approval to Enter into Professional Services Agreements with Two Orthopedic Surgeons There was a speaker card presented with a request to speak regarding the establishment of an orthopedic program. President Battani introduced the speaker, Pat Reynolds, Operating Room Manager of Alameda Hospital. Ms. Reynolds spoke in favor of a Comprehensive Orthopedic Program and in favor of the two orthopedic surgeons the Hospital is considering. Ms. Stebbins stated that management has identified that creating a strong orthopedic program will be a benefit to the Hospital. This program was discussed in detail at the recent Finance and Management Committee which recommended it to go forward as a presentation to the District Board. Ms Stebbins introduced Tony Corica, Director of	Director Gorelick made a motion to move forward with management's recommendation to establish an orthopedic program and to negotiate as per management's recommendation with Dr. DiStefano and Dr. Pirnia. Director McCormick seconded the motion. The motion carried.

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Topic	Discussion	Action / Follow-Up
	Physician Relations and Mary Bond, RN, Executive Director of Nursing. Mr. Corica and Ms. Bond gave a PowerPoint presentation and also handed out material for review. Director Gorelick asked if the purpose of the presentation was to approve management to move forward with negotiations. Mr. Corica responded that if authorized, they would move forward with negotiations tomorrow. Ms. Stebbins added that management feels they will reach an agreement and asked Mr. Corica to speak about the specifics of the contracts, noting that it is a standard form which the Hospital has used in the past. Mr. Corica then reviewed the proposed contract beginning on page 56 of the Board Packet highlighting details which pertain to compensation including base salaries and incentive compensation. Discussion continued regarding details of the professional services agreement. Mr. Driscoll clarified that the contract between Alameda Hospital and each physician will be "employment-like" but is not a traditional employment contract. In the State of California, hospitals do not have employment contracts with physicians and our agreement will be a Professional Services Agreement that would contain reporting and accountability standards between the Physician and the Hospital. Alameda Hospital management will be responsible to assist in the set-up and maintenance of the practice, while not dictating how the physicians will practice medicine. Management will provide guidance and oversight. Director Chen questioned the purpose for the two physicians coming to Alameda Hospital. Mr. Corica answered that Alameda Hospital presents an opportunity to the physicians to develop an orthopedic program. These physicians have a positive history with the Hospital and the surgical staff. They both have worked well with our staff in the past. Ms. Stebbins added that the physicians are attracted to the area and the demographics are great for establishing a new practice. Ms. Bond stated that there are great market opportunities for establishing a new group, and their salary and benefits are clearly identified, unlike if they were to enter into a private practice on their own. This situation is beneficial to the physicians as well as Alameda Hospital. Director Chen asked if current staffing levels could support the increased volume. Discussion followed regarding additional staff required to support this program. Ms. Bond stated that the current staffing levels are sufficient to support the projected volumes outlined in the pro forma. President Battani raised concerns regarding productivity standards, incentive base for work RVU's and salary. She requested that the contract reflect specific detailed language in these areas for the purpose of accountability on behalf of both the physicians and the Hospital.	

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Topic	Discussion	Action / Follow-Up
	Director Deutsch expressed concern relating to the physicians' roles in management, marketing, networking and referrals. Ms. Stebbins reaffirmed that Hospital management would assist in marketing and management of the practice.	
The Board recessed for a brief break at 8:49 p.m. and returned to session at 8:54 p.m.		
	3) Approval of Proposed FY 2012 Executive Performance Metrics and Incentive Compensation Plan Ms. Stebbins presented the proposed plan on pages 64-67 of the Board Packet, calling attention to the five general deliverables. Director Gorelick inquired as to which part(s) are not subject to pass/fail. Ms. Stebbins stated that Water's Edge would not be subject to pass/fail. There was discussion regarding wage increases to all staff. President Battani added that this discussion is not about financial decisions with other staff members and is not about whether or not to have an Executive Performance Compensation Plan. This plan is written into the contract of the Chief Executive Officer. She added that the Hospital needs to have the available funds to cover incentives. She stated that she does not think it is appropriate to waiver from pass/fail at this time. Director Gorelick stated that in his opinion, all incentives should be pass/fail. He does not feel that anything is at risk unless this standard is upheld and that every year prior was based on pass/fail. President Battani asked for two volunteers from the Board who will meet with Ms. Stebbins to draft a proposal which will reflect a method for a deferral of incentive payment which will be complete before the May District Board Meeting. Directors McCormick and Gorelick volunteered and will organize themselves and then consult with Ms. Stebbins. Ms. Stebbins suggested that the two Board Members consult each other to formulate a proposal first and then arrange a meeting with her.	Agenda item was deferred to a future Board Meeting. Directors McCormick and Gorelick will consult with each other and then schedule a meeting with Ms. Stebbins to draft a proposal to reflect the statements discussed.
Director Gorelick excused himself from the meeting at 9:30 p.m.		
C. Board President Report Director Battani did not have a report.		
D. Chief Executive Officer Report 1) FY 2012 Goals and Objectives 2nd Quarter Update		No action taken.

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Topic	Discussion	Action / Follow-Up
	Directed Board Members to pages 68-77 in packet noting that updates are highlighted in yellow. 2) Update on Management of Rehabilitation Services Management has met with Rehab Department Staff. It has been recognized that it is appropriate to separate long-term rehab from inpatient and outpatient rehab services. Management will continue to explore rehab management through Select Therapies with a thorough proposal including a financial analysis. A leadership role for inpatient and outpatient rehab services will be posted to see if there is an internal candidate first. 3) Monthly CEO Report Ms. Stebbins called attention to the report found on pages 81-92 of the packet, adding that the AB-97 Resolution has statistical projections for March which turned out to be a less favorable month although average daily census seems to be picking up now. 4) Monthly Quality Metrics A report on Alameda Hospital's Stroke Program was presented by Michaele Baxter, RN, Stroke Coordinator. Information was handed out and is included in the Board Packet.	
E.	Medical Staff President Report James Yeh, DO, Medical Staff President, stated that the CME programs for April are slated for April 10 and April 24 with the following speakers presenting: • April 10 - John Salzman, MD – Breast Cancer and Radiation Therapy • April 24 - Speaker and topic to be announced	No action taken.
F.	Community Relations and Outreach Committee Report Director Chen reported on the March 27, 2012 Community Relations and Outreach Committee noting the following: Deborah Stebbins presented an update on Alameda Hospital at the committee meeting. She discussed challenges, the hospital's financial picture, strategies for growth and partnering, program development and community outreach. Alameda Hospital has begun to utilize social media (Facebook and Twitter) to announce community events and programs. A direct mail postcard is being developed which will highlight Waters Edge and senior services. The Let's Move Alameda 2012 initiative will focus on a community-wide	No action taken.

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Topic	Discussion	Action / Follow-Up
	pledge for a healthy lifestyle. Community members and organizations throughout Alameda will be encouraged to take the pledge. A volunteer appreciation reception will be held on April 17, 2012 in Conference Room A. This event is to recognize volunteers including District Board members, Board committee members, Foundation Directors, and Alameda Hospital Auxiliary. The Alameda Hospital Foundation is accepting nominations for this year's Kate Creedon award. This annual award recognizes individuals who have made a positive impact on the health care of Alameda citizens and will be presented at the Foundation's Annual Fall Gala.	
VII. **General Public Comments** There were no additional comments.		
VIII. **Board Comments** There were no comments.		
IX. **Adjournment**	Being no further business, the meeting was adjourned at 9:47 p.m.	

Attest:

____
Jordan Battani
President

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Elliott Gorelick
Secretary

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CITY OF ALAMEDA HEALTH CARE DISTRICT

Minutes of the Board of Directors

March 31, 2012
SPECIAL MEETING
Alameda Boys and Girls Club, Alameda. CA

Directors Present:

Jordan Battani
Elliott Gorelick
Stewart Chen, DC
J. Michael McCormick
Robert Deutsch, MD

Legal Counsel Present:

Thomas Driscoll, Esq.

Management:

Deborah E. Stebbins
Kerry Easthope
Dennis Eloe

Medical Staff:

James Yeh, DO

Guests:

Panos Lykidis, Camden Group

Submitted by: Kristen Thorson

Topic	Discussion	Action / Follow-Up
I. Call to Order	Jordan Battani called the Open Session of the Board of Directors of the City of Alameda Health Care District to order at 8:00 a.m.	
II. Roll Call	Kristen Thorson called roll, noting that a quorum of Directors were present.	
III. Closed Session Agenda	The meeting was adjourned into Executive Closed Session at 8:01 a.m.	
IV. Reconvene to Public Session	The meeting was reconvened into public session at 11:55 a.m. A. Announcements from Closed Session	Director Battani reported that there was no action taken in closed session.
X. Board Comments	None	
VI. General Public Comments	None	
XII. Adjournment	A motion was made to adjourn the meeting and being no further business, the meeting was adjourned at 11:56 a.m.	

Attest:

Jordan Battani
President

Elliott Gorelick
Secretary

DATE: April 30, 2012

FOR: May 7, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Kerry Easthope, Chief Financial Officer

SUBJECT: Acceptance of the 2011 Environment of Care Annual Report

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The Hospital Safety Committee hereby submits the enclosed 2011 Annual Environment of Care (EOC) report for acceptance by the District Board of Directors. The primary objective of the Safety Committee is to assess various elements of the Hospital to ensure a safe environment for patients, employees and visitors. The committee meets bi-monthly, or more often as needed. At these meetings, each sub-committee reports on its activities and progress toward achieving its established goals, as well as any other relevant events that require committee discussion and action. The activities and sub-committees of the Safety Committee are defined by the Joint Commission standards for Environment of Care. The activities of the sub-committees are then summarized into an annual report which includes key accomplishments and goals for the upcoming year.

Enclosed are sub-committee annual reports covering the following areas of Environment of Care:

- Emergency Management
- Medical Equipment Management Plan
- Utilities Management
- Fire / Life Safety Management
- Human Resources Safety Plan
- Hazardous Materials and Waste Management (HAZMAT)
- Security Management
- Staff Education and Training
- Infection Control

There has also been an exerted effort to have greater employee involvement in emergency management education and exercises. Gloria Williams, Emergency Management Coordinator, has done a commendable job providing staff in each department with emergency management education throughout the year. In addition, Environment of Care will be a key participant in the hospital-wide Safety Fair and Joint Commission Fair which will be held later in 2012, in preparation for our 2013 Joint Commission Accreditation Survey.

Of particular noteworthiness during 2011, we had improvement/success with our HAZMAT initiatives, employee injury rates, infection control and emergency management.

The HAZMAT committee was able to maintain current the hospitals Material Safety Data Sheets (MSDS) online. All new and existing staff continues to be in-serviced on how to use spill kits, based upon the types of chemicals used in their area. There were two “code orange” HAZMAT drills conducted during 2011.

During 2011, there were eight (8) blood borne pathogen exposures. Our Infection Preventionist, Rosemarie Delahaye, has done a commendable job educating and training staff on the proper precautionary measures to minimize these exposures.

The Hospital is required to participate in a number of emergency management drills throughout the year. In 2011, we had two major disaster drills. We also participated in the Statewide Medical Health Disaster Drill, the City of Alameda Disaster Drill and a County-wide table top exercise. These have allowed the hospital to identify areas of strength, as well as areas that need improvement in order to be successful in the event of an actual disaster or large scale emergency. Participation with other local and state agencies provides valuable training on interaction and communication with other agencies in the event an emergency disaster situation.

Bio- Medical Management continues to achieve greater than 95% compliance on timely completion of preventative maintenance checks and repairs. This has allowed our equipment and medical systems to remain in good operational order, preventing disruption to service while ensuring a safe Environment of Care for our patients and staff.

The committee’s meetings and activities are organized and well-documented. It is our goal to maintain a high level of preparation and progress to ensure a safe Environment of Care during the 2012 calendar year and to expand our programs to Waters Edge once it becomes part of Alameda Hospital.

Alameda Hospital
Emergency Preparedness Subcommittee
Annual Report 2011

I. Summary of Effectiveness

Alameda Hospital is committed to providing a safe, accessible, effective and efficient environment of care program consistent with its mission, service and applicable governmental mandates. This includes fostering the protection, safety and well-being of patients, visitors, physicians, personnel, and volunteers and adhering to our social responsibility and commitment to the community.

The basis of the Emergency Management Disaster Program is to ensure effective mitigation, preparation, response and recovery in all disasters or emergencies affecting the environment. An "all hazards" approach is utilized to support a level of preparedness sufficient to address a wide range of emergencies regardless of the cause. Emergency planning includes planning and management of the six critical areas of emergencies as identified by the Joint Commission: communication, resources and assets, safety and security, staff roles and responsibilities, utilities, and clinical activities.

II. Scope

The scope of the Emergency Management Plan addresses issues for patients, visitors, physicians, personnel, volunteers, and property. Program administration is delegated by the Safety Committee to the Safety Officer, Emergency Management Coordinator and Emergency Management Subcommittee. The Alameda Hospital EM program personnel work in collaboration with the City of Alameda, Alameda County Emergency Medical Services Agencies, Public Health Department, Bay Area Health Care Facilities and other State and Federal agencies

III. Major Accomplishments 2011

a. Drills/Events

    i. Two major Disaster Events – O2 disruption due to pressure relief valve malfunction and ECC overload due to sudden influx of patients. Both events were well managed utilizing HICS and patient care was not comprised or deficient.

    ii. Participated in one Statewide Medical Health Disaster drill – Water disruption due to contamination at Community level.

    iii. Participated in City of Alameda disaster drill.

    iv. Participated in one County-wide Table-Top disaster Drill

b. HVA Annual, Review, and Revision completed in collaboration with City, County, and Bay Area Health Care Facilities.

c. Successfully met EOC requirements for State Licensing and Certification Survey in October.

d. Continue to attend and participate in City, County, and Community Disaster Planning meetings and discussions (see attached list of community meetings).

e. Met requirements to receive maximum reimbursement to the Hospital from annual HPP Grant.

f. Received additional PAPRS (high efficiency filters) to replace outdated items from HPP grant per request.

g. Received Disaster Tag Kit from HPP as result of active collaborative participation in DPHC (Disaster Preparedness Health Care Coalition)

IV. 2011 Objectives and Goals

A. Increase number of Tabletop Drills/Exercises	No increase in number.
B. Provide more internal drills.(Code Yellow, Code Orange, etc.)	Internal drills increased by two
C. Provide Disaster Preparedness Provide Disaster Preparedness	100% Nursing Supervisors Review for Nursing Supervisors in depth review in December.
D. Increase communication to staff	Disaster Preparedness Review Module added to Annual Nursing Update Classes. Disaster information shared in Clinical Newsletters regularly.
E. Meet requirements for HPP Grant For Health Care Facilities	Requirements met for maximum reimbursement.

V. 2012 Goals and Objectives

A. Increase number of Tabletop Drills/Exercises
B. Include Waters Edge SNF in Disaster Preparedness EOC program
C. Representation from South Shore and Waters Edge to attend at least one Disaster Preparedness Committee meeting per quarter.
D. Increase Alameda Hospital staff knowledge and ability to communicate with County EOC, City EOC, and Bay Area HCF during disaster
E. Review/Revise/Update department specific disaster plans as needed to increase knowledge and ability to function at the department level.
F. Continue to collaborate with city, county, and Bay Area multi-jurisdictional hazard mitigation planning.
G. Meet requirements for maximum reimbursement from HPP grant

Alameda Hospital
Medical Equipment Management Plan
Annual Evaluation Report
2011

Objectives:

The objectives of the Medical Equipment Management Plan are designed to provide an Environment of Care that is safe for patients, staff and visitors of the medical center. Specific objectives for 2011 were:

OBJECTIVES	THRESHOLD	MET	NOT MET	ACTION PLAN
Minimize could not locate devices	< 5%	YES		
Capturing all incoming medical equipment for safety/performance testing	100%		YES	Request the assistance of EOC members to meet objective

Scope:

The scope of the Medical Equipment Management Plan is to test and ensure the operating safety of all clinical equipment utilized in the hospital according to requirements set fort by The Joint Commission (TJC), Occupational Safety and Health Act (OSHA), Nation Fire Prevention Association (NFPA), College of American Pathology (CAP), state law, and the equipment manufacturer.

Performance:

Performance of the Medical Equipment Management Plan included the below measurable Performance Indicators during 2011:

Performance Indicator	**Compliance Rate**
• Measure the completion rates of Planned Maintenance for medical devices	97.6%
• Measure the Corrective Maintenance for medical devices	95.9%

Effectiveness:

The effectiveness of the Medical Equipment Management Plan and the 2011 Opportunities for Improvement were reviewed and found to be successful in contributing to the overall safety of the Environment of Care and patient safety. Specifically:

- The development and implementation of the proactive communication with departmental managers on ways of helping to minimize the "could not locate" equipments.
- The development and implementation of educating department managers and charge nurses on the need to capture all incoming medical devices for electrical safety and performance testing to prevent any possible safety issues.
- Focus on prioritizing service request to eliminate longer turn around time of medical devices which resulted in timely availability of medical equipments for patient use.
- Establishing a process of renting devices in cases of extended period of service time.

Summary of Activities:

- Met the Medical Equipment Management Plan set forth in the 2011 Annual Report.

- Met the Medical Equipment Management Plan Opportunities for Improvement identified in the 2011 Annual Report.

- Annual PM Compliance Aggregate for 2011 was 97.6%. The Planned Maintenance Compliance for Life Support Devices was 100%

- 6% of annual total inventory due for Preventative Maintenance could not be located.

- 2% of annual corrective maintenance were physical damages.

Planning Objectives/Opportunities for Improvement for 2011

- Continue to focus on PM compliance and improve our percentage for 2012.
- Continue to improve communications between hospital staff and the clinical Engineering Department on equipment status.
- Continue to close the loop in equipment not located for inspection by communicating to department managers a list of equipment not found
- Continue to maintain an accurate inventory by including Temporary Equipment (Rental. Demo, Leased, Patient Owned) within the clinical Engineering computer database.

Alameda Hospital
2011 Annual Evaluation of the Environment of Care Program
Utilities Management

I. Summary of Effectiveness

The utility program continues to be diligent and successful with an active Safety Committee and support from Administration.

A. All preventative maintenance (PM's) completed

B. Extensive unplanned issues (see below) were evaluated and projects were developed to address the problems.

II. Scope

Alameda Hospital strives to maintain a Utilities System program which promotes a safe, controlled and comfortable environment of care for the benefit of patients, staff and visitors. Management of the Program is the responsibility of the Engineering Department.

It includes continuous monitoring, regular preventive maintenance, inspections, repairs, testing and corrective work orders. These activities continuously evaluate risks associated with utility systems and equipment and determine which factors, if any, need monitoring to assure proper performance. Services offered and sites covered by the plan remain essentially the same.

III. Objectives and Goals for 2011

Overall Goals:
- Assess and minimize the risks of utility failures
- Reduce the potential for hospital-acquired illness
- Ensure the operational reliability of utility systems through PM's

2011 Specific Objectives and Goals	Status
1. New X-Ray Equipment – 2011 Installation	1. 99%

IV. Performance Indicators 2011:

A. Complete Preventative Building Maintenance: 100% complete

B. Service all work order request and incident reports: 98% complete

C. Projects:
PAC's Outlet 100% complete
Nikon Khoden Telemetry 100% complete
Roofing Repairs 75% complete

V. New Unplanned Issues in 2011

New unplanned issues addressed by the Safety Committee in 2011 include:

A. Computer Room A/C Replacement

B. 2 and 3 West Nurse Call Failure and Repairs

C. A/C Compressor Replacement (1)

VI. Objectives and Goals for 2012

A. Heating Boiler Replacement mandate by 1/1/13

B. Pyxis Outlet Project

C. Close OSHPD outstanding completed projects

D. Update all Utilities Management policies

VII. Performance Indicators for 2012

A. Building Maintenance Program

B. Work Orders

C. Projects completed

D. 2012 goals completion

Alameda Hospital
2011 Annual Evaluation of the Environment of Care Program
Fire/Life Safety Management

I. Summary of Effectiveness

The Fire/Life Safety Program continues to be diligent and successful with an active Safety Committee, Fire subcommittee, Safety Officer and support from Administration.

- All fire safety exercises were conducted and evaluated with minimal intervention. In-service provided as needed. The need for Interim Life Safety Measures (ILSM) was appropriately evaluated and activated if determined necessary. No fire watches were required.

II. Scope

The scope of the Fire (and Life) Safety Plan addresses the protection of patients, staff, physicians, visitors and property from fire, smoke and other products of combustion by following established operational plans and systems. Alameda Hospital strives to meet the Life Safety Code (NFPA-101), The Joint Comission, State and Local regulations. The Plan is administered by the Safety Committee, Fire Safety subcommittee, Safety Officer and Engineering Director. Sites, services and hours of operation have not materially changed.

III. Objectives and Goals for 2011

1. Fire and Life Safety sprinkler testing to increase to quarterly.

2011 Objectives and Goals	Status
1. Fire and Life Safety sprinkler testing to increase to quarterly.	Completed – 100%

IV. Performance

Performance Indicators included:

A. A system was developed to score/rate the performance at the fire site during an exercise and track outcome.

Overall rating for this year was:

	Hospital:	SNF:
for night:	1.8	1
for days:	2.2	1
for pm:	1.8	1

Alameda Hospital
2011 Annual Evaluation of the Environment of Care Program
Fire/Life Safety Management

B. Life Safety Questions: Target 95%

Hospital: 80% SNF: 100%

Questions 5: Are hallways cleared?
Question 6: Are stairwell doors kept closed?

C. Associate Knowledge Questions target 95%,

Hospital: 81% SNF: 100%

Question #3: Where fire alarm pull stations are located?
Question #5: Where evacuation gurneys are located?

V. New Unplanned Issues in 2011

1. All chimes and strobes were tested and replaced as needed, directed by Department of Public Health Life Safety Inspector.

VI. Objectives and Goals for 2012

1. Reviewed and implemented by Joint Commission EP changes in Fire and Life Safety.
2. All new codes will be reviewed.
3. Document verification of alarm received at Protection One (signaling company) monthly.
4. Improve staff response at the fire drill site for all shifts.
5. Update all Fire Safety policies.
6. Elevator recall to be performed by a certified technician monthly.
7. Comply with EOC and JC standards.

VII. Performance Indicators for 2012

1. Track and evaluate scoring of performance at the fire site during exercises.

2. Reinforce staff knowledge each quarter with regard to Life Safety question #3 – Are doors closed by dept/ unit staff? and question #5 – Are hallways cleared?; and Associate Knowledge question #2 – Where fire extinguisher are located? and question #4 – Where oxygen shut-offs are located? , with a goal of 95% compliance.

3. 2012 goals completion.

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: January 25, 2012

To: Alameda Hospital Safety Committee

From: Karen Hopkins, Benefits Coordinator

Subject: 2011 Annual Evaluation – Employee Safety

2011 SUMMARY:

* **Decrease in TOTAL injuries/illnesses.** In 2010 we saw a large decrease (32%) in our work-related injuries/illnesses. This was mostly due to a change in our reporting – we no longer report scabies exposures. In 2011 we again saw a large decrease (34%). This year the decrease was in our "First Aid Only" cases – our reportable cases (those that are reported to our Worker's Comp Carrier) increased 24% (from 21 in 2010 to 26 in 2011.)
    - Strains and sprains rose from 8 in 2010 to 19 in 2011. Most of these were related to assisting patients. The second leading cause was employees hurrying.
    - Blood borne Pathogen Exposures rose from 2 in 2010 to 8 in 2011.
* **Improvement in reporting of injuries/illnesses**
    - New process – ECC staff alerting HR staff to injury/illness by phone. HR staff can watch for paperwork and ensure reports are submitted timely.
* **New Worker's Comp Carrier – ALPHA Fund.**
    - Strong risk-management program/support
    - Stipend available to help our program

GOALS FOR 2012:

* Avail ourselves to ALPHA Fund resources to build safety program.
    - Re-establish Employee Safety Sub-Committee
        - Look at incentive program.
        - Look at purchasing additional safety products to assist employees and prevent injuries.
* Encourage Employee Wellness
    - Improve accessibility of EAP program & benefits to employees and managers.

Alameda Hospital
2011 Annual Evaluation of the Environment of Care Program
Hazardous Materials and Waste Management

I. Scope

The scope of the Hazmat Committee is to ensure that hazardous materials and hazardous wastes are managed appropriately and that all employees are notified and trained in the safe use and disposal of these materials as it pertains to their job. Applicable personnel receive training in the proper management of all forms of wastes generated. The Plan is administered by the Hazardous Materials/Waste Management Subcommittee and Safety Officer under the direction of the Safety Committee. Services offered and sites covered by the Plan remain essentially the same.

II. Summary of Effectiveness for 2011 Objectives and Goals

2011 Goals	Effectiveness
1. Continue to look for published information	100% Complete
2. Continue training for spill teams	100% Complete
3. Spill kit inventory quarterly audits	Ongoing; 100% complete each quarter
4. Track new MSDS	Ongoing; tracked # of new chemicals
5. Created a chemical spill cheat sheet	100% Complete

III. 2011 Quality Performance Indicators

Quality Indicator	**Performance and Goals**	**Evaluation and Effectiveness**
New training - new hire orientation - Spill training in Sub Acute / EVS	100%	Completed
Number of new MSDS	100%	42 new MSDS's
Major Hazard Spills	100%	No spills in 2011
Nurses' training	100%	Sub Acute floors were trained on MSDS and chemical spills
Code Orange Drills 1 major / 1 minor	100%	1 major spill drill in Pharmacy 1 minor spill (a actual spill of Formalin in the OR on 12/16/11) used as a minor spill drill.
Sensors for Formalin exposure in Lab and OR	100%	Ongoing

IV. Objectives and Goals for 2012

1. Continue to look for published information
2. Continue to track and update chemical list new MSDS
3. Update Policy and Procedure for Haz-Mat for 2012
4. Continue training
   i. New hire
   ii. Nurses' competency(annual)
   iii. Periodic training as needed
5. Code Orange Drills – twice / year (1 major – 1 minor)
6. Spill Kit Inventory
7. Chemical Inventory Update

V. Performance Indicators for 2012

1. Major Hazardous Spills
2. Number of new MSDS sent to committee
3. New training completed
4. Number of Employees' trained
5. Formalin exposure monitor in the Lab and OR

VI. Unplanned Issues for 2011

1. No Issues

SECURITY RISK ASSESSMENT
ALAMEDA HOSPITAL

ALAMEDA, CA

January 2012

PROVIDED FOR:
Anthony Corica
Director, Physician Relations

PREPARED BY:
Peter Evins Branch Manager
SECURITAS SECURITY SERVICES USA

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ALAMEDA HOSPITAL

SECURITY RISK ASSESSMENT

The completed security risk assessment attempts to evaluate the crime, threat level and security vulnerabilities for the Alameda Hospital facility. Additionally, the security risk assessment attempts to evaluate the effectiveness and adequacy of existing security programs, i.e., access control, security staffing and deployment and electronic security systems, to mitigate the risk associated with threat levels and security vulnerabilities

Crime Threat Level:

The assessment data, i.e., CAP Index, California and City of Alameda Police Department statistics, reflect a slightly increasing threat level for the Alameda Hospital facility. Although the threat level to Alameda Hospital from the adjacent community remains lower than the national average, there are clearly zones within Alameda Hospital's service area that represent a significantly higher crime threat level. Alameda Hospital's patient population is drawn from those service zones with higher crime risk, so the crime threat potential to Alameda Hospital will be increased in the future.

Perimeter and Building Access Control:

As noted in the assessment, the Alameda Hospital campus perimeter is easily accessible to pedestrians and vehicles; however, the low crime threat level from immediately adjacent community areas substantially reduces the risk posed by the campus perimeter vulnerability. Alameda Hospital building access controls are considered adequate provided that established policies and procedures are consistently implemented.

Security Staffing and Deployment:
The security staffing level for Alameda Hospital is considered adequate given the current threat level and vulnerability issues reflected in the security incident data for 2007- 2010

Electronic Security Systems:
The use of electronic security systems at Alameda Hospital is relatively limited but considered sufficient given the facility size and threat level.

ALAMEDA HOSPITAL

SECURITY RISK ASSESSMENT

I. SCOPE OF ASSESSMENT:

The completed assessment is limited to an overview of security risk related to the threat level, within the Alameda Hospital service area, and general vulnerability of the Alameda Hospital facility.

Items reviewed during the assessment include:

A. Security incident data, 2007, 2008, 2009, 2010, 2011

B. Alameda Hospital Security Management Plan

C. City of Alameda Police Department Crime Data, 2004-2010

D. CAP Index data, 2010

B. Security officer staffing levels and deployment.

F. Perimeter and building access control measures.

F. Electronic security systems.

ALAMEDA HOSPITAL

SECURITY RISK ASSESSMENT

II. ASSESSMENT METHODOLOGY:

The methodology used to complete the security risk assessment for Alameda Hospital included the following elements:

A. Site visits and inspection of property and buildings.

B. Review and trend analysis of security incident data.

C. Review and trend analysis of reported crime statistics for Alameda County, and City of Alameda

D. Review and analysis of CAP Index data.

III. THREAT LEVELS:

The threat levels for Alameda Hospital assets, including employees, patients, visitors, property, are a function of the community in which the healthcare facilities are located and the type and

level of provided healthcare services. Changes in the community, i.e., population growth, demographic fluctuation, or changes in the level of provided healthcare services, i.e., expanding emergency services, may alter the threat level and/or increase the vulnerability of the organizations assets.

A. California and **FBI** Crime Index (Alameda County) and City of Alameda Police Department Crime Statistics:

Between the years of 2007- 2010 the total reported crimes in the City of Alameda decreased by 4.7%. However, total reported serious crimes in the immediately adjacent City of Oakland Police department (see graph).

ALAMEDA HOSPITAL

SECURITY RISK ASSESSMENT

B. Security Incidents - Alameda Hospital:

During the period 2006-2011 Alameda Hospital documented security incidents have remained relatively static.

2006: 10 documented security incidents
2007: 9 documented security incidents
2008: 11 documented security incidents
2009: 12 documented security incidents
2010: 5 documented security incidents
2011: 4 documented security incidents (YTD Jan.-Oct.)

C. CAP Index 2010 Data:

The CAP Index scores for Alameda Hospital, although higher than the California State scores and Alameda County scores, are misleading in that high risk areas within the neighboring City of Oakland are included in the three mile radius data that forms thebasis for the CAP Index scores.

Within the City of Alameda and Alameda Hospital service area, as reflected in the CAP Index "Crimecast Map," there are several districts within the City of Alameda, represented by yellow shading, that pose some increased risk to the Alameda Hospital facility.

ALAMEDA HOSPITAL

SECURITY RISK ASSESSMENT

IV. PERIMETER AND BUILDING ACCESS CONTROL:

The Alameda Hospital campus, while relatively compact, is open and accessible on two sides of the campus perimeter to both pedestrian and vehicle traffic from the City of Alameda streets that bound the campus property.

Building access control, during non-business hours, is maintained through a scheduled lock- down of building perimeter entrances and unoccupied interior areas. Access to the facility buildings, following patient visiting hours, is limited to the Main Lobby entrance. After- hour visitors are required to enter through the Main Lobby entrance and obtain visiting authorization and visitor identification from the PBX department staff. Building access control is supported by security patrol inspection of secured perimeter entrances and interior areas.

Recommendation:

No recommendations.

ALAMEDA HOSPITAL

SECURITY RISK ASSESSMENT V.

SECURITY STAFFING AND DEPLOYMENT:

The Alameda Hospital security officer schedule provides for 56 hours weekly which include the following distribution:

A. Security officer/Patrol	**56.0 hrs**

Alameda Hospital security coverage consists of a single security officer from 1900 to 0300, seven days per week, including Saturday, Sunday and holidays.

Alameda Hospital security officer deployment, which is detailed in the Alameda Hospital "Security Post Orders" manual, includes mobile patrol, stationary observation, and response capability functions. Security officer communication is maintained through 2-way radio with the Alameda Hospital PBX department.

Recommendation:
No recommendation.

VI. ELECTRONIC SECURITY SYSTEMS:

Alameda Hospital employs limited electronic security system applications, i.e., CCTV, access control, alarms, in conjunction with security officer staffing, to reduce vulnerability and mitigate risk. CCTV systems are monitored by PBX staff however; CCTV system does not have a recording capability. Access control systems consist of electrical locking systems with keypad access.

Recommendation:

1. CCTV system value, e.g., incident review, is limited by the lack of recording capability. Acquisition of CCTV multiplex equipment is recommended.

Alameda Police Department

Crime Statistics

Crime Summary 2006 - 2010						
PART 1	2006	2007	2008	2009	2010	2009-2010
						Difference
Murder	2	3	3	4	1	-75.00%
Rape	7	9	9	13	15	15.38%
Robbery	81	106	107	87	74	-14.94%
Assault	131	88	92	95	83	-12.63%
Burglary	323	304	325	325	389	19.69%
Theft +$400	314	368	386	426	382	-10.33%
Theft 200-400	264	303	231	310	251	-19.03%
Theft -$200	719	759	661	654	727	11.16%
Auto Theft	292	245	272	240	215	-10.42%
Arson	9	17	12	12	10	-16.66%
TOTAL PART 1	2142	2199	2098	2166	2147	-0.88%

PART 2	2006	2007	2008	2009	2010	2009-2010
						Difference
Simple Assault	315	325	318	331	278	-16.01%
Forgery	309	390	309	245	219	-10.61%
Emb/Fraud	67	57	61	77	68	-11.68%
Weapons Off	64	44	65	63	40	-36.51%
Sex Off	32	33	35	17	27	58.82%
Family/Child	35	32	26	29	29	0.00%
Narcotics	551	447	323	299	226	-24.41%
DUI	227	224	196	187	153	-18.18%
Liquor Laws	3	7	6	7	10	42.86%
Drunk	621	555	556	585	513	-12.31%
Dist Peace	11	82	81	55	50	-9.09%
Vice/Gamble	6	2	0	1	0	-100.00%
JUV (601 W&I)	122	106	95	97	80	-17.53%
Vandalism	598	607	570	441	424	-3.85%
All Other	1273	1004	1085	957	698	-27.06%
TOTAL PART 2	4337	3915	3726	3391	2815	-16.99%
GRAND TOTAL	6479	6114	5824	5514	4962	-10.01%

Summary of Part 1 Crime Offenses, 1969 - 2008

Year	Murder	Forcible Rape	Robbery	Felony Assault	Burglary	Total Larceny	Auto Theft	Total Offenses	1 Year % Change
1969	88	197	2,572	1,131	14,182	19,727	6,220	44,117	10.77%
1970	66	212	2,494	1,111	13,783	20,222	5,013	42,901	-2.76%
1971	91	220	2,945	1,696	14,348	19,331	5,396	44,027	2.62%
1972	86	261	2,906	1,771	13,078	18,608	5,422	42,132	-4.30%
1973	100	251	2,879	1,790	14,738	16,244	4,746	40,748	-3.28%
1974	80	246	2,883	2,177	14,144	16,702	4,279	40,511	-0.58%
1975	106	316	3,189	2,292	13,986	18,858	4,076	42,823	5,71%
1976	94	309	2,905	2,214	13,200	18,857	3,590	41,169	-3.86%
1977	91	366	3,116	2,268	12,750	17,498	3,702	39,791	-3.35%
1978	94	351	2,821	2,159	12,501	17,789	3,189	38,904	-2.23%
1979	108	374	3,072	2,531	12,351	18,923	3,930	41,289	6.13%
1980	116	435	4,250	2,743	13,124	20,093	3,406	44,167	6.97%
1981	123	430	3,836	2,756	14,171	20,070	3,401	44,787	1.40%
1982	101	446	3,195	3,175	12,780	20,947	3,007	43,651	-2.54%
1983	97	478	3,289	3,060	11,647	19,622	2,742	40,935	-6.22%
1984	114	426	3,170	3,023	12,413	19,598	2,923	41,667	1.79%
1985	96	531	3,329	3,317	11,846	20,871	3,409	43,399	4.16%
1986	130	538	3,798	4,071	12,231	22,673	4,060	47,501	9.45%
1987	114	538	3,176	4,372	10,793	22,449	4,812	46,254	-2.63%
1988	112	498	3,144	4,394	10,962	23,662	5,943	48,715	5.32%
1989	129	563	3,246	4,237	9,879	23,951	6,545	48,550	-0.34%
1990	146	517	3,240	4,536	8,503	19,077	7,174	43,193	-11.03%
1991	149	460	3,933	4,941	8,848	20,695	7,281	46,307	7.21%
1992	165	418	4,610	4,947	8,870	21,310	7,766	48,086	3.84%
1993	154	353	4,557	4,794	8,355	18,991	7,772	44,977	-6.47%
1994	140	323	3,877	3,983	7,026	17,800	7,217	40,366	-10.25%
1995	137	N/A	N/A	N/A	N/A	N/A	N/A	N/A	---
1996	93	322	3,622	4,131	6,058	19,878	5,070	39,174	-3.00%
1997	99	306	3,482	4,342	5,923	18,909	4,987	38,048	-2.87%
1998	72	340	2,651	3,998	6,119	18,554	5,182	36,916	-3.12%
1999	60	305	2,190	3,199	5,094	15,437	4,788	31,073	-15.83%
2000	80	320	1,929	2,709	3,506	11,652	4,864	25,060	-19.35%
2001	84	295	2,125	2,826	3,696	13,081	5,520	27,627	10.28%
2002	108	249	2,452	2,852	4,252	13,703	6,258	29,874	8.13%
2003	109	267	2,445	2,762	4,568	12,551	5,511	28,213	-5.56%
2004	82	262	2,190	2,616	4,324	10,984	6,877	27,335	-3.11%
2005	93	293	2,590	2,543	5,646	7,087	8821	27,073	-0.96%
2006	145	306	3534	3614	5070	8725	10549	31943	17.99%
2007	120	297	3,460	4,023	4,737	8,929	9,923	31,489	-1.42%
2008	116	338	3,323	4,129	4,488	8,915	8,085	29,394	-0.06653

CAPbasic
SITE REPORT

1:3 Site Report Scores
Thursday, September 23, 2010

Securitas Security Services - Oakland

Alameda Hospital
Alameda Hospital 2070 Clinton Avenue
Alameda Ca 94501, CA 94501

			County .
CAP Index	295	248	268
Homicide	232	172	190
Rape	100	106	160
Robbery	325	259	265
Aggravated Assault	219	176	197
Crimes Against Persons	250	205	227
Burglary	108	97	159
Larceny	71	93	130
Motor Vehicle Theft	319	164	186
Crimes Against Property	95	98	137

			Count
Past - 2000	283	237	263
Current - 2010	295	248	268
Projected - 2015	279	224	263

CRIMECAST scores range from 0 to 2000 and indicate the risk of crime at a site compared to an average of 100. A score of 400 means that the risk is 4 times the average and a score of 50 means the risk is half the average.

Notes:

This Site's National CAP Index

Past Scores (2	National		
CAP Index	283	237	263
Homicide	239	182	200
Rape	141	148	185
Robbery	304	241	261
Aggravated Assault	243	209	215
Crimes Against Persons	259	222	234
Burglary	149	130	176
Larceny	67	87	112
Motor Vehicle Theft	365	187	191
Crimes Against Property	115	118	148

Projected S • res (2015			
CAP Index	279	224	263
Homicide	229	168	189
Rape	80	81	140
Robbery	316	242	266
Aggravated Assault	207	156	197
Crimes Against Persons	238	184	227
Burglary	93	82	151
Larceny	80	96	157
Motor Vehicle Theft	295	152	191
Crimes Against Property	86	84	135

CAPbasic SITE REPORT

1:3 Site Report Map
Thursday, September 23, 2010

Securitas Security Services - Oakland

Alameda Hospital
Alameda Hospital 2070 Clinton Avenue
Alameda Ca 94501, CA 94501
Lat: 37.7709, Lon: -122.2635

This Site's National CAP Index
295

Current Scores (2010)	National	State	County
CAP Index	**295**	**248**	**268**
Homicide	232	172	190
Rape	100	106	160
Robbery	325	259	265
Aggravated Assault	219	176	197
Crimes Against Persons	250	205	227
Burglary	108	97	159
Larceny	71	93	130
Motor Vehicle Theft	319	164	186
Crimes Against Property	95	98	137

CAP Index	National	State	County
Past - 2000	283	237	263
Current - 2010	295	248	268
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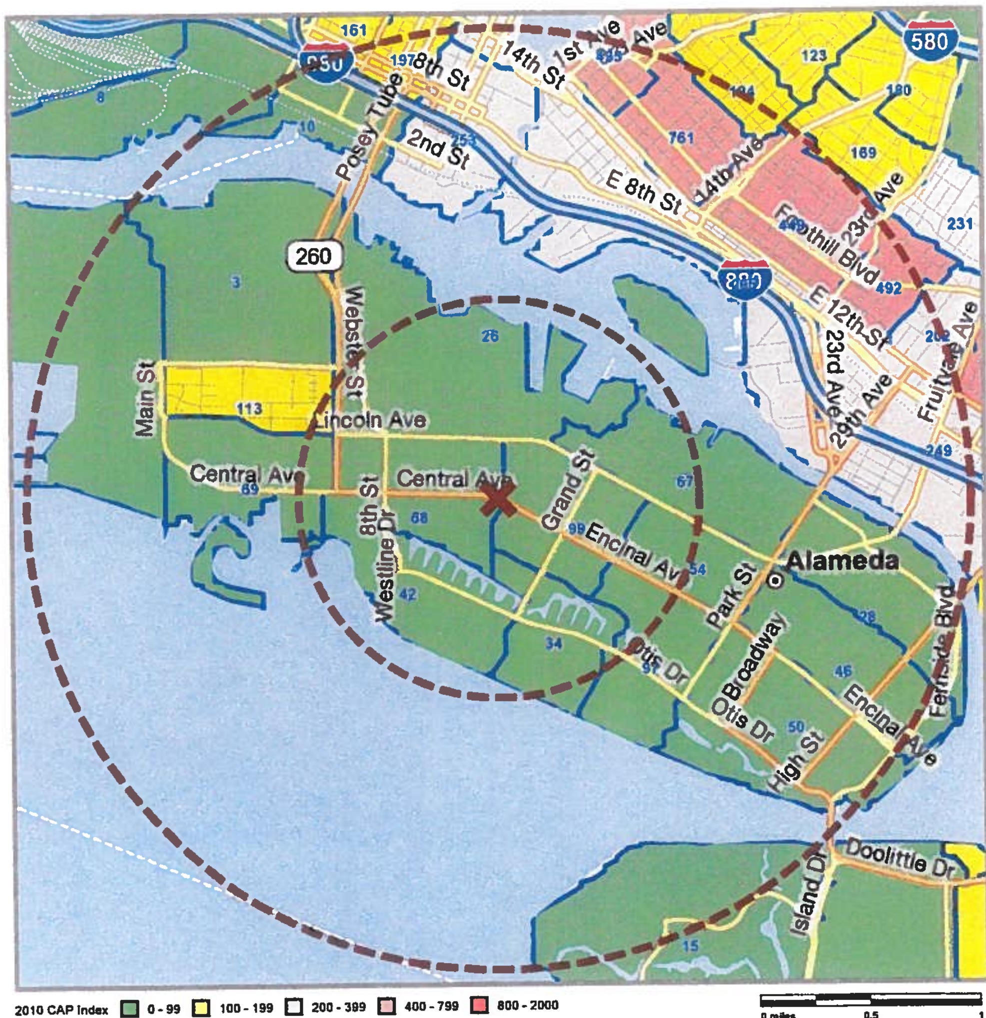
CRIMECAST scores range from 0 to 2000 and indicate the risk of crime at a site compared to an average of 100. A score of 400 means that the risk is 4 times the average and a score of 50 means the risk is half the average.



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CITY OF ALAMEDA HEALTH CARE DISTRICT

Date: March 20, 2012

To: Kerry Easthope, Chairman of the Safety Committee
Safety Committee Members

From: Mary Bond, Executive Director for Nursing Services

Subject: 2011 Education Report

The Educational component of employment at Alameda Hospital continues to support the Hospital's Mission Statement:

> "To attract and retain outstanding employees, to foster an environment where employees gain a sense of satisfaction and accomplishment from their work; and to create a safe and pleasant work setting."

Education at Alameda Hospital continued to remain de-centralized for department specific initiatives and opportunities to individual departments in CY2011. Nursing Managers, Supervisors, and staff provided nursing education. Individual department Mangers or Directors provided educational material for their staff.

Additionally, hospital-wide education continued in a multi-disciplinary fashion with ad-hoc committee designation and participation.

All staff received the monthly "Clinical News and Views" newsletter. Topics in 2011 included:

- Wound Management
- Stroke Signs & Symptoms
- Infection Prevention
- Patient Safety
- Core Measures
- Performance Improvement
- Medication Safety
- Discharge Planning

Additional nursing educational topics for 2011 included:

- Mock Codes
- Pain as the 5th Vital Sign
- Palliative Care
- Documentation
- Safety & Body Mechanics
- Procedural Sedation
- Waived Testing
- Electronic Medical Record
- HCAHPS Scores
- Transplant-Donor Update

The Nursing Update Program for Registered Nurses continued on a bi-monthly basis during CY2011. Topics were updated to include:

- RN Scope of Practice
- Student Policies
- Patient Safety
- National Patient Safety Goals
- Stroke Patient Positioning
- Blood Glucose Monitoring
- Telephone/Verbal Orders
- Donor Referrals

The Clinical Informatics team held a total of 19 educational activities in 2011 which included super-user training, applications training, and 3-day classes on the Electronic Health Record. All Emergency Room personnel were trained on the ER (EDM1) module that went up live in early May 2011.

Perioperative Services held 32 educational programs in 2011 covering topics such as Bair Hugger monitoring, CO2 monitoring, use of Hemostatic agents, new procedures, sharps safety, equipment setup and maintenance, and infection prevention. Added in 2011 was a Perioperative Skills/Competency Day that included Code Blue response, Cell Saver & Blood Bank procedures, Arterial Line setup, Jackson Table setup, Aseptic technique, Malignant Hyperthermia, and Ergonomics.

Other classes/in-services included instruction in BLS (Basic Life Support), Suicide Observation, Non-Violent Crisis Intervention. Additionally off-site training continued for required certification in ACLS (Advanced Cardiac Life Support) and PALS (Pediatric Advanced Life Support).

The Sub-Acute and Long-Term Care units instituted weekly educational programs in 2011 with a total of 72 programs held. Education included those required by California Title 22 as well as Dementia, Alzheimer, Blood-borne Pathogens, Interpersonal Relationships, and Death & Grief Management.

Elder and Dependent Adult Abuse as well as Disaster Planning and Preparation continued in 2011 as yearly requirements. All departments continued to remain current for specific competencies.

A major portion of education in 2011 was in preparation for Joint Commission Certification as a Primary Stroke Center. Over 80% of all hospital personnel and physicians attended the classes. Topics included the signs and symptoms of stroke, tPA administration, NIHSS screening, medications, post tPA care, order sets, performance improvement measures, and rehabilitation management. The Hospital successfully achieved Stroke Certification within 9 months of initial application.

The Hospital continued with the on-line web-based program (HCCS) for all annual mandatory training in 2011. The sessions include but are not limited to:

- Disaster Preparedness
- Environmental Safety
- Electrical Safety
- Hazard Communication
- Infection Control
- Body Mechanics
- HIPAA
- Ergonomics

- Customer Service
- Hand Hygiene
- Ethics
- Controlling Violence
- Patient Rights
- Fire Safety

This HCCS program takes approximately 2-4 hours to complete. To meet compliance and risk issues (SB198) and to help ensure the competency of our staff, all active employees must complete HCCS on-line or attend a live program and pass competency assessments once a year. The employees are paid for their attendance at all mandatory classes.

Educational summaries for the Nursing division contain more detailed information on the plan, classes, forums, and inservice programs given as well as specific programs provided to our Sub Acute and Skilled Nursing employees. Those summaries are filed in the Nursing Administrative offices and are available for review.

Date: January 26, 2011

To: Alameda Hospital Safety Committee

From: Rosemarie Delahaye, RN, Infection Preventionist

Subject: 2011 Annual Report – Blood Borne Pathogen Exposure

Summary of Effectiveness

Number of blood borne pathogen exposures per quarter – 2011. Total of 8

Q-1	3
Q-2	0
Q-3	3
Q-4	2

There was an increase this year as compared to 2010. Managers and directors continue to remind their staff about this issue. There is no evidence of any viral transmission.
This issue is addressed actively through use of safety needles throughout the hospital, as well as personal protective equipment. Ongoing vigilance and monitoring continues for all staff that has exposure to blood borne pathogens.

Benchmarks – previous years

2010	2
2009	8
2008	13
2007	5
2006	9

Goals for 2012

Speak at staff meetings for non-nursing staff about this issue when requested by the manager or director. This topic will be addressed at Nursing Update which is held twice monthly.

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: April 30, 2012

FOR: May 7, 2012 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: Deborah E. Stebbins, CEO

SUBJECT: Approval of Revisions to the City of Alameda Health Care District Policy #2008-0b - Signature Authority

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RECOMMENDATION:

Management recommends that revisions be made to the District Policy 2008-0b Signature Authority as reflected in the attached document.

BACKGROUND:

The District operates a number of bank accounts for business purposes that require checks to be written and monies to be deposited and withdrawn in the normal course of business. The Board of Directors authorizes the officers of the District and management to operate these accounts as signatories.

Since the Kerry Easthope has accepted the position of Chief Financial Officer, the Associate Administrator position will be taken off and an additional signatory is being added for back-up purposes. Changes are outlined in red.

2070 Clinton Avenue • Alameda, CA 94501 • TEL (510) 522-3700 • www.alamedahospital.org

City of Alameda Health Care District
Policy 2008-0b
SIGNATURE AUTHORITY

I. PURPOSE

The District maintains a number of bank accounts for business purposes that require checks to be written and monies to be deposited and withdrawn in the normal course of business. This policy defines the responsibility and authorization limits for the disbursement of funds by the District to its vendors and employees by check.

II. POLICY

a. The Board of Directors authorizes the following officers and management positions to serve as the organizations check signors:

i. Board Members

1. President
2. Treasurer

ii. Management

1. Chief Executive Officer
2. Chief Financial Officer
3. ~~Associate Administrator~~
~~4.~~3. Chief Nursing Officer
~~5.~~4. Director of Physician Relations
5. Director of Quality and Resource Management
6. Long Term Care Administrator

iii. Vendors

1. HealthComp Designee – Self insured health & dental claims payments

b. The Board of Directors authorizes the preparation and use of a facsimile signature of the Chief Executive Officer, in lieu of a manual signature which can be affixed to all hospital generated accounts payable and payroll related disbursements. A facsimile signature is defined to include, but is not limited to, the reproduction of any authorized signature by a photographic, photo static, or mechanical device. Facsimile signature does not include the use of a rubber stamp signature.

c. The Board of Directors authorizes the following signature requirements with regard to the dollar value of all disbursements:

   i. Disbursements of $9,999 or less require the authorized facsimile signature or in the case of a manually prepared check the manual signature of one of the authorized officers or management positions of the organization.

   ii. Disbursements of $10,000.00 or more requires the authorized facsimile signature and the manual signature of one of the authorized officers or management positions of the organization or in the case of a manually prepared check the manual signature of two of the authorized officers or management positions of the organization.

   iii. A log of all disbursements executed by facsimile signature will be reviewed once a month by the Chief Executive Officer or ~~Associate Administrator.~~Long Term Care Administrator.

DATE: April 30, 2012

FOR: May 7, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Kerry Easthope, Chief Financial Officer

SUBJECT: Approval to Enter into a Contract with MuirLab for Reference Lab Work

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RECOMMENDATION:

Management is recommending that the District Board authorize management to enter into a contract with MuirLab as our primary reference outsource lab. The Hospital is currently using Quest Diagnostics for low volume and other esoteric tests that we do not perform in-house. The fee schedule between Quest Diagnostics and MuirLab is very comparable and it is not anticipated that there will be any financial impact on Alameda Hospital. This change is being recommended based upon service and support concerns with Quest Diagnostics.

BACKGROUND:

Alameda Hospital Laboratory has been using Specialty Lab for the esoteric lab tests and send outs for several years. About one year ago, Specialty Lab was bought by Quest Diagnostics and there have been many changes in the way our reference lab work has been processed and resulted during this time. As a result of these changes (many of which have not been well communicated) the level of service and support that we once received from Specialty Lab/Quest has diminished.

One of the primary and most problematic issues has been the lack of communication on changes to the result codes. This has caused delays in patient testing and many lab results do not cross over to our system, causing further delays in patient care. Quest's causal and non-responsive approach toward this problem has made it challenging for our internal lab to maintain expected quality and turn-around times for lab work. Further, as a result of Quest sending our lab work to multiple cities/locations, we have no single point of contact for resolution of these and other ongoing issues.

DISCUSSION:

In addition to processing most of the lab work for John Muir in Walnut Creek and their Concord hospital campus, MuirLab is a reference lab for Washington Hospital in Freemont, Doctor's Hospital in San Pablo, and Lodi Medical Center. They also perform lab work for dozens of skilled nursing and long term care facilities throughout the greater Bay Area. Management has

contacted the three hospitals to inquire about their experience with MuirLab. All three agreed that MuirLab is a good reference laboratory and that the level of service, support and result turn-around time has met their expectations. MuirLab is looking to grow their operations outside their primary service area and have ample capacity to process Alameda Hospital's reference lab work Because MuirLab performs all lab processing at their Concord location, communication along with service and support are expected to be much better. MuirLab has a very extensive testing menu and they are willing to pay for the interface and set-up required for communication between our Meditech system and their system. The value of this initial interface and system set-up is valued at $51,000. The term of the contract is five years. Alameda Hospital may terminate the contract without cause by providing 60-days written notice. In the event of early termination, the unamortized portion of this upfront interface expenditure becomes responsibility of the Hospital.

The MuirLab fee schedule is also comparable with Quest (approximately $15,000 per month). About 7% of our overall test volumes are sent to Quest for processing. These are tests are low volume and other esoteric tests that we do not have the volume or capability to perform in-house. However, over time as our in-house technology and capabilities have improved, we have and will continue to do more internally.

Implementation and parallel testing will begin upon contract execution followed by complete transfer to MuirLab within 90 days. We currently do not have a contract with Quest Diagnostics, but receive reference lab pricing through our Med Assets group purchasing organization.

CITY OF ALAMEDA HEALTH CARE DISTRICT

CONTINUING MEDICAL EDUCATION PROGRAM
OF THE MEDICAL STAFF

MISSION STATEMENT - 2012

GOALS:

The Medical Staff of Alameda Hospital is committed to providing Category I continuing medical education consistent with established accreditation standards which will provide attendees with the most up to date information on treatment modalities, advances in clinical practice and research, and updates based on evidence based medicine and the solid needs assessment. A coordinated linkage between quality improvement activities and the CME program will continue to generate opportunities for sustained improvements in clinical practice. In recognition of the American Board of Medical Specialties and the ACGME standards, Alameda Hospital will offer its physicians CME along the following competency tracks: 1) medical knowledge, 2) patient care, 3) interpersonal and communication skills, 4) professionalism, 5) practice-based learning and improvement, and 6) systems-based practice.

SCOPE:

The scope of the CME Program shall include:

- Health care issues related to patients admitted to Alameda Hospital as well as health care issues relative to our community patient population;
- Medico-legal topics, bioethics, behavioral education, socioeconomic and public health issues.
- Quality improvement, performance improvement, and utilization review,.
- System development for the electronic health record and computerized physician order entry.

Except as may be exempt by State law, all courses shall include the appropriate cultural and linguistic competencies.

ADMINISTRATION:

The Chairman of the Continuing Medical Education Committee shall be responsible for overseeing all CME activities of Alameda Hospital.

Membership of the CME Committee shall include a broad physician representation of

physician constituency of the Medical Staff as well as representatives from Nursing, Quality Improvement and the Medical Library and other relevant professionals as may be appropriate. Members shall serve staggered terms to ensure continuity of the program.

ACTIVITIES:

The CME Program offers hospital-based conferences of one or two hours duration and may, based on need, offer courses lasting up to one or more days. Teaching methodology will include didactic, interactive, demonstration of techniques and panels.

EXPECTED RESULTS:

It is expected that participation in the CME activities at Alameda Hospital will result in improved medical knowledge, enhanced skills, practice improvement and overall ability to better provide the quality care expected by patients. It is expected that a significant number of learners will report that learning objectives have been met and/or that the learner intends to make a change in practice.

AUDIENCE:

Characteristics of potential participants in the CME Program shall include physicians who range in degree of specialization from tertiary care to specialists to primary care as well as other healthcare professionals.

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Approved by: CME Committee: 03/23/12
Medical Executive Committee: 03/30/12
Board of Directors:

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: April 27, 2012

FOR: May 7, 2012 District Board Meeting

To: City of Alameda Health Care District, Board of Directors

From: James Yeh, D.O., President, Medical Staff

Re: Proposed Revisions to Medical Staff Rules: Article 2

RECOMMENDATION:

The Medical Executive Committee respectfully requests your approval of the proposed revisions to Article 2, Anesthesia Service, of the Medical Staff Rules and Regulations.

BACKGROUND:

The proposed revisions comply with current ASA (American Society of Anesthesiology) standards for clinical practice. These standards are regarded as the generally accepted principles of patient management. The proposed revisions also include a reference to Administrative Policy No. 28, Procedural Sedation Management.

In accordance with Article 10, Section 10.1 of the Medical Staff Bylaws the proposed revisions have been approved by the members of the Medical Executive Committee as well as members of the Active Staff.

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Proposed amendments: Article 2

ALAMEDA HOSPITAL
MEDICAL STAFF RULES & REGULATIONS

TITLE: **ARTICLE 2: ANESTHESIA SERVICE**	**EFFECTIVE DATE:** **06/01/97** **06/12/01** **Page 1 of 3**

A. **Medical Director**

. The Anesthesia Service in under the direction of the Medical Director of Anesthesia as appointed by the Medical Executive Committee and approved by the Board of Directors with individual anesthesiologists functioning as independent contractors.

B. **Organization**

The Anesthesia Service is organized, directed and integrated with other related departments or services of the hospital.

C. **Administrative Responsibilities**

The Medical Director of Anesthesia shall have the administrative responsibility for anesthesia services. This will include assignment of surgical cases on an equitable basis among staff anesthesiologists. Requests by surgeons or patients for a specific anesthesiologist will be honored **whenever possible.**

D. **Policies and Procedures**

Anesthesia Policies and Procedures shall be reviewed by the Surgery/Gynecology Committee and approved by the Medical Executive Committee and the Board of Directors. Copies of the Policies and Procedures are to be maintained in the Surgery Office.

E. **Administration of General Anesthesia**

~~All g~~ **G**eneral anesthesia shall be directly administered by an anesthesiologist **or by a qualified individual who has been granted privileges and is legally authorized to administer general anesthesia.**

F. Pre-Anesthesia Evaluation

A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services.

G. Post Anesthesia Evaluation

1. Requirement Defined

A post-anesthesia evaluation is required any time general, regional or monitored anesthesia has been administered to a patient. The American Society of Anesthesiology (ASA) guidelines do not define procedural sedation as anesthesia. Current practice dictates that a patient receiving procedural sedation must be monitored and evaluated before, during and after the procedure by trained practitioners, however, a postanesthesia evaluation is not required (71 FR 68691).

2. Responsibility Defined

A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services. The postanesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care.

H. Procedural Sedation Management

Refer to Administrative Policy No. 28, incorporated herein by reference.

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THE CITY OF ALAMEDA HEALTH CARE DISTRICT

ALAMEDA HOSPITAL

UNAUDITED FINANCIAL STATEMENTS

FOR THE PERIOD ENDING MARCH 31, 2012

CITY OF ALAMEDA HEALTH CARE DISTRICT
ALAMEDA HOSPITAL
MARCH 31, 2012

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ALAMEDA HOSPITAL
MANAGEMENT DISCUSSION AND ANALYSIS
MARCH, 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 March 31, 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

This month the hospital experienced a negative bottom line. $295,000 was budgeted and a negative ($401,000) was realized. Year-to-date the hospital's bottom line is negative by ($1,112,000).

This month's results included two unusual adjustments to contractual allowances. $35,000 was established as a reserve for a potential pay-back associated with this year's Skilled Nursing payments. As was discussed last month, the state has the ability to recapture certain skilled nursing payments for services unpaid as of 12/31/2011. Additionally, the 2010 Medi-Cal cost report was settled with a payable of $402,000. This is $203,000 greater than anticipated. Without these two adjustments the month's bottom line would have been negative by $163,000.

In addition to the contractual adjustments, March activity was down. March is historically a very busy month. As such, March activity was budgeted very high. This year February was the busy month and March ended up being a down month. Therefore there is a large budget variance for both inpatient and outpatient services. Compared to how the hospital has been performing this year, March inpatient revenues are down about 4.6% and outpatient revenues are actually up 6.9%.

March discharges are below budget 6.1% and patient days were under budget 11.7%. The average length of stay was 7.6% below budget. Patients days in all inpatient services were down with acute patients down 14.5%, Sub-Acute down 7.0% and Skilled Nursing down 14.0%. On the other hand, inpatient surgery cases were 57 which was above the budgeted volume of 50.

Overall outpatient activity was mixed this month. This month outpatient registrations were down 16.3% yet Emergency Room visits were above budget by 5.6%. YTD outpatient volumes are about 8.5% below budget while Emergency visits equal to budget. Outpatient surgeries were below budget for the month by 4.2%, but continue above budget YTD by 5.8%.

Gross revenue in March is generally in line with activity. Overall gross revenues were 11.1% below budget, with the inpatient component down 15.2% and outpatient down 2.5%. The inpatient revenue variance is largely due to revenues being budgeted at a relatively high level in March. The outpatient budget includes $428,000 for Wound Care. Without this budget item, outpatient revenues would be slightly above budget. Net patient revenues were 22.9% of Gross revenues. This is slightly above the YTD net to gross value.

The Case Mix Index (CMI) ran above the YTD average. The overall CMI in March was 1.3071; down from last month's of 1.3572, but still above the YTD average.

There were a number of expenses categories that ran over budget this month. Employee benefit costs, purchased service and other operating costs were significantly over budget. Employee benefit costs include costs associated with employee health usage. These costs fluctuate according to their usage. March billings for these costs were unusually high. Purchased services were high because of services for outside billing, information systems and engineering. Other operating expenses include costs for employee recruitment. This month's costs include the fees associated with two recruited employees. On the other hand, Labor and supply costs continue below budget. Supply costs had been averaging about $150,000/mo. under budget. This month supply costs were $40,000 under. YTD expenses are very close to budget, just 0.3% over budget or $166,000.

Actual cash is down significantly from the prior month. It decreased from $1,825,000 to $428,000. Expressed in days-cash-on-hand, the hospital went from 12.4 days in February to 2.2 days in March. The reason for this decrease is two-fold. The timing of Payroll at month-end caused a $642,000 decrease. Also, the IGT program was funded in March which utilized $820,000 in cash.

Cash should improve significantly over the next few weeks. It is expected that the hospital will not only receive its initial IGT contribution but an additional $547,000 in early May. This month the hospital will receive approximately $2,600,000 in tax monies and then in June, the hospital should receive its AB915 monies. AB 915 is a program designed to reimburse government hospitals for underfunded Medi-Cal outpatient services. This should result in an additional $480,000 in reimbursement.

Cash collections in March were $5.5M. This is the first time this year cash collections exceeded net revenues and caused net Accounts Receivable to decrease.

Accounts payable grew slightly by $57,000 from $8,885,000 to $8,942,000. AP days were 142. This is down slightly from the previous month. The cash coming in from Tax, IGT and AB915 plus improved AR collections should allow for a significant reduction in AP and allow the hospital to set aside a reasonable cash reserve.

Lastly, the current ratio ended the month at 1.0. This is a decrease from the previous month and is right on the threshold necessary to meet Bank of Alameda's criteria for funding the Wound Care project and extending the hospitals line of credit.

ACTIVITY

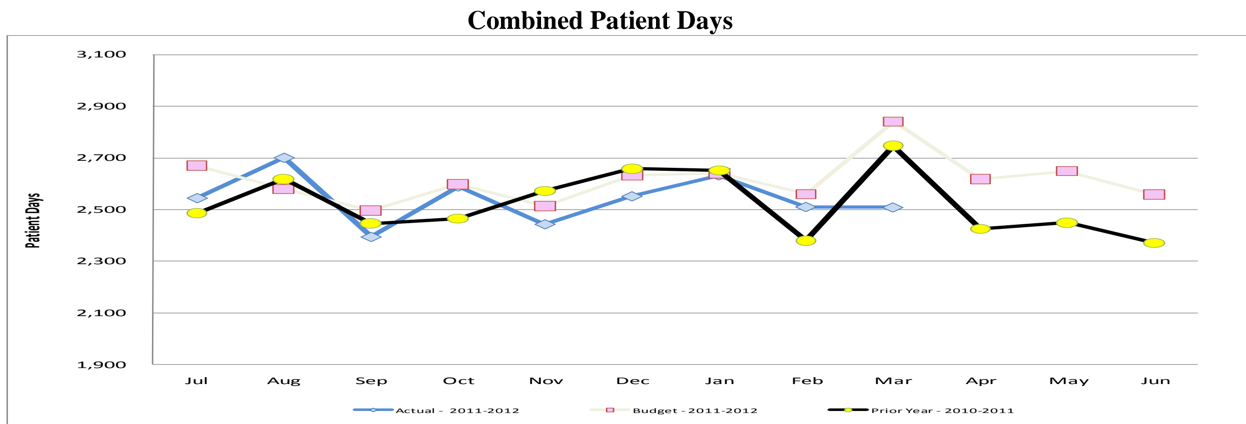
ACUTE, SUBACUTE AND SNF SERVICES

Patient days were below budget for the month and below March of last year. This month's acute days were down 14.5%, Sub-Acute was down 7.0% and Skilled Nursing was down 14.0%. YTD days are now (2.8%) under budget.

March's acute care patient days were 154 days less than budget for the month and 16.6% below the prior year's average daily census of 35.0. The acute care program is comprised of the Critical Care Unit (2.7 ADC, below budget 52.0%), Definitive Observation Unit (10.2 ADC, 13.6% below budget) and Med/Surg Units (16.3 ADC, 2.9% below budget). The CCU unit was closed a few days during the month, and the nice weather in March contributes to the lower acute census.

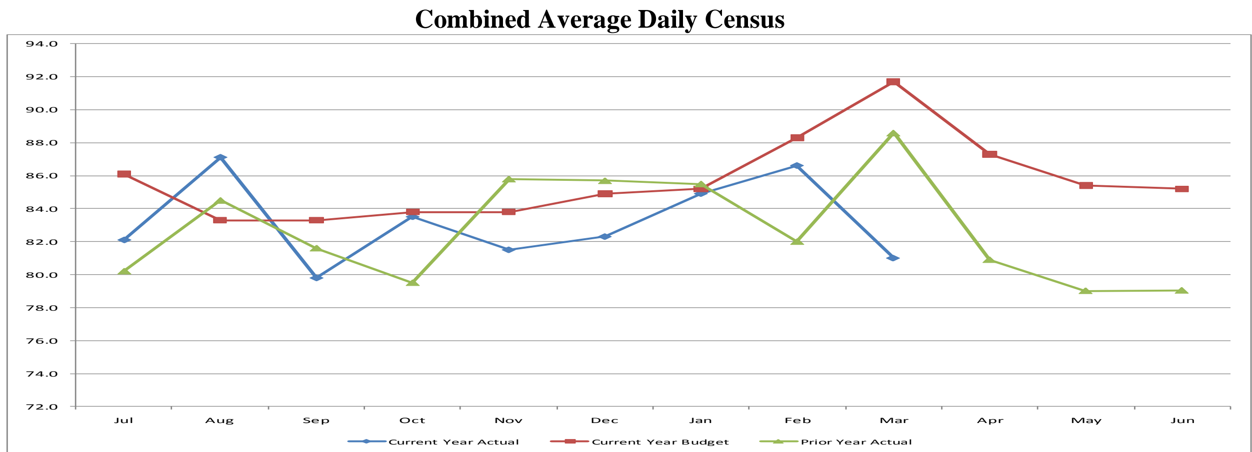
The graph, below, shows the total patient days by month for fiscal year 2012 compared to the operating budget and fiscal year 2011 actual.

Combined Patient Days



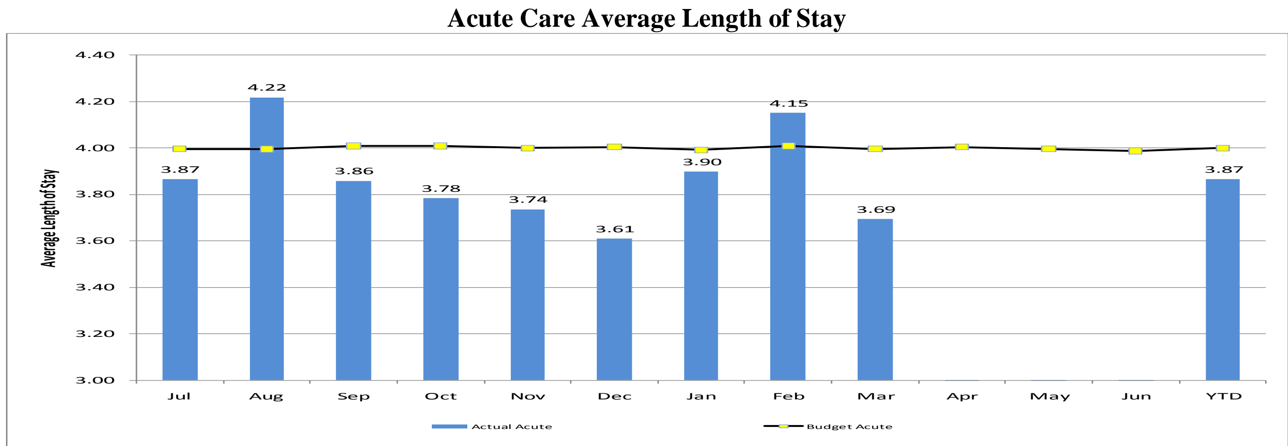
The graph below shows the average daily census for all inpatient services. The actual ADC was 80.94 versus budget of 91.65 an unfavorable variance of 12.1%.

Combined Average Daily Census



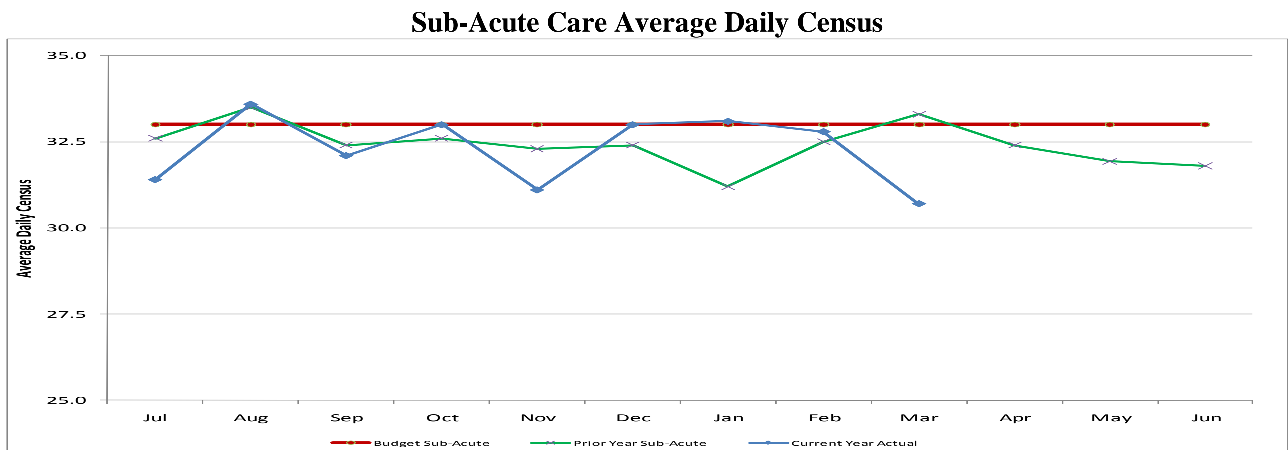
The acute average length of stay (ALOS) decreased from the high in February of 4.15 to 3.69 in March, back below 4.0. Budgeted acute ALOS is 4.0, and YTD is still under that target. The overall acute ALOS for FY 2011 was 4.13. The graph below shows the ALOS by month compared to the budget.

Acute Care Average Length of Stay



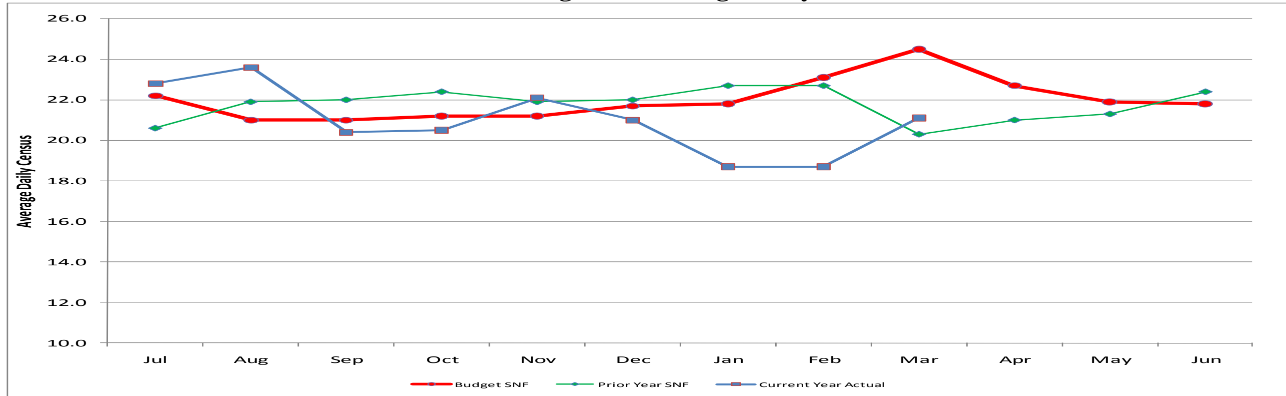
The Sub-Acute programs average daily census of 30.68 in March was below budgeted projections by 7.3%. The graph below shows the Sub-Acute programs average daily census for the current fiscal year as compared to budget and the prior year.

Sub-Acute Care Average Daily Census



The Skilled Nursing Unit (South Shore) patient days were 14.0% or 106 patient days lower than budgeted for the month of March. YTD days are also down compared to both budget and the prior year. However, efforts to improve census have been fruitful as census has climbed back up from the lows of the prior few months. The graph, below, shows the Skilled Nursing Units monthly average daily census as compared to budget and the prior year.

Skilled Nursing Unit Average Daily Census

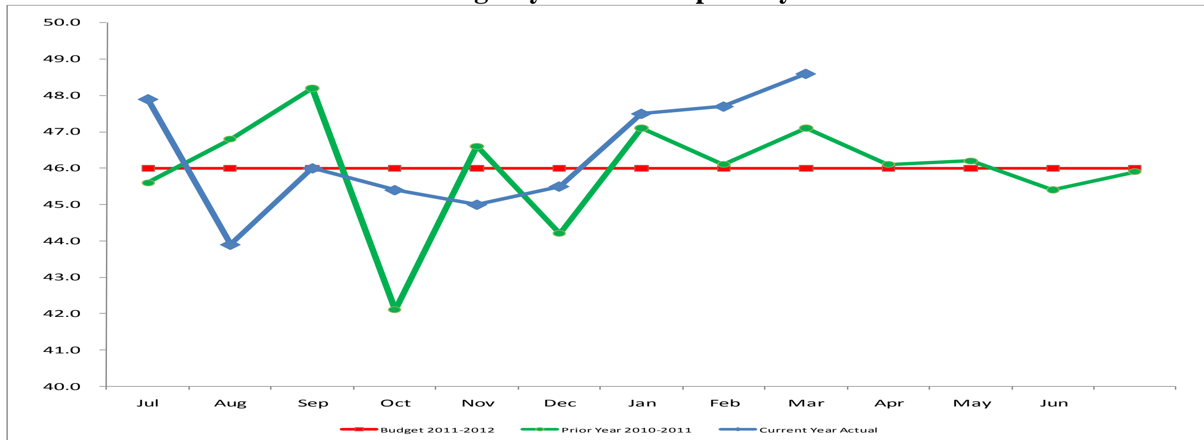


ANCILLARY SERVICES

Outpatient Services

Emergency Care Center visits in March were 1,506. This is 80 visits (5.6%) over the budget of 1,426. 17.3% of ECC visits resulted in inpatient admissions versus 19.2% in February. On a per day basis, the total visits represent an increase of 1.9% from the prior month daily average. In March, there were 315 ambulance arrivals versus 267 in the prior month. Of the 315 ambulance arrivals in the current month, 224 or 71.1% were from Alameda Fire Department (AFD) ambulances.

Emergency Care Visits per Day



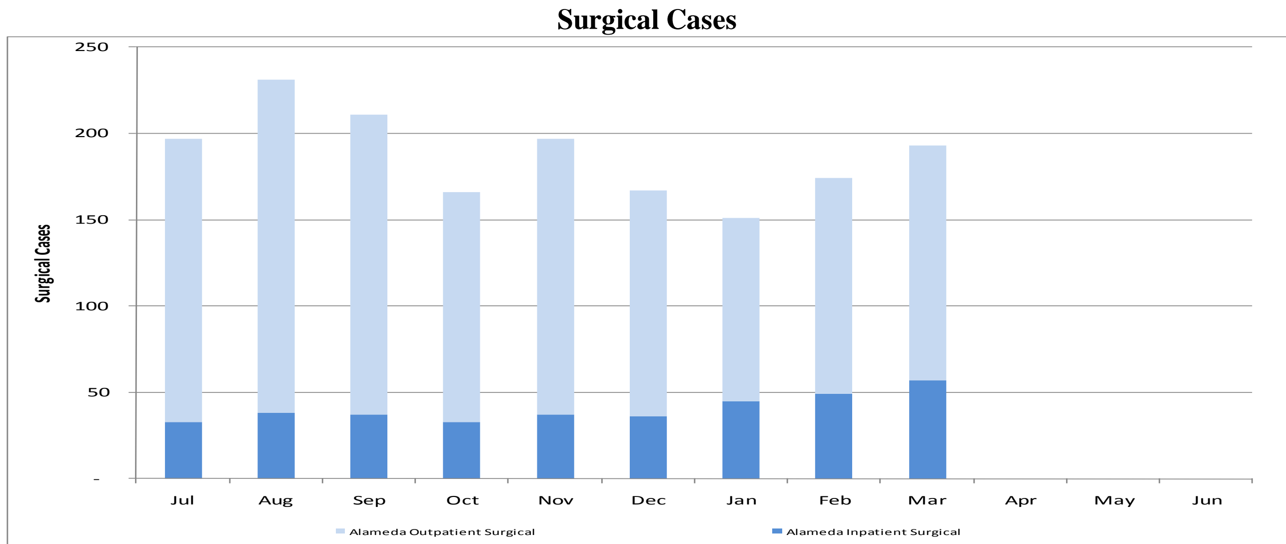
Outpatient registrations were 1,901, or 16.3% below budget. March's average daily registrations were 61.3 which was 4.07% lower than the prior month. This is in consistent with YTD outpatient registrations which are below budget by 8.5%. This month Laboratory, Radiology and Nuclear Medicine were down 247, 52 and 20 visits respectively. On the other hand visits were up in MRI (15 visits), CT Scan (20 visits), Physical Therapy (46 visits) and Occupational Therapy (17 visits). There were no Wound Care visits but visits were again budgeted as the program was expected to start in February. This equated to a total of 380 visits for the two months.

Surgery

The year-to-date surgery cases were 1,699 or 3.1% above the budget of 1,648 and also above last year. For the month, total surgery cases were just above budgeted expectations by 0.5% at 193 cases versus the budget of 192 cases. Inpatient cases were above budget 7 (14.0%) while outpatient cases were 6 (4.2%) below budget. Inpatient and outpatient cases totaled 57 and 136

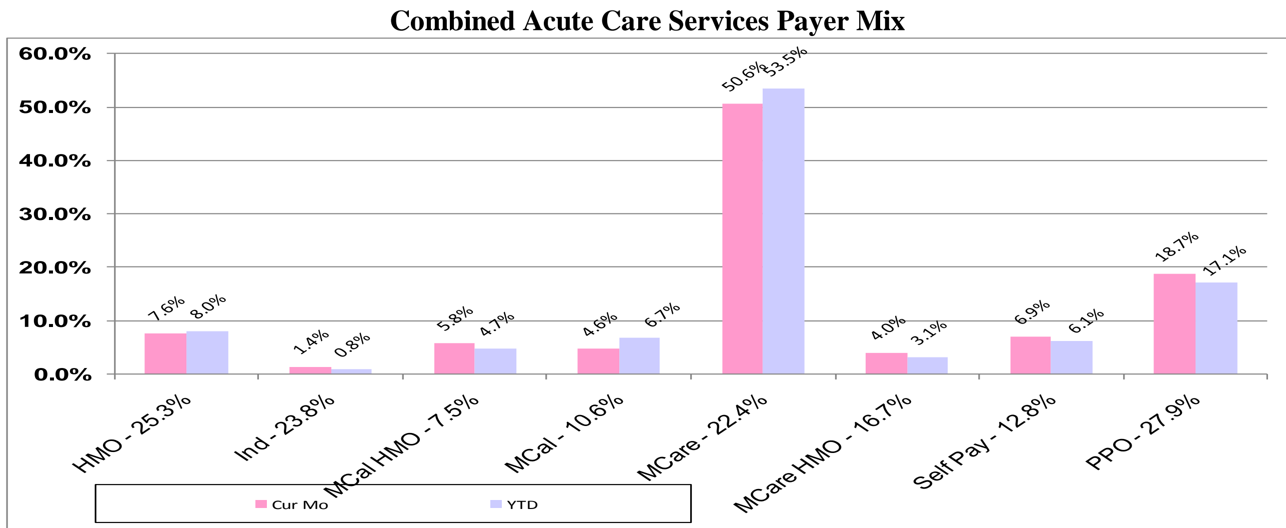
in March versus 49 and 125 during the prior month. Inpatient surgery was busy again in March.

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

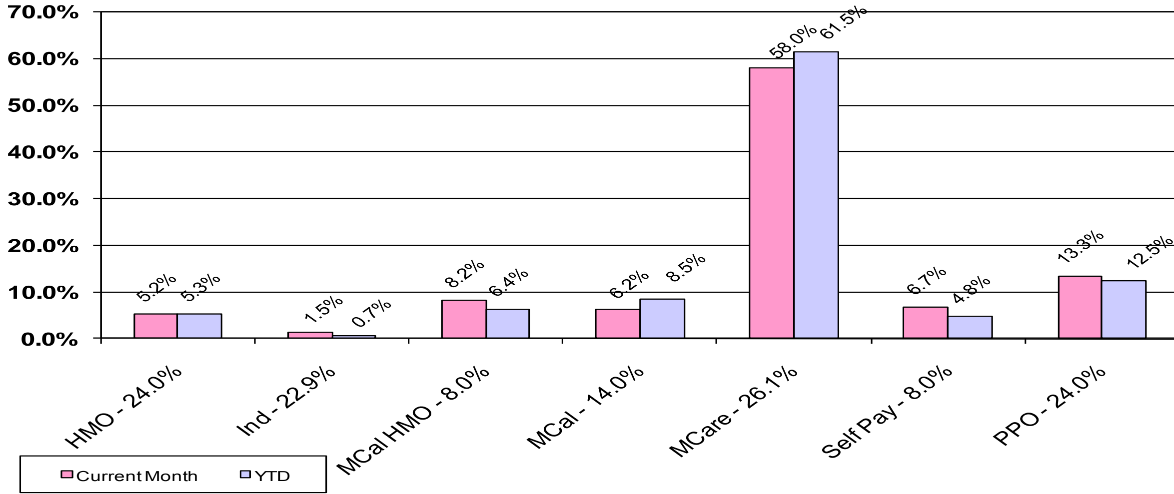


Payer Mix

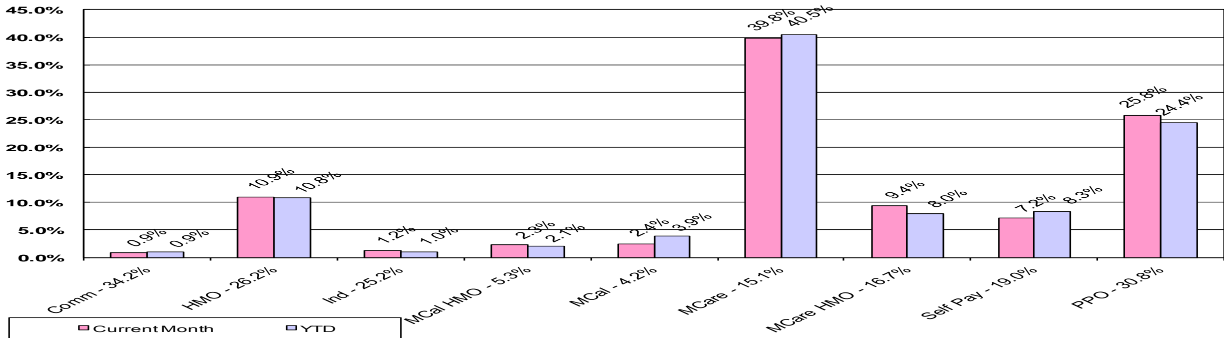
Combined acute care services, inpatient and outpatient, Medicare and Medicare Advantage total gross revenue in March made up 54.5% of the month's total gross patient revenue. Combined Medicare revenue was followed by HMO/PPO utilization at 26.3%, Medi-Cal Traditional and Medi-Cal HMO utilization at 10.4% and self pay at 6.9%. 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.



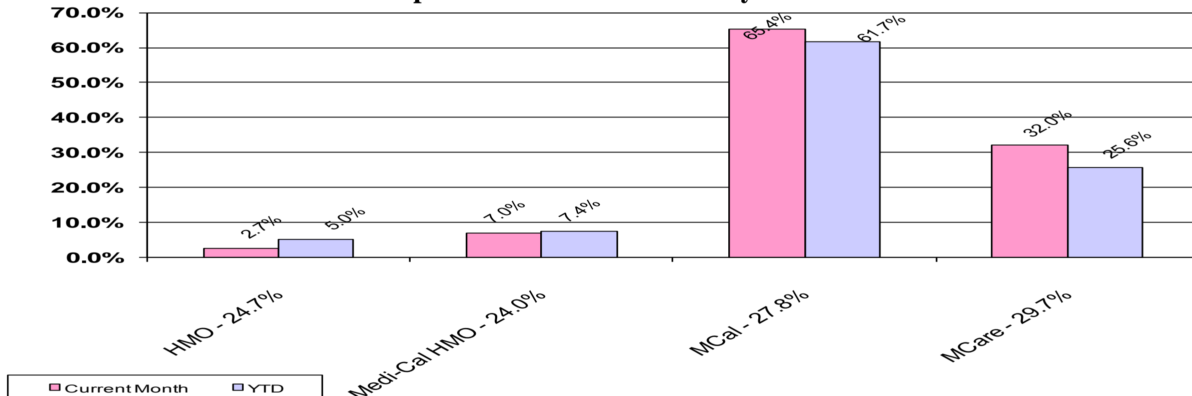
The inpatient acute care current month gross Medicare and Medicare Advantage charges made up 58.0% of our total inpatient acute care gross revenues followed by HMO/PPO at 18.5%, Medi-Cal and Medi-Cal HMO at 14.5% and Self Pay at 6.7% of the inpatient acute care revenue. The graph below shows inpatient 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.

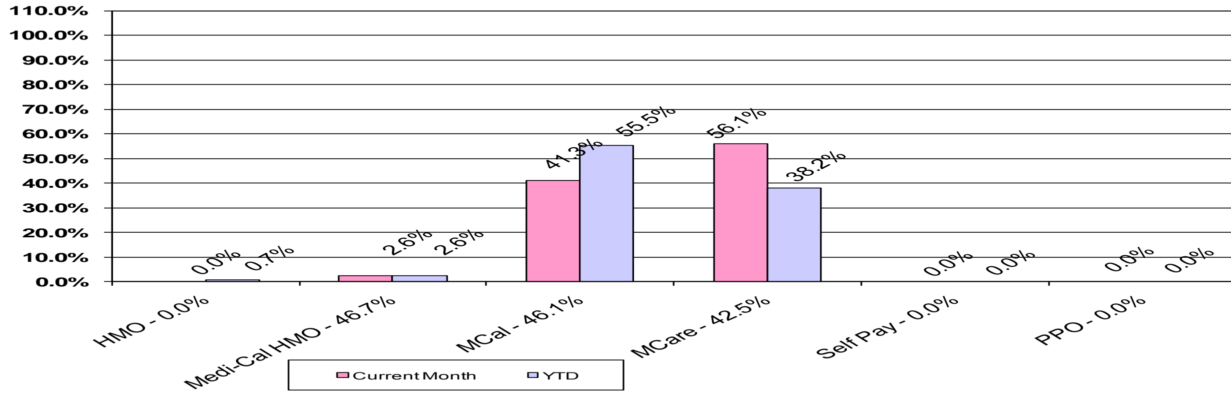


In February, the Sub-Acute care program again was dominated by Medi-Cal utilization of 67.7%, down from a high of 70% in January. Medicare was 25.7% and HMO/PPO rounds out the unit at 4.2%. The graph below shows the payer mix for the current month and fiscal year to date and the current months estimated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



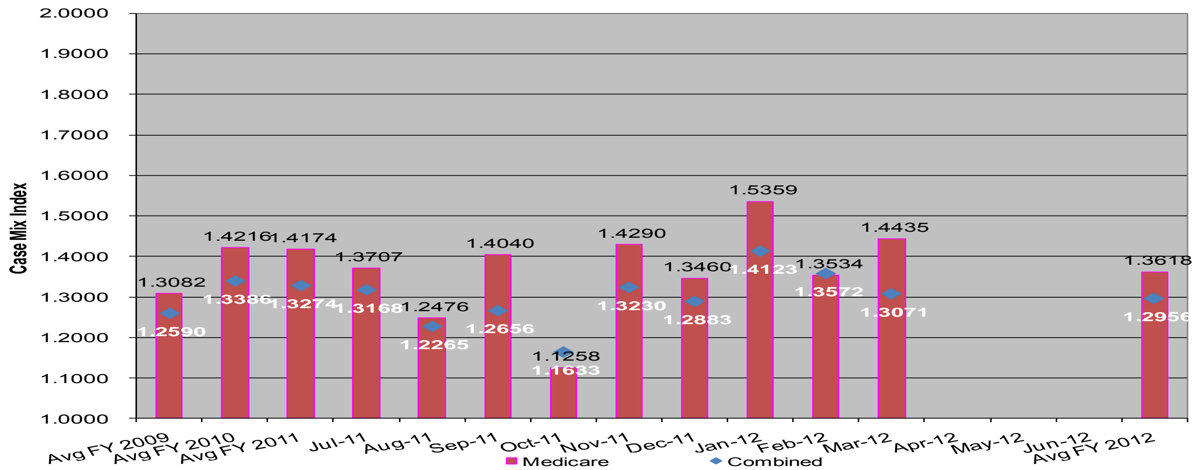
The graph below shows the current month and fiscal year to date skilled nursing payer mix and the current month's estimated level of reimbursement for each payer. Note the change in volumes between Medicare and Medi-Cal. This reflects the successful placement of an increasing volume of post-acute skilled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

Inpatient Skilled Nursing Payer Mix



Case Mix Index

The hospital's overall Case Mix Index (CMI) for March was 1.3071, down from the prior months of 1.3572, and below the March 2011 of 1.4580. The Medicare CMI increased from 1.3534 in February to 1.4435 in March. 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 March 2012 the CMI was 1.2969. This represents a 6.2% decline compared to the same time frame last year. 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.

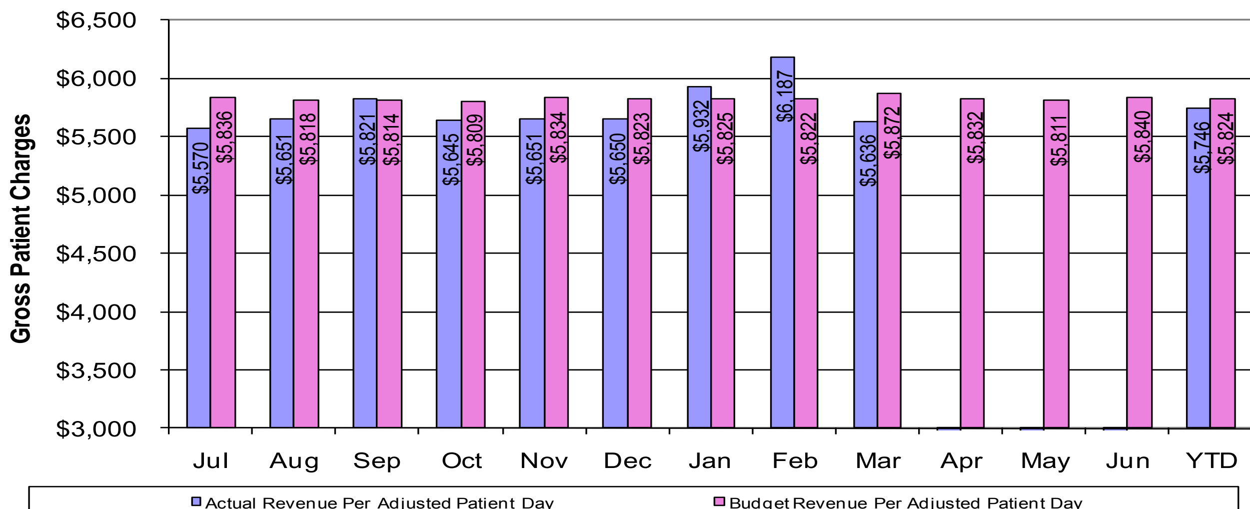
Case Mix Index Comparison

Financial Class	Jun 10 - Mar 11	Mar 11 YTD	Mar 12 YTD	Mar 12 YTD Volume
Blue Cross	0.0000	0.9873	0.0000	-
Commercial - Non-Contracted	1.9649	2.1959	1.1095	9
HMO	1.2522	1.1826	1.3154	90
Industrial	1.8373	1.6500	1.6603	9
Kaiser	1.8412	1.8890	1.8012	10
Medi-Cal HMO	1.0008	1.0069	1.0559	123
Medi-Cal	1.2724	1.2898	1.2126	108
Medicare	1.4724	1.4858	1.3690	1,121
Medicare HMO	1.3568	1.3549	1.3574	192
Personal Pay	1.0105	1.0290	1.1291	144
Medi-Cal Pending	1.8334	1.9058	2.0751	4
PPO	1.2613	1.2801	1.1050	231
VA	1.4051	1.3387	1.3925	45
Combined	**1.3758**	**1.3825**	**1.2969**	2,086

Revenue

Gross patient charges in March fell below the budget by $2.8 million, or 11.4%. Inpatient revenues were $2.5 million budget below the budget and outpatient revenues were down $277,000. Inpatient days were below budget by 11.7%, consistent with the inpatient gross revenue, yet inpatient surgeries and emergency visits were above budget. Outpatient registrations were 16.3% under budget. Outpatient revenues were lower than budget as a result of the lower volume. On an adjusted patient day basis, total patient revenue was $5,636, below the budget of $5,872 for the month of March and lower than February gross revenue per APD of $6,187. 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.

Gross Charges per Adjusted Patient



Contractual Allowances

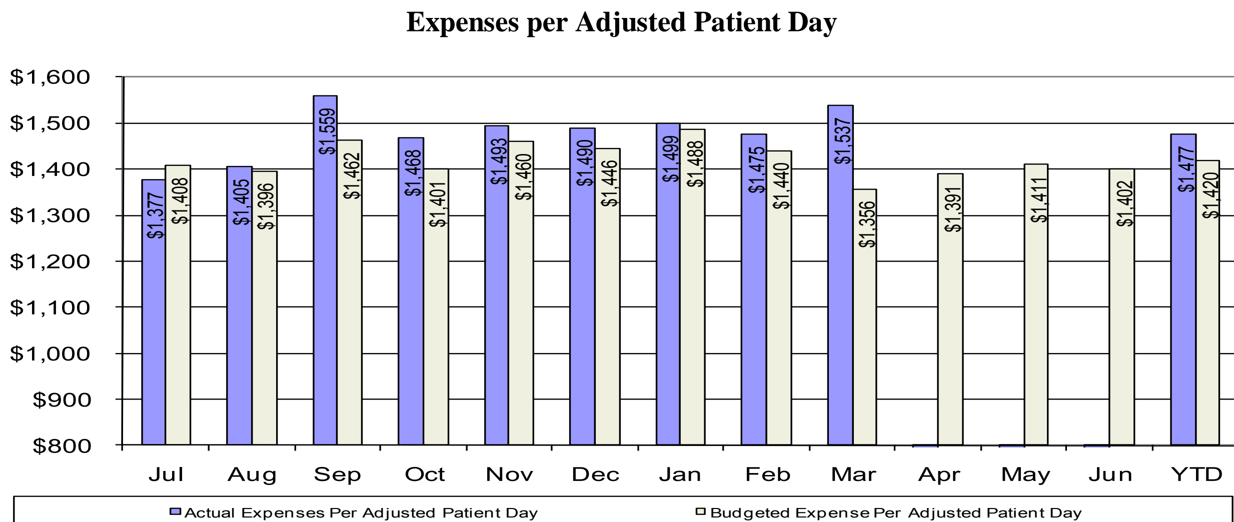
Contractual allowances are computed as deductions from gross patient revenues based on the difference between gross patient charges and the contractually agreed upon rates of reimbursement with third party government-based programs such as Medicare, Medi-Cal and other third party payers such as Blue Cross. As such net revenues as a percentage of gross revenues were very close to budget. A collection ratio of 22.2% was budgeted and 22.9% was realized.

Expenses

Total Operating Expenses

Total operating expenses were higher than the fixed budget by $270, 000 or 4.7% and YTD is above budget by just 0.3%. Salaries continue below budget however benefits were up. Non-medical professional fees were not as high this month but several areas were up as discussed below.

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 again this month which is expected with lower volume and the fixed nature of many expenses.



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 favorable to the fixed budget by $70,000 and yet were unfavorable to budgeted levels on a per adjusted patient day (PAPD) basis by $40 or 5.5%. Year to date salaries and agency expenses are running just above budget by 2.5% PAPD.

Benefits

Benefits were unfavorable to the fixed budget by $124,000 or 15.4%, and over budget per adjusted patient day by 24.7%. Group Health Insurance – Non Alameda Hospital contributed to this positive variance.

Professional Fees

Professional fees which had been running over budget were favorable to budget this month.

Supplies
Supplies were favorable to budget by $43,000 (5.5%). This is positive; however, the favorable supply cost variance was down from previous months. This month the 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 $214,000 above the fixed budget and $62 unfavorable PAPD. Expenses were up in Pathology, Dietary, Engineering, Information Systems, Accounting, Patient Accounting and hospital Administration.

Rents and Leases
Rents and leases were above the fixed budget by $32,000, and above budget $11 PAPD in March at $38 per adjusted patient day versus a budget of $28.

Other Operating Expense
Other operating expenses were $40,000 over the fixed budget and $12 over the budget on a per adjusted patient day basis. This variance relates to the payment of recruitment fees for two new hospital employees.

Balance Sheet

Total assets decreased almost $1.3M from the prior month, mostly due to the decrease in Cash which was partially offset by the increase in Other Receivables. The following items make up the increase in current assets:

- Total unrestricted cash and cash equivalents for March decreased by almost $1.9M and days cash on hand including restricted use funds decreased to 2.2 days on hand in March from 12.4 days on hand in February. This was largely due to the funding of the IGT program and the timing of payroll.

- Net patient accounts receivable decreased in March by $252,000 compared to an increase of $678,000 in February. Days in outstanding receivables were 64.8 at March month end, a drop from the high of 66.5 days in February. Collections in March were $5.5 million compared to $4.4 million in February. March also had 2 more business days than February.

- Other Receivables increased by almost $900,000 due to the IGT program. Third Party Settlements, Inventories and Prepaids remained fairly constant from one month to the next.

Total liabilities decreased by only $627,000 compared to an increase of $42,000 in the prior month. This decrease in the current month was the result of the following:

- Accounts payable and accrued expenses increased $57,000. This small increase is an improvement over prior month's accrued expenses.

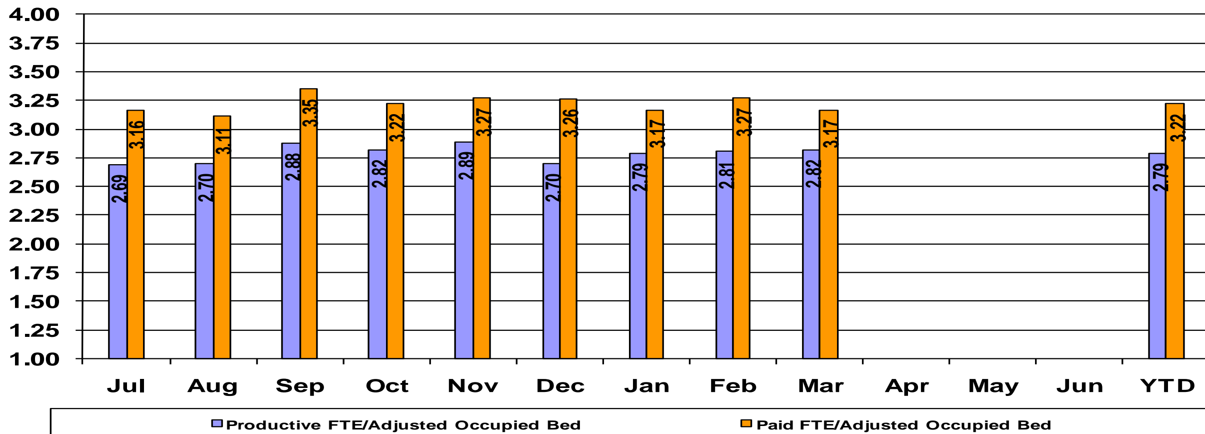
- Payroll related accruals decreased by $643,000 as a result of the timing of pay period end in relation to the month end.

- 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 2.82, above the budget of 2.63 FTE's by 6.9%, and paid FTE's were 3.17 or 5.4% 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 March is 1.0. This is a decrease from last month's ratio of 1.03.

A/R days

Net days in Accounts Receivable are currently at 64.8. This is down from prior month. We are working hard to bring this number down to 51, which will help our cash position.

Days Cash on Hand

Days cash on hand for March was 2.2. This has decreased from prior month of 12.4 because of IGT and payroll timing. It is expected that this will increase next month with receipt of the Districts tax monies.

The following pages include the detailed financial statements for the seven (9) months ended March 31, 2012, of fiscal year 2012.

ALAMEDA HOSPITAL
KEY STATISTICS
MARCH 2012

	ACTUAL MARCH 2012	CURRENT FIXED BUDGET	VARIANCE (UNDER) OVER	%	MARCH 2011	YTD MARCH 2012	YTD FIXED BUDGET	VARIANCE	%	YTD MARCH 2011
Discharges:										
Total Acute	245	265	(20)	-7.5%	233	2,125	2,105	20	1.0%	1,882
Total Sub-Acute	5	2	3	150.0%	2	20	14	6	42.9%	18
Total Skilled Nursing	10	10	-	0.0%	19	79	80	(1)	-1.3%	79
	260	277	(17)	-6.1%	254	2,224	2,199	25	1.1%	1,979
Patient Days:										
Total Acute	905	1,059	(154)	-14.5%	1,085	8,215	8,422	(207)	-2.5%	8,074
Total Sub-Acute	951	1,023	(72)	-7.0%	1,032	8,887	9,075	(188)	-2.1%	8,946
Total Skilled Nursing	653	759	(106)	-14.0%	630	5,778	6,037	(259)	-4.3%	6,005
	2,509	2,841	(332)	-11.7%	2,747	22,880	23,534	(654)	-2.8%	23,025
Average Length of Stay										
Total Acute	3.69	4.00	(0.30)	-7.6%	4.66	3.87	4.00	(0.14)	-3.4%	4.29
Average Daily Census										
Total Acute	29.19	34.16	(5.13)	-15.0%	35.00	29.87	30.63	(0.75)	-2.5%	29.36
Total Sub-Acute	30.68	33.00	(2.40)	-7.3%	33.29	32.32	33.00	(0.68)	-2.1%	32.53
Total Skilled Nursing	21.06	24.48	(3.53)	-14.4%	20.32	21.01	21.95	(0.94)	-4.3%	21.84
	80.94	91.65	(11.07)	-12.1%	88.61	83.20	85.58	(1.44)	-1.7%	83.73
Emergency Room Visits	1,506	1,426	80	5.6%	1,461	12,754	12,650	104	0.8%	12,640
Outpatient Registrations	1,901	2,271	(370)	-16.3%	2,197	16,621	18,168	(1,547)	-8.5%	17,881
Surgery Cases:										
Inpatient	57	50	7	14.0%	47	377	398	(21)	-5.3%	401
Outpatient	136	142	(6)	-4.2%	139	1,322	1,250	72	5.8%	1,244
	193	192	1	0.5%	186	1,699	1,648	51	3.1%	1,645
Adjusted Occupied Bed (AOB)	125.42	135.86	(10.44)	-7.7%	126.87	122.46	126.86	(4.40)	-3.5%	124.69
Productive FTE	353.09	357.70	(4.61)	-1.3%	386.79	344.10	344.26	(0.16)	0.0%	368.67
Total FTE	397.39	408.57	(11.18)	-2.7%	438.55	396.42	405.39	(8.97)	-2.2%	425.48
Productive FTE/Adj. Occ. Bed	2.82	2.63	0.18	6.9%	3.05	2.81	2.71	0.10	3.5%	2.96
Total FTE/ Adj. Occ. Bed	3.17	3.01	0.16	5.4%	3.46	3.24	3.20	0.04	1.3%	3.41

City of Alameda Health Care District
Statements of Financial Position
March 31, 2012

	Current Month	Prior Month	Prior Year End
Assets			
Current Assets:			
Cash and Cash Equivalents	$ 428,701	$ 2,253,861	$ 1,784,141
Patient Accounts Receivable, net	10,311,955	10,563,953	7,249,185
Other Receivables	4,569,093	3,674,460	8,090,457
Third-Party Payer Settlement Receivables	661,578	661,578	150,000
Inventories	1,146,202	1,152,120	1,183,358
Prepaids and Other	222,070	300,951	262,359
Total Current Assets	17,339,599	18,606,923	18,719,500
Assets Limited as to Use, net	35,702	24,337	483,716
Fixed Assets			
Land	877,945	877,945	877,945
Depreciable capital assets	43,405,170	43,397,622	43,383,571
Construction in progress	3,570,359	3,515,044	2,921,048
Depreciation	(39,471,735)	(39,404,854)	(38,862,494)
Property, Plant and Equipment, net	8,381,739	8,385,757	8,320,070
Total Assets	**$ 25,757,040**	**$ 27,017,017**	**$ 27,523,286**
Liabilities and Net Assets			
Current Liabilities:			
Current Portion of Long Term Debt	$ 1,552,815	$ 1,579,531	$ 746,074
Accounts Payable and Accrued Expenses	8,937,239	8,885,354	6,987,765
Payroll Related Accruals	4,089,480	4,732,459	3,991,254
Deferred Revenue	1,432,594	1,909,641	5,725,900
Employee Health Related Accruals	629,895	629,895	343,382
Third-Party Payer Settlement Payable	631,035	368,344	(3,930)
Total Current Liabilities	17,273,058	18,105,224	17,790,445
Long Term Debt, net	806,915	845,575	1,142,109
Total Liabilities	18,079,973	18,950,799	18,932,554
Net Assets:			
Unrestricted	7,471,364	7,871,880	8,037,015
Temporarily Restricted	205,702	194,337	553,716
Total Net Assets	7,677,066	8,066,217	8,590,731
Total Liabilities and Net Assets	**$ 25,757,040**	**$ 27,017,017**	**$ 27,523,286**

City of Alameda Health Care District
Statements of Operations
March 31, 2012
$'s in thousands

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Patient Days	2,509	2,841	(332)	-11.7%	2,747	22,880	23,534	(654)	-2.8%	23,025
Discharges	260	277	(17)	-6.1%	254	2,224	2,199	25	1.1%	1,979
ALOS (Average Length of Stay)	9.65	10.26	(0.61)	-5.9%	10.81	10.29	10.70	(0.41)	-3.9%	11.63
ADC (Average Daily Census)	80.9	91.6	(10.71)	-11.7%	88.6	84	85.9	(2.39)	-2.8%	84.0
CMI (Case Mix Index)	1.3071				1.4546	1.2951				1.3734
Revenues										
Gross Inpatient Revenues	$ 14,140	$ 16,682	$ (2,542)	-15.2%	$ 16,162	$ 131,524	$ 137,061	$ (5,537)	-4.0%	$ 126,322
Gross Outpatient Revenues	7,771	7,973	(202)	-2.5%	7,206	62,526	65,667	(3,141)	-4.8%	61,083
Total Gross Revenues	21,912	24,655	(2,743)	-11.1%	23,368	194,050	202,728	(8,678)	-4.3%	187,405
Contractual Deductions	16,775	18,223	1,448	7.9%	17,161	145,414	149,392	3,979	2.7%	134,157
Bad Debts	(17)	765	782	102.2%	891	3,365	6,429	3,063	47.6%	5,845
Charity and Other Adjustments	136	187	51	27.1%	190	1,505	1,551	47	3.0%	1,447
Net Patient Revenues	5,017	5,480	(462)	-8.4%	5,127	43,766	45,355	(1,589)	-3.5%	45,957
Net Patient Revenue %	22.9%	22.2%			21.9%	22.6%	22.4%			24.5%
Net Clinic Revenue	51	30	21	69.5%	45	336	177	159	90.1%	303
Other Operating Revenue	15	10	5	49.0%	10	239	91	148	163.3%	91
Total Revenues	**5,084**	**5,520**	**(436)**	-7.9%	**5,182**	**44,341**	**45,623**	**(1,282)**	-2.8%	**46,351**
Expenses										
Salaries	2,869	2,904	35	1.2%	3,048	25,614	25,502	(113)	-0.4%	26,756
Temporary Agency	127	163	35	21.8%	271	1,051	1,342	291	21.7%	1,876
Benefits	927	803	(124)	-15.4%	948	7,697	7,168	(529)	-7.4%	7,255
Professional Fees	321	339	18	5.3%	342	3,373	2,688	(685)	-25.5%	2,715
Supplies	740	783	43	5.5%	744	5,520	6,788	1,268	18.7%	6,589
Purchased Services	588	374	(214)	-57.3%	369	3,471	3,320	(151)	-4.5%	3,331
Rents and Leases	148	116	(32)	-27.9%	74	847	833	(14)	-1.7%	618
Utilities and Telephone	53	65	12	17.8%	64	589	584	(5)	-0.8%	566
Insurance	25	17	(8)	-45.1%	31	246	152	(94)	-62.2%	285
Depreciation and amortization	67	77	10	13.4%	77	646	642	(4)	-0.6%	719
Other Opertaing Expenses	111	71	(40)	-55.7%	58	823	692	(131)	-19.0%	763
Total Expenses	**5,977**	**5,713**	**(264)**	-4.6%	**6,026**	**49,876**	**49,710**	**(166)**	-0.3%	**51,472**
Operating gain (loss)	**(894)**	**(193)**	**(701)**	-363.1%	**(844)**	**(5,535)**	**(4,087)**	**(1,448)**	35.4%	**(5,122)**
Non-Operating Income / (Expense)										
Parcel Taxes	478	478	0	0.0%	479	4,324	4,302	22	0.5%	4,307
Investment Income	1	0	0	177.0%	0	5	(114)	119	-104.4%	9
Interest Expense	(12)	(12)	1	4.5%	(9)	(138)	(13)	(126)	985.3%	(80)
Other Income / (Expense)	26	22	4	16.6%	1,473	233	201	31	15.6%	1,648
Net Non-Operating Income / (Expense)	**493**	**488**	**5**	**1.0%**	**1,943**	**4,423**	**4,376**	**47**	**1.1%**	**5,884**
Excess of Revenues Over Expenses	**$ (401)**	**$ 295**	**$ (696)**	**-235.6%**	**$ 1,099**	**$ (1,112)**	**$ 289**	**$ (1,401)**	**-484.5%**	**$ 762**

City of Alameda Health Care District

Statements of Operations - Per Adjusted Patient Day

March 31, 2012

	Current Month					Year-to-Date				
	Actual	Budget	$ Variance	% Variance	Prior Year	Actual	Budget	$ Variance	% Variance	Prior Year
Revenues										
Gross Inpatient Revenues	$ 3,637	$ 3,973	$ (336)	-8.5%	$ 4,069	$ 3,896	$ 3,937	$ (41)	-1.0%	$ 3,698
Gross Outpatient Revenues	1,999	1,899	100	5.3%	1,814	1,852	1,886	(34)	-1.8%	1,788
Total Gross Revenues	5,636	5,872	(236)	-4.0%	5,883	5,748	5,824	(76)	-1.3%	5,486
Contractual Deductions	4,315	4,340	25	0.6%	4,321	4,308	4,292	(16)	-0.4%	3,927
Bad Debts	(4)	182	187	102.4%	224	100	185	85	46.0%	171
Charity and Other Adjustments	35	45	9	21.3%	48	45	45	(0)	0.0%	42
Net Patient Revenues	1,291	1,305	(15)	-1.1%	1,291	1,297	1,303	(6)	-0.5%	1,345
Net Patient Revenue %	22.9%	22.2%			21.9%	22.6%	22.4%			24.5%
Net Clinic Revenue	13	7	6	83.1%	11	10	5	5	96.1%	9
Other Operating Revenue	4	2	1	60.9%	3	7	3	4	171.5%	3
Total Revenues	**1,308**	**1,315**	**(7)**	-0.5%	**1,305**	**1,314**	**1,311**	**3**	0.2%	**1,357**
Expenses										
Salaries	738	692	(46)	-6.7%	767	759	733	(26)	-3.6%	783
Temporary Agency	33	39	6	15.6%	68	31	39	7	19.3%	55
Benefits	239	191	(47)	-24.7%	239	228	206	(22)	-10.7%	212
Professional Fees	83	81	(2)	-2.3%	86	100	77	(23)	-29.4%	79
Supplies	190	187	(4)	-2.1%	187	164	195	31	16.1%	193
Purchased Services	151	89	(62)	-69.9%	93	103	95	(7)	-7.8%	98
Rents and Leases	38	28	(11)	-38.1%	19	25	24	(1)	-4.9%	18
Utilities and Telephone	14	15	2	11.2%	16	17	17	(1)	-4.0%	17
Insurance	6	4	(2)	-56.7%	8	7	4	(3)	-67.2%	8
Depreciation and Amortization	17	18	1	6.5%	19	19	18	(1)	-3.7%	21
Other Operating Expenses	29	17	(12)	-68.2%	15	24	20	(5)	-22.7%	22
Total Expenses	**1,537**	**1,361**	**(177)**	-13.0%	**1,517**	**1,477**	**1,428**	**(49)**	-3.5%	**1,507**
Operating Gain / (Loss)	**(230)**	**(46)**	**(184)**	-400.1%	**(213)**	**(164)**	**(117)**	**(47)**	39.7%	**(150)**
Non-Operating Income / (Expense)										
Parcel Taxes	123	114	9	8.0%	121	128	124	5	3.6%	126
Investment Income	0	0	0	199.1%	0	0	0	0	175.5%	0
Interest Expense	(3)	(3)	(0)	-3.1%	(2)	(4)	(3)	(1)	24.8%	(2)
Other Income / (Expense)	7	5	1	26.0%	371	7	6	1	19.2%	48
Net Non-Operating Income / (Expense)	**127**	**116**	**11**	**9.1%**	**489**	**131**	**126**	**5**	**3.9%**	**172**
Excess of Revenues Over Expenses	**$ (103)**	**$ 70**	**$ (173)**	-246.5%	**$ 277**	**$ (33)**	**$ 9**	**$ (42)**	-465.4%	**$ 23**

City of Alameda Health Care District
Statement of Cash Flows
For the Nine Months Ended March 31, 2012

	Current Month	Year-to-Date
Cash flows from operating activities		
Net Income / (Loss)	$ (400,517)	$ (1,111,656)
Items not requiring the use of cash:		
Depreciation and amortization	66,881	$ 645,550
Write-off of Kaiser liability	-	$ -
Changes in certain assets and liabilities:		
Patient accounts receivable, net	251,998	(3,062,770)
Other Receivables	(894,633)	3,521,364
Third-Party Payer Settlements Receivable	262,691	123,387
Inventories	5,918	37,156
Prepaids and Other	78,881	40,289
Accounts payable and accrued liabilities	51,885	1,949,474
Payroll Related Accruals	(642,979)	98,226
Employee Health Plan Accruals	0	286,513
Deferred Revenues	(477,047)	(4,293,306)
Cash provided by (used in) operating activities	(1,696,922)	(1,765,773)
Cash flows from investing activities		
(Increase) Decrease in Assets Limited As to Use	(11,365)	448,014
Additions to Property, Plant and Equipment	(62,863)	(707,219)
Other	1	546,005
Cash provided by (used in) investing activities	(74,227)	286,800
Cash flows from financing activities		
Net Change in Long-Term Debt	(65,376)	471,547
Net Change in Restricted Funds	11,365	(348,014)
Cash provided by (used in) financing and fundraising activities	(54,011)	123,533
Net increase (decrease) in cash and cash equivalents	(1,825,160)	(1,355,440)
Cash and cash equivalents at beginning of period	2,253,861	1,784,141
Cash and cash equivalents at end of period	$ 428,701	$ 428,701

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results			Unaudited Results	
	FY 2008	FY 2009	FY 2010	FY 2011	YTD 3/31/2012
Profitability Ratios					
Net Patient Revenue (%)	22.48%	22.69%	24.16%	23.58%	22.55%
Earnings Before Depreciation, Interest, Taxes and Amortization (EBITA)	-0.72%	3.62%	4.82%	-1.01%	-0.74%
EBIDAP[Note 5]	-10.91%	-5.49%	-3.66%	-13.41%	-10.49%
Total Margin	-3.75%	1.03%	2.74%	-2.61%	-2.51%
Liquidity Ratios					
Current Ratio	0.98	1.15	1.23	1.05	1.00
Days in accounts receivable ,net	51.70	57.26	51.83	46.03	64.79
Days cash on hand (with restricted)	30.6	13.6	21.6	14.1	2.4
Debt Ratios					
Cash to Debt	187.3%	115.3%	249.0%	123.3%	19.68%
Average pay period	58.93	58.03	57.11	62.68	76.07
Debt service coverage	(0.14)	3.87	5.98	(0.70)	(0.19)
Long-term debt to fund balance	0.26	0.20	0.14	0.18	0.24
Return on fund balance	-29.59%	8.42%	18.87%	-19.21%	-14.48%
Debt to number of beds	20,932	13,481	10,482	11,515	14,657

City of Alameda Health Care District
Ratio's Comparison

Financial Ratios	Audited Results			Unaudited Results	
					YTD
	FY 2008	FY 2009	FY 2010	FY 2011	3/31/2012
Patient Care Information					
Bed Capacity	135	161	161	161	161
Patient days(all services)	22,687	30,463	30,607	30,270	22,880
Patient days (acute only)	11,276	11,787	10,579	10,443	8,215
Discharges(acute only)	2,885	2,812	2,802	2,527	2,125
Average length of stay (acute only)	3.91	4.19	3.78	4.13	3.87
Average daily patients (all sources)	61.99	83.46	83.85	82.93	83.20
Occupancy rate (all sources)	45.92%	52.94%	52.08%	51.51%	51.68%
Average length of stay	3.91	4.19	3.78	4.13	3.87
Emergency Visits	17,922	17,337	17,624	16,816	12,754
Emergency visits per day	48.97	47.50	48.28	46.07	46.38
Outpatient registrations per day[Note 1]	84.54	82.05	79.67	65.19	60.44
Surgeries per day - Total	14.78	16.12	13.46	6.12	6.18
Surgeries per day - excludes Kaiser	5.54	5.14	5.32	6.12	6.18

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: April26, 2012

FOR: May 7, 2012 District Board Meeting

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

THROUGH: Finance and Management Committee

FROM: Kerry Easthope, Chief Financial Officer

SUBJECT: Recommendation to Enter into an Agreement with Select Therapies for Long Term Care Rehabilitation Services Management

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Recommendation:

The Finance and Management Committee and management recommend that the District Board of Directors authorize entering into a contract with Select Therapies to provide management and rehabilitation personnel for the rehab services provided at South Shore and the Subacute Unit (LTC Services).

The total overall financial opportunity associated with this recommendation at current outpatient rehab volumes and current Medicare A Average Daily Census (ADC) at South Shore is $460,227 per year.

With the incorporation of outpatient rehab volumes from the Orthopedic Program and an increasing the Medicare ADC at South Shore the financial results will increase to $632,000 per year. This is discussed in more detail under the Financial Analysis section starting on page 5.

Background:

Over the past month, management has had continued discussions about our current and future needs for Rehabilitation Services. The addition of Waters Edge Skilled Nursing Facility to the hospital, together with our interest in enhancing our acute inpatient and outpatient rehab programs, are driving our approach on how to best structure and manage the department going forward.

Under the direction of Richard Espinoza, our new Long Term Care Administrator, we are implementing policies & procedures and clinical protocols that are consistent throughout our Long Term Care (LTC) units (Subacute, South Shore and now Waters Edge). This consistency is especially important now that LTC services have become such a significant part of our overall patient population. In addition, all three facilities will be surveyed as one unit by the California Department of Public Health and having standardized clinical and administrative policies & procedures are required.

Waters Edge recently contracted with Select Therapy, a professional Rehab management firm specializing in long term care therapy, to provide Physical Therapy, Occupational Therapy and Speech Therapy services to the residents at that facility. In meeting with Select Therapy, we believe they can provide the types of comprehensive clinical programs and services necessary for the success of our LTC units, which differ from the acute care setting. By retaining Select Therapies as the contracted rehab company, we will maintain the continuity and high quality of care provided at the facility during the transition to the hospital.

Discussion:

Needs and Benefits of a Strong LTC Rehab Program:

A strong rehab program is critical to the success of our LTC service lines. The positive affects of a well managed LTC Rehab program include:

- Effective and efficient communication & coordination of care with physicians and nursing personnel.
- Well documented plans of care that lead to successful outcomes, both clinically and financially, for monitoring both skilled and custodial residents at all three LTC facilities. This includes Quality Assurance monitoring, Prospective Payment System (PPS), MDS 3.0 reimbursement & regulatory requirements and performance improvement activities that are consistent throughout our LTC service lines.
- Quality of life for the custodial nursing and Subacute residents to prevent decline in function and to assess / assist in developing plans and treatment to increase overall function for the resident.
- Facility specific programs based upon their unique resident needs such as – homeward bound and community reentry programs, wheelchair and bed positioning, contracture management & splinting, pain management, behavior and dementia management, falls prevention & post falls intervention, environmental adaptations, continence improvement, cognitive function and wound care.
- Financial management: this requires up to date understanding of Medicare (PPS), MDS 3.0, detailed understanding of Medicare part B caps, Medi-cal and other third party reimbursement contracts to ensure that we are appropriately reimbursed for the care that is provided and contracted for, which requires daily monitoring.
- Marketing and community / physician outreach: long term care programs that have a quality and innovative rehab program is a very important factor that prospective residents, families and other referring acute care hospitals when choosing a facility.
- State surveys and regulatory compliance: Waters Edge, South Shore and the subacute unit comprise our skilled nursing services within the hospital. It will be expected that the policy & procedures, education/training, and ancillary services provided be consistent in each of these units.

Given the above factors, we feel that it is important to have all of our LTC rehab services be provided by Select Therapy who can provide a spectrum of programs and resources that are needed to make all of our LTC service lines successful. Although we acknowledge that our hospital based rehab staff have done a respectable job working with the residents in the Subacute unit and at South Shore, we continue to receive feedback that there is a need for improved

communication with nursing personnel, coordination of scheduling of resident therapy sessions, processes for managing resident plans of care and modifying those plans when there is a change in condition in conjunction with changes in the residents insurance benefits. Furthermore, the addition of Waters Edge will increase our skilled nursing capacity by over 100 residents, many of whom will be high rehab utilizing residents. We do not currently have the capability to manage this in-house.

Needs and Benefits of a Strong Outpatient and Acute Inpatient Rehab Program:

Rehabilitation Services (Speech Therapy, Occupational Therapy and Physical Therapy) are core service lines of any acute care hospital and nearly every physician specialty refers patients for rehab services and our ability to provide timely access to a quality /comprehensive rehab program is an essential component of the hospital's future growth and success.

For patients in the acute care setting, rehab services are integral part of the patient care plan. Physicians rely on timely assessments by the rehab staff in order to understand the physical needs and capabilities of the patients they are caring for and to modify their orders accordingly. Physicians and discharge planners rely on these assessments to help determine when the patient is physically ready for a safe discharge from the hospital.

The need for a comprehensive and well managed inpatient and outpatient rehab program will be even more essential as we develop an orthopedic program here at the hospital, as was presented at the April 2nd Board Meeting. Not only will orthopedic surgeons use physical and occupational therapy after surgical procedures, they will also recommend therapy on a conservative basis for those patients experiencing other types of injury or chronic health problem, strength training, continued physical fitness, or pre-surgical treatment. As such, our rehab services program will be promoted in conjunction with our orthopedics program throughout Alameda and our greater service area. Rehab Services address a key component of the Hospital's strategic plan to increase outpatient services that will better serve the community and the Hospital.

Service Expectations:

At a minimum these management recommendations should accomplish the following:

- First and foremost, implement the clinical programs and establish best practices to meet the needs of our patients resulting in improved clinical outcomes. This applies to LTC as well as the Outpatient / Inpatient programs.
- Increased utilization of rehab services based upon the patients needs and abilities. Work with other clinical staff and physicians in a team effort to create best practices to improve clinical outcomes.
- Improved financial performance through increased rehab service utilization, increased physician referrals and operational efficiencies.
- Improved overall productivity of the Rehab Services department by allowing staff to focus on specific service areas and patient types (e.g. LTC, acute inpatient and outpatient) based upon industry benchmarks.

- More timely access for initial outpatient rehab assessments and more efficient scheduling of follow up visits.
- Additional training, education and skill development of the rehab personnel.
- Develop a comprehensive rehab services program to support the needs of quality Orthopedics program.
- Participate in marketing and community awareness of our rehab services programs.

Staffing Model:

The staffing model for this recommendation was developed based upon the actual amount of paid time associated with services provided in each service area (inpatient, outpatient, subacute and South Shore). It also takes into consideration both core staffing needs of the department as well as staffing/productivity benchmarks in the industry.

The following is a summary of the hospital based staffing needs to support both recommendations. Please see Attachment A for a more detailed breakdown of current staffing allocation. Further discussion regarding the suggested change in staffing levels is included in the Financial Analysis section that follows as it coincides with assumptions on patient volumes.

	Current Staffing	Outpatient	Inpatient/ Outsource LTC	New
Speech	0.5			.5
OT	1.6		(.4)	1.2
PT/PT Assist	5.4	(1.5)	(1.0)	2.9
Manager (PT)		1.0		1.0
Receptionist	1.0			1.0
Total	8.5	(.5)	(1.4)	6.6

All of our current rehab staff, other than the receptionist work less than full time, most are .64 or .48 status. One of the initial tasks of the Rehab Manager will be to determine what modifications will need to be made to the staff work schedule and ensure that the rehab personnel are properly aligned with the patient care activity.

Speech Therapy is currently considered at a “core” staffing level. Even though the staffing model on Attachment A indicates that .13 FTE is associated with care in LTC services and could be reduced with outsourcing this service to Select Therapies, Speech Therapy is an essential component of the hospital’s stroke certification program and timely swallow assessments and dysphasia training make it necessary to maintain current staffing levels.

With this model Occupational Therapy be reduced by .4 FTE for time allocated to LTC services. Even though the total inpatient & outpatient staffing need is .76, our Occupational Therapist provide a valuable employee ergonomics program that has resulted in fewer and less severe workers compensation lost time and expense. This service is very valuable and is recommended to remain at 1.2 FTE’s. The 1.2 FTE’s will also provides a solid core staffing level to support our inpatient and outpatient service as needs.

Physical Therapist / PT Assistants will be most affected by this recommendation. Do to recruiting challenges we have been using a full time registry physical therapist for the past year. This has been a needed but more expense resource and will be the first position to be reduced. It is expected that the new Rehab Manager for the Inpatient/Outpatient program will be a working manager and spend about half of their time performing direct patient care.

The Manager will also assess and determine what the appropriate staffing requirements will be for physical therapists and PT Assistants. In addition to the registry therapist, a 1.0 FTE of staff therapy hours (PT /PT Assistants) will be reduced to achieve the outpatient productivity benchmarks at our current visit volumes.

Lastly, with the Manager working half time providing patient care, there would be no additional reductions if this person is an internal candidate, however, if a Manager is brought in from the outside, and additional .5 FTE would need to be reduced. A summary of the industry productivity benchmarks for outpatient rehabilitation programs is outlined on Attachment B.

Select Therapy has committed to interview and offer employment to any interested rehab staffs that are affected by the staffing reductions associated with this recommendation.

Financial Analysis:

The incremental financial opportunity of this recommendation is derived primarily from the Outpatient program and Medicare A patients at South Shore skilled nursing.

Acute Inpatient:
The acute inpatient and subacute units require core staffing to ensure that assessments and treatments are completed on a timely basis; however the reimbursement for these programs is included in the DRG or per diem payment. For these nursing units, we want to provide additional rehab services as needed to achieve the desired clinical outcomes and quality of life for our patient's, meet the expectations of our physicians and enhance our ability to promote these services to physicians and the community. However, there is no incremental reimbursement projected for these services.

The acute inpatient staffing levels will need to be monitored and adjusted accordingly based upon fluctuations in inpatient census and the number of patient assessments. This will most likely increase with an active orthopedic surgical program at the hospital. Having a dedicated inpatient therapy team will allow the outpatient program to schedule patients more effectively resulting in staffing efficiency and our ability to facilitate a greater number of outpatient visits while maintaining the service level expected of our inpatient services.

Outpatient:
Outpatient rehab care is reimbursed based upon the number of patients treated and the amount of time, measured in 15 minute billable units, spent with each patient. Both the number of visits and the amount of time spent with each patient are determined by the clinical needs of the patient as indicated in the physician orders. It is expected that post orthopedic patients will require more rehab than other medical patients and this will increase revenues for the department. In addition, the orthopedic program is projected to about 4,100 new outpatient visits per year. As previously mentioned, there are established industry productivity benchmarks for outpatient rehab programs that are applied on the financial analysis.

Attachment C demonstrates that the current staffing, visits, revenues, expenses and contribution margin for our outpatient services. It then demonstrates a waterfall financial affect of implementing appropriate staffing levels based upon the industry standards and the financial impact of adding an orthopedics program. The anticipated affect on the Contribution Margin is as follows:

FY 2012	Benchmark Staffing	Orthopedics	With Changes
($145,367)	$53,144	$63,530	($28,693)

Implementing the appropriate staffing levels and compliment of Physical Therapists / PT Aides will improve the contribution margin by $53,144 per year.

With the addition of the Orthopedic Program, outpatient rehab is projected to improve the contribution margin by an additional $63,530 and even more importantly, serve as an essential component of a much larger Orthopedics Program that is estimated to net $793,504 in year one. It is essential to establish a comprehensive rehab component in order for the orthopedic program to be successful.

As previous discussed, it is necessary to have a dedicated working Rehab Services Manager who can work with nursing services and administration to implement the acute inpatient and outpatient clinical programs that will be required to grow this service line. The manager will also need to implement patient scheduling, staff scheduling, and to help market and promote the rehab services to physicians and the community.

Even though we can significantly improve the financial performance of the outpatient program through these changes, we have learned that we need to focus on rehab service reimbursement in our future third party payor contract negotiations to yield greater reimbursement per visit. The greatest revenue opportunity associated with this recommendation will come from enhanced and carefully managed rehab services provided in our LTC service areas.

Outpatient Rehab Space and Equipment Needs:
The existing rehab department has five treatment bays and a small equipment area. Although there is capacity in this area to treat an increased number of patients, additional exercise and rehab equipment space will be needed to support the Orthopedic Program once ramped up. There is space within the hospital where the Cardiofit program once was that could possibly be used for expansion of our rehab service area. Longer term, we may want to relocate the outpatient program to Marina Village, where our Wound Care program is located.

Much of the equipment in rehab is old and needs to be replaced. Fortunately, rehab equipment is modestly priced compared to other Hospital equipment. In the FY 2013 capital budget we will allow for $10,000 - $15,000 to replace old monitoring equipment, exercise bikes, and other needed rehab equipment.

Long Term Care Service Lines:
South Shore patients, like those at Waters Edge, can greatly benefit from a more comprehensive rehab program as discussed previously. From a financial perspective, the short term Medicare A

patients require more rehab care than the long term custodial residents since many of these patients will be discharged once their level of function has improved to the highest practicable level. Reimbursement for the Medicare A patient is based upon established Resource Utilization Group (RUG) scores which are determined in large part, by the amount of therapy services provided. For the current fiscal year to date, South Shore has been operating at a 2.16 Medicare A ADC. Under the direction of our new Long Term Care Administrator, we believe this average census can increase to 4.0. Together with a dedicated and LTC focused rehab program managed by Select Therapy, the amount of rehab care will also increase, resulting not only in improved clinical outcomes for the patients, but also higher RUG scores and increased reimbursement. See Attachment D.

Rehab care provided in the subacute unit, like acute inpatient, is included in the per diem rate paid to the hospital. However, because we have received feedback from our clinical staff that our subacute patients could benefit from additional rehab care, the Select Therapy proposal includes staffing to double the amount of therapy time provided.

The following is a summary of the financial opportunity at South Shore. The complete financial analysis is on Attachment E.

FY 2012 (2.16 ADC)	Select Therapies (2.16 ADC)	Select Therapies Increase in ADC – 4.0
$226,920	$407,083	$515,417

There will be some Part B therapy services provided to the long term custodial resident; however, this reimbursement is capped at $3,760. We have not fully monitored or maximized this potential in the past. The financial opportunity is about $23,500 per year.

The most significant opportunity is with our Medicare A patients. As noted on the financial analysis, even with the current Medicare A days at South Shore, it is conservatively estimated that under Select Therapies management, this program will produce $180,164 additional revenue each year. The current average reimbursement per Medicare A day is $481, only $96 higher than the per diem Medi-Cal rate of $385 per day. This rate is lower in part, because about 28% of Medicare A patient days did not get any rehab and were paid solely based upon nursing services; this provides an opportunity not only for better patient care but also better financial results.

Having a more comprehensive LTC rehab program will allow us to take care of a greater number of post acute rehab patients, many being post surgical patients. We are budgeting a 4.0 Medicare A average daily census at South Shore which will result in reimbursement of $1,034,583, an increase of $515,417 over the current performance.

The opportunity for a positive financial contribution is much greater for the LTC programs than for the outpatient program if it is properly staffed and managed. From a financial management perspective, this is the driving force behind outsourcing this component to Select Therapy and they have a proven track record in this area.

Key Terms of recommended Select Therapy Contract:

The Select Therapy contract is a one year contract that will automatically renew for successive one year terms unless terminated by either party by providing 90 days notice after the initial one year term. The fee schedule is variable, based solely on the Medicare A days at each RUG levels. Therefore, Select's fee is based upon billable time that we will get reimbursed for. The Select fee for Part B services is 70% of the Part B fee. Rehab services provided in the subacute unit is $30 per billable unit (time actually spend treating residents). It is our expectation that Select Therapies will bring creative programs to the subacute unit to enhance the quality of life of these residents. Select will participate in Quality Assurance / Performance Improvement and other hospital committees as do other management staff.

Select will also utilize Casamba, a rehab specific software application that helps document the patients care plan, but also tracks the patient's progress and coordination with billing and reimbursement. Select Therapy provides rehab service in over 100 skilled nursing facilities in California and around the county with approximately 20 facilities in Central and Northern California. Providing rehab services to LTC residents is what they do.

If approved, we would like to implement the recommended changes effective July 1, 2012, to coincide with the new fiscal year. We will monitor performance throughout the year and report actual results against expectations.

DATE: May 2, 2012

FOR: May 7, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Tony Corica, Director of Physician Relations

SUBJECT: Approval of Revisions to the Terms and Conditions of the Orthopedic Professional Service Agreements and Authorization to Execute Such Agreements

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RECOMMENDATION:

Management is requesting approval of the attached revisions to the terms and conditions of the orthopedic Professional Service Agreements relating to compensation and authorization to execute such agreements upon Board approval.

BACKGROUND:

The City of Alameda Health Care District Board unanimously approved entering into Professional Service Agreements with two orthopedic surgeons at their April 2, 2012 meeting. The negotiations that began following that meeting resulted in increased compensation being proposed for the surgeons.

DISCUSSION:

After discussion with the fellowship-trained sports orthopedist and spine orthopedist, it was agreed that their practices would initially treat a majority of general orthopedic practices while ramping up their respective specialties. A decrease of the Physician Work RVU (WRVU) Threshold to 5,775 per year and increase of the Incentive Bonus to $54/WRVU over the threshold is more in line with general orthopedic volume and compensation. A one-time relocation bonus not to exceed $5,000 /physician and a one-time signing bonus of $15,000/physician was added. It was further agreed that a review of the WRVU Threshold and Incentive Bonus would take place after Year 2.

While the compensation changes and bonuses increased the total clinic expenses by approximately $211,000 over the three years, the projected salaries, signing bonuses and relocation reimbursements for the two orthopedists are well within fair market value for general orthopedists. The Total Program Direct Margin for the Comprehensive Orthopedic Program that incorporates the Clinic Direct Margin and Hospital Direct Margin is projected to contribute significant monies in each of the three years, and in excess of $6.6 M over that period.

Revised compensation documents and proformas are attached for reference.

REVISED

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~~ 5,775 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)~~ fifty-four dollars ($54.00) 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.

5. **Review of WRVU Threshold and Incentive Bonus**. It is understood that a review of the WRVU Threshold and Incentive Bonus shall take place after Year Two so that either party may initiate a good faith renegotiation of the WRVU Threshold and/or Incentive Bonus. If, within sixty (60) days thereafter, the parties fail to come to agreement on the amount of the WRVU Threshold or Incentive Bonus, either party may thereupon terminate the agreement upon sixty (60) days written notice to the other party.

6. **Signing Bonus**. A one-time payment from the Hospital to the Physician in the amount of $15,000.

7. **Moving Expense Reimbursement**. A one-time payment from Hospital to Physician for Physician's actual cost (not to exceed $5,000) of Physician's household property to Alameda County or Contra Costa County in California.

REVISED

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~~ 5,775 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)~~ fifty-four dollars ($54.00) 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.

5. **Review of WRVU Threshold and Incentive Bonus**. It is understood that a review of the WRVU Threshold and Incentive Bonus shall take place after Year Two so that either party may initiate a good faith renegotiation of the WRVU Threshold and/or Incentive Bonus. If, within sixty (60) days thereafter, the parties fail to come to agreement on the amount of the WRVU Threshold or Incentive Bonus, either party may thereupon terminate the agreement upon sixty (60) days written notice to the other party.

6. **Signing Bonus**. A one-time payment from the Hospital to the Physician in the amount of $15,000.

7. **Moving Expense Reimbursement**. A one-time payment from Hospital to Physician for Physician's actual cost (not to exceed $5,000) of Physician's household property to Alameda County or Contra Costa County in California.

Alameda Hospital Orthopedic Program Pro Forma 4/02/2012

	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 4/02/12	2.0	600,000	2.0	582,000	2.0	739,000	1,921,000	
Physician Salaries 4/25/12	**2.0**	**600,000**	**2.0**	**687,300**	**2.0**	**768,300**	**2,055,600**	**RVU Threshold decreased to 5775, $/WRVU increased to $54**
Total Salaries 4/02/12		695,680		704,720		982,360	2,382,760	
Total Salaries 4/25/12		**695,680**		**810,020**		**1,011,660**	**2,517,360**	**Three Yr increase of $134,600**
Benefits 4/02/12		187,834		190,274		265,237	643,345	27% of Total Salaries
Benefits 4/25/12		**187,834**		**218,705**		**273,148**	**679,687**	**Adjusted due to salary increase**
Signing Bonus 4/25/12		**30,000**		**-**		**-**	**30,000**	**One-time payment**
Relocation 4/25/12		**10,000**		**-**		**-**	**10,000**	**One-time payment, not to exceed $5,000/MD**
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 4/02/12		347,247		390,308		509,353	1,246,908	
Total Non-Wage 4/25/12		**387,247**		**418,739**		**517,264**	**1,323,250**	
Total Clinic Expenses 4/02/12		**1,042,927**		**1,095,028**		**1,491,713**	**3,629,668**	
Total Clinic Expenses 4/25/12		**1,082,927**		**1,228,759**		**1,528,924**	**3,840,610**	
Clinic Direct Margin 4/02/12		**(413,421)**		**186,088**		**193,537**	**(33,796)**	
Clinic Direct Margin 4/25/12		**(453,421)**		**52,357**		**156,326**	**(244,738)**	

Alameda Hospital Orthopedic Program Pro Forma 4/02/2012

HOSPITAL	Year 1	Year 2	Year 3	Total	Source:
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" 7/11 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**	

	Year 1	Year 2	Year 3	Total
Clinic Direct Margin 4/02/12	**(413,421)**	**186,088**	**193,537**	**(33,796)**
Clinic Direct Margin 4/25/12	**(453,421)**	**52,357**	**156,326**	**(244,738)**
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**
Total Program Direct Margin 4/25/12	**753,503**	**2,490,925**	**3,398,042**	**6,642,470**

Alameda Hospital

CITY OF ALAMEDA HEALTH CARE DISTRICT

DATE: May 3, 2012

FOR: May 7, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Michael McCormick, District Board Treasurer
Elliott Gorelick, District Board Secretary

SUBJECT: Approval of Proposed FY 2012 Executive Performance Metrics and Incentive Compensation Plan

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RECOMMENDATION:

At the April meeting of the Board of Directors we were appointed as a Subcommittee to work with management to refine the draft Incentive system presented by the CEO at the April Board meeting. Based on our own deliberations and a follow-up discussion with Ms. Stebbins and Mr. Easthope, we are recommending the following structure for a FY 2012 incentive system:

1. **Base Incentive Program:** No incentive payments would be awarded unless the budgeted bottom line of $540,000 is achieved. Given the financial results through March, 2012 it is highly unlikely that the budgeted bottom line will be achieved by the end of the fiscal year.

2. **Special Project Incentive**: Due to the unique nature of the Waters Edge acquisition, which took over a year to plan and negotiate and is likely to have a extended and profound impact of the Hospital's financial performance, a one-time special incentive could be awarded to the two management team members who were directly involved in completing the analysis and negotiations, the CEO, Deborah Stebbins and CFO, Kerry Easthope.

The recommendation is to award this special incentive on a deferred basis during FY 2013 and as a potential addition to any base incentive plan developed for FY 2013. Further, we recommend that the Board commit to defining the structure of the FY 2013 no later than August, 2012. An award of the special bonus would be based on the following:

1. Successful transition of the licensure and certification into Alameda Hospital by September 1, 2012. Evaluation of whether the special bonus is to be awarded will be based on operational results through December 31, 2012.

2. The potential bonus would be twenty percent (20%) of the base bonus percentages defined for the achievement of the budget in FY 2012, i.e.

    a. 20% of 25% for the CEO
    b. 20% of 15% for the CFO

3. The bonus award would be contingent on YTD achievement of an overall positive revenue over expense for the first half of FY 2013 (July 1, 2012-December 31, 2012).

4. The bonus would be contingent upon achievement of the financial results projected in the Waters Edge pro forma for a pro-rated basis for the period of time between the date of transition to Alameda Hospital through December 31, 2012.

DATE: May 2, 2012

FOR: May 7, 2012 District Board Meeting

TO: City of Alameda Health Care District, Board of Directors

FROM: Deborah E. Stebbins, Chief Executive Officer

SUBJECT: May CEO Report to the Board of Directors

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1. **Executive Re-organization**:

Enclosed is a new management organization chart for Alameda Hospital which illustrates the changes announced with the transition of Kerry Easthope into the Chief Financial Officer role and acceptance by Brian Jung of the new position of Chief Business Development Officer. This re-organization is an expedient way to fill the CFO role with a seasoned financial leader who also knows the organization and the creation of a new role focused solely on new program development, volume and revenue. Join me in welcoming Brian to the organization; I believe he brings energy, creativity and a track-record of accomplishments in numerous aspects of the health care industry.

Tony Corica will report to Brian in terms of Tony's physician relations role which is closely related to many of our volume and business development efforts. Tony also oversees our compliance program, keeping an appropriate check and balance of compliance management independent of Finance.

I am shifting the primary responsibility of revenue cycle management from myself to Kerry Easthope, although I will continue to participate in process improvement in this important area.

Some other minor changes include reassignment of the acute inpatient and outpatient therapy services from Phyllis Weiss to Mary Bond, thereby grouping therapeutic services that support our expanding orthopedic program and certified stroke center under the same executive who oversees the related inpatient nursing services.

These changes are FTE neutral but will actually reduce our expenses by bringing the CFO function back in-house and reducing reliance on interim contract staff.

2. **Schedule**:

Annual Hospital week is May 6-12, 2012 and we will celebrate by the managers and directors serving breakfast, lunch and dinner to our staff on May 9, 2012, Board members are welcome to participate in these events. Contact Kristen if you would like to help honor our employees during one of these events.

Nurse's week is also scheduled for May 6-12, 2012. Once again this year, we will be awarding the annual Florence Nightingale award to a member of our nursing staff who has demonstrated professional excellence. This year we had an unprecedented 12 nominees for this award, submitted by nursing colleagues, nurse managers and physicians. This event is scheduled for May 10, 2012 at 2:00 p.m. in the Dal Cielo Conference Room. We will also be awarding new Staff Nurse III promotions to qualifying nurses at the same event.

3. <u>Community Outreach</u>:

Last week I gave a presentation to the Board of Directors of the Harbor Bay Isle Association which is comprised of the Board leaders from each of the Bay Farm neighbor associations. I also participated on Monday, April 30 at an event in Hayward sponsored by the Hayward Firefighters Association for Congressman Pete Stark. After 17 terms in Congress, Congressman Stark will no longer cover Alameda after the latest round of Congressional redistricting. In the future we will be under Congresswoman Barbara Lee's district.

As a part of our outreach and communications strategy, the key executive and physician leadership will be participating later this month in a seminar Mike McMahon, a member of the Alameda Board of Education, has agreed to provide to us on the topic of social networking as a communication strategy. Not only is this form of communication increasingly broadly used by all organizations, it can be a very cost effective vehicle compared with traditional forms of marketing and advertising.

4. <u>Local Hospital Updates</u>:

St. Rose Hospital: There has been a transition in the CEO role at St. Rose Hospital (Hayward) departing and being replaced by leadership engaged by Washington Hospital. A Joint Powers Arrangement (JPA) has been formed collaboratively by the County and Washington Hospital to provide governance and financial assistance to St. Rose.

San Leandro Hospital: It has been reported that the legal challenges mounted by the Eden Hospital District in an attempt to preserve acute care and emergency services at San Leandro Hospital are winding down and that San Leandro is likely to fall under the control of the Sutter system. While there has been no formal announcement of Sutter's intentions to close the Hospital, the prevailing assumption is that acute care and ER services there will close. A previous agreement between the County and Sutter in which the County was going to assume operation of San Leandro facility for purposes of relocating the County acute rehabilitation services is no longer in effect, the County is still interested in preserving and expanding its Rehab program. If the County takes over the facility, it is still not clear if they would continue to operate the ER or downsize it into an urgent care program.

5. <u>Wound Care</u>:

The Wound Care construction and implementation continue to progress on schedule. Construction is just over 50% complete and is currently scheduled for completion on June 8th. At that point, we will take occupancy of the building, complete furnishing and

equipping the facility for operations and prepare for licensing survey with the California Department of Public Health.

We are currently completing the selection process for a program medical director and plan to have that position solidified the in the second week of May.

Simultaneous with finalizing the construction schedule, staff is engaged in weekly program implementation planning. This includes development and review of Policy and Procedures as well as implementation of the Revenue Cycle component of the Wound Care Program.

Our new Program Director, Beth Brizee, RN, RCFA, has began marketing and outreach activities in preparation for bringing this new program on-line which is currently scheduled to begin operations on Monday, July 2, 2012.

6. <u>Seismic and Other Regulatory Compliance Planning Activities</u>:

There are three outstanding items that need to be complete for Seismic SB 1953, Non Structural Performance Category (NPC) 2 compliance. These items are:

1. Anchorage of emergency lighting, signage and the electrical circuits that support these systems
2. Anchorage of our Telecommunications equipment
3. Replacement of the Bulk Oxygen Vessel behind the hospital

We are currently working with our construction management firm and architects to get proposals and cost estimates to complete these projects by the end of calendar year 2012 or as soon thereafter as possible. We hope to have the proposals and cost estimates within the next month.

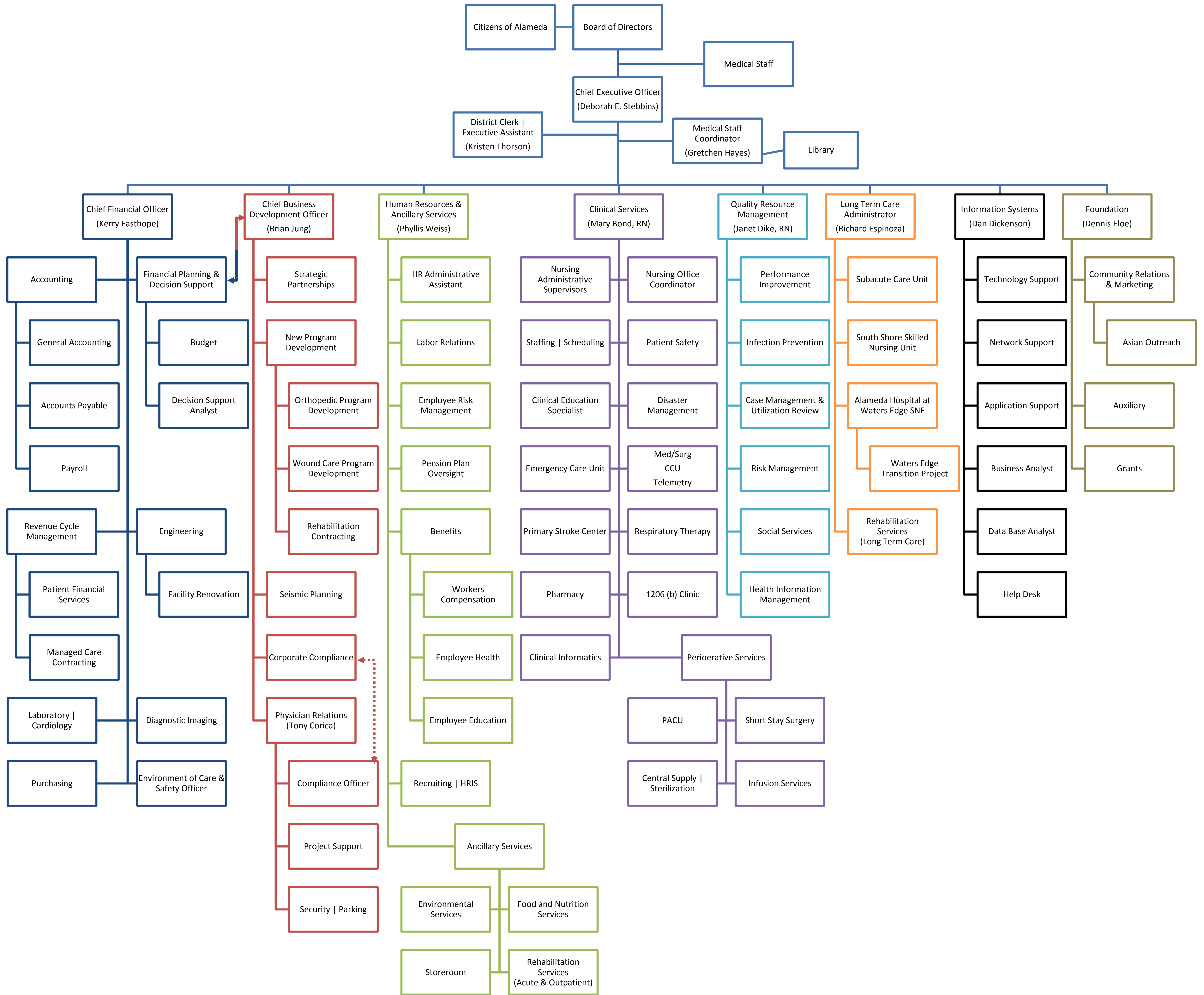
There is an extension option available under SB 499 for NPC 3 compliance which would extend the compliance date from January 2013 to January 2030. However, we need to have the NPC 2 work complete in order for OSHPD to process these extension applications.

There are two other regulatory compliance projects that the hospital needs to advance during this next year. The first is replacement of the burner units on our two boilers. This requirement is being enforced by the Bay Area Air Quality Management District. We are working with our mechanical engineer on this project which needs to be complete by January 1st 2012. The cost of this replacement is estimated at less than $100,000.
The second is a CMS requirement that all skilled nursing facilities, including Sub-acute units, must be fully sprinklered by August 2013. We have initiated planning meetings with our construction management firm and architect to understand the best approach for completing this work and to obtain proposals and cost estimates for this work. As with the other projects, we will be bringing forth recommendations for approval to advance these projects in the near future.

7. April Key Statistics:

Key Statistics April 2012
May 7, 2012 Report to Board

	April Preliminary	April Budget	% Δ compared to Budget	% Δ compared to March	March Actual
Average Daily Census	86.40	87.31	-1.0%	6.8%	80.93
Acute	33.27	31.63	5.2%	14.0%	29.19
Subacute	31.50	33.00	-4.5%	2.7%	30.68
South Shore	21.63	22.68	-4.6%	2.7%	21.06
Patient Days	2,592	2,619	-1.0%	3.3%	2,509
ER Visits	1,376	1,380	-0.3%	-8.6%	1,506
OP Registrations	1,889	2,135	-11.5%	-0.6%	1,901
Total Surgeries	153	184	-16.8%	-20.7%	193
Inpatient Surgeries	39	46	-15.2%	-31.6%	57
Outpatient Surgeries	114	138	-17.4%	-16.2%	136
Case Mix Index	1.3221				1.3071



City of Alameda Health Care District Organizational Chart

Rev: April 13, 2012