BOARD OF TRUSTEES SPECIAL MEETING

Friday, June 6, 2025
9:00am – 3:00pm

Alameda Health System
55 Harrison Street, Oakland, CA 94607
Ronna Jojola Gonsalves, Clerk of the Board
(510) 535-7515

LOCATION:
Open Session, In Person:
55 Harrison Street, Oakland
This meeting is in person only. There will be no Zoom option.

See Parking Information Below

MEMBERS

Alan E. Fox
Lilavati Indulkar, MD
Nicholas Moss, MD
Rachel Richman
Greg Garrett
Donna Linton
Nely Obligacion
David Sayen
Sblend A. Sblendorio

BOARD OF TRUSTEES SPECIAL MEETING AGENDA

Public Comment Instructions
Members of the public who wish to address the Board regarding an item on the agenda or in their purview, may see the Clerk of the Board to sign up. Each speaker will be allotted between one and three minutes to speak, depending on the number of speakers present.

This is a reminder that this meeting is an in person only meeting. There will be no option to attend remotely. Please see below for directions to the meeting venue.

OPEN SESSION / ROLL CALL

PUBLIC COMMENT:

A. Welcome
David Sayen, Board President
James E.T. Jackson, Chief Executive Officer

B. Federal and State Policy Changes Impact to Services
John Minot-Schwartz, Director of Reimbursement and Finance Strategy

C. Strategic Plan/OKR Integration
Jeanette Dong, Chief Strategy Officer

D. Mission Integration Update
Mini Swift, MD, Interim Chief Mission Integration Officer

CLOSED SESSION

1. Public Employee Performance Evaluation
[Pursuant to Government Code Sections 54957(b)(1)]
Title: Chief Executive Officer

TRUSTEE COMMENTS

ADJOURNMENT

Directions for Parking: There is a parking garage at 255 2nd Street, with a sky bridge on the third floor to the 55 Harrison Street building. Metered street level parking is also available.

Our Mission
Caring, Healing, Teaching, Serving All

Strategic Vision
AHS will be recognized as a world-class patient and family centered system of care that promotes wellness, eliminates disparities and optimizes the health of our diverse communities.

Values
Compassion, Commitment, Teamwork, Excellence, Integrity, and Respect.

Meeting Procedures
All items appearing on the agenda are subject to action by the Board of Trustees. Staff recommendations are subject to action and change by the Board of Trustees.

The Board of Trustees is the Policy Body of the Alameda Health System. The Board has several standing Committees where Board matters are the subject of discussion at which members of the public are urged to testify. Board procedures do not permit: 1) persons in the audience at a Committee meeting to vocally express support or opposition to statements by Board Members or by other persons testifying; 2) ringing and use of cell phones, pagers, and similar sound-producing electronic devices; 3) signs to be brought into the meeting or displayed in the room; 4) standing in the meeting room. Citizens are encouraged to testify at Committee meetings and to write letters to the Clerk of the Board or to its members, 1411 East 31st Street Oakland, CA 94602.

Members of the public are advised that all Board and Committee proceedings are recorded (audio), including comments and statements by the public in the course of the meetings. Copies of the audio recordings will be made available to the public. Copies of the agendas and supporting documents can be found here. By attending and participating in Board/Committee meetings, members of the public consent to audio recording of any statements they may make during the proceedings.

Disability Access

To request accommodation or assistance to participate in the meeting please contact the Clerk of the Board. Requests made at least 48 hours in advance of the meeting will help to ensure availability.

In order to accommodate persons with severe allergies, environmental illness, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to perfumes and various other chemical-based scented products. Please help us to accommodate these individuals.

The AHS Board of Trustees is committed to protecting the private health information (PHI) of our patients. We ask that speakers refrain from disclosing or discussing the PHI of others. Please also know that, should you decide to disclose your PHI, the Trustees will still likely refer your matter, to the extent it involves PHI, to the executive staff for a confidential review of the facts and for confidential handling. If you would like more information regarding the confidentiality of PHI as it relates to the Health Insurance Privacy and Accountability Act, please refer to 45CFR Section 164.101, et.seq.

Federal and State Policy Changes Impact to Services

Federal & State Budget Impacts

John Minot-Schwartz

Director, Reimbursement & Finance Strategy

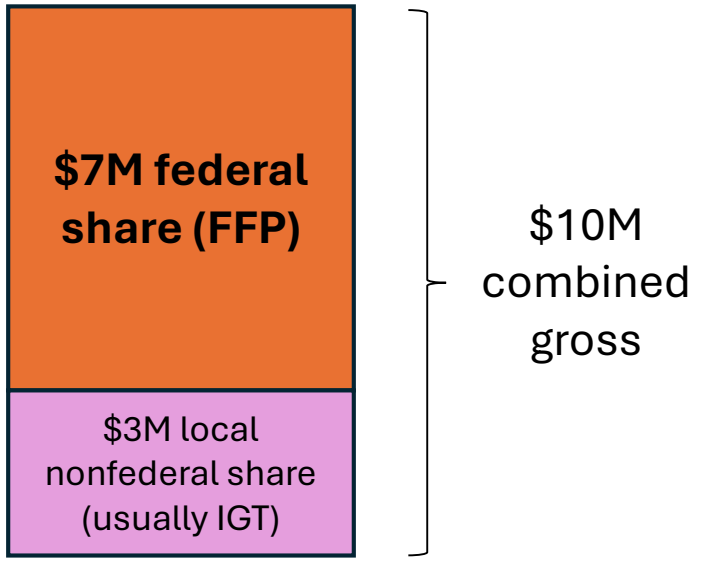
Background: AHS Dependent on Supplemental Revenues that are Self-Financed Federal Funds

- Over and above Medi-Cal patient care revenues
- Federal funds unlocked by a variety of regulatory pathways
- State does not put up General Fund for most of these (helping them grow over time)

Largest supps. in FY 2025-26 draft budget	$M FFP
Global Payment Program (GPP)	96
Quality Incentive Program (QIP)	104
Enhanced Payment Program (EPP)	85
Rate-range IGT (RR)	52
Graduate Medical Education (GME)	14

Background: Federal Medical Assistance Percentage (FMAP)

- Rate at which federal government matches state/local Medicaid expenditures
- Traditional FMAP varies state by state, California is at 50% (the lowest rate any state can have) due to higher average income
- Affordable Care Act FMAP is 90% nationwide, but only for enrollees qualifying in new ACA categories (low-income adults without dependents)
  - Majority of Medi-Cal spending for CA is still matched at 50%



(illustration only)

Tax/spending legislation as passed by House could have major impacts on AHS

1. Work requirements, six-month redeterminations, other roadblocks to enrollment (effective 12/31/2026)

   Center for Budget & Policy Priorities: Up to **56%** of Medi-Cal enrollees could have enrollment jeopardized by work requirements

2. Reduction of ACA FMAP from 90% to 80% for states voluntarily enrolling undocumented immigrants (effective 10/1/2027)
3. Change to approval standard that could reduce EPP and QIP from current sizes (effective TBD, probably not before 1/1/2026)
4. Other effects are indirect & harder to estimate, coming via state budget (provider tax changes, etc.)

Governor’s budget makes preemptive cuts; federal action could prompt more

- Primary impact: major reductions to enrollment & benefits for State-Only Expansion population (undocumented), effective 1/1/2026
- CAPH has estimated $12.6M cut to AHS during CY 2026, so $6.3M during FY 2025-26
  - Discussions underway that could reduce this impact

Legislative risk vs. executive risk

- FMAP changes, work requirements, other fundamental changes to Medicaid need Congressional approval
- **Most AHS supplementals require periodic discretionary approval by CMS**, which could in theory cut or even eliminate them without exceeding its legal authority
- Provider tax freeze/reduction will likely go through by regulation if not by legislation, hitting state budget (but AHS mostly indirectly)

Impacts could come at a delay

In addition to delays written in House bill:

- EPP and QIP are typically paid about two years after service period
- Major EPP and QIP increases were approved for CY 2025 service period but will not start to be paid until FY 2026-27
- There would be a major cash delay for the EPP and QIP increases without any Congressional changes to Medicaid; possible cuts makes that delayed amount even more uncertain
  - For CY 2026 portion (or later) since CY 2025 is already approved
- Rate-range and AB85 reconciliation also come at a significant delay, though rate-range has been improving

Scenario planning

Assumption for each, by scenario	Nuclear	Realistic	Light
FMAP	90% ACA becomes 80%	No change	No change
GPP	Allowed to expire without renewal after 12/31/2026 (funds revert to DSH)		
Other supplementals	20% due to work requirements reducing services to be supplemented	10% to major streams only, due to CMS cutting	5% to major streams only
HQAF*	Cut 50%**	Cut 25%	Not cut

*Note AHS nets only about $7M/year HQAF (provider fee)
CHA has **not estimated 50% cuts, but public systems like AHS receive HQAF in a special pool that could be more under threat than average if HQAF is reduced.

Why 20% for work requirements?

- Work requirements (and 6-month redeterminations) will disproportionately remove low-utilizing people from Medi-Cal
- Medi-Cal enrollees tend to have complicated lives & often irregular employment, so compiling documentation for application is difficult – but those frequently receiving medical care will be better motivated
  - If not on their own, then when they come to our facilities for care, we will help eligible people enroll
- Even if CBPP's estimate of 56% enrollment at risk bears out, Medi-Cal paid services would drop much less than that
- Most supplementals (except GPP) are available roughly proportional to our service levels / spending, not raw enrollment

Estimates of different-scenario impact
Full year of impact, fully phased in

$M impact, net	Nuclear	Realistic	Light
GPP	($19M)	($19M)	($19M)
EPP	(21)	(9)	(4)
QIP	(27)	(11)	(5)
RR	(14)	(6)	(3)
GME	(4)	-	-
Misc.	(5)	-	-
FFS IP	(16)	-	-
HQAF	(4)	(2)	-
Total	**(110)**	**(47)**	**(32)**

Potential for mitigation of these impacts

- AHS's Federal Changes Work Group is engaged in contingency planning
- FMAP reduction could be litigated (unconstitutionally coercive?)
- California could implement work requirements to make them less burdensome / impactful
  - Proactively provide proof of employment from government records, etc.
- Significant losses in Medi-Cal supplementals could translate to bringing back 1991 Realignment funds per AB85 formula
  - But would offset no more than 80% of losses, and bring no more than ~$50M back in

Mission Integration Update

ALAMEDA HEALTH SYSTEM

Mission Integration at Alameda Health System

U. Mini B. Swift MD MPH FACP
Interim, Chief Mission Integration Officer
June 6,2025
55 Harrison Street, Oakland CA

AHS Mission

Caring, Healing, Teaching, Serving All

What personal experiences, values, or identities most shape how you interpret our mission-especially in times of constraint?

01 Definitions

What is Mission Integration (MI)?

- Mission is
  - embedded into all aspects of AHS operations.
  - guides decision making at all levels

- Ensuring that AHS's identity and values are lived out every day.

Pacita Abad, *L.A. Liberty*, 1992; collection Walker Art Center, Minneapolis, T.B. Walker Acquisition Fund, 2022; courtesy Pacita Abad Art Estate and Spike Island, Bristol; photo: Max McClure

ALAMEDA HEALTH SYSTEM

The Case for Mission Integration

- **Consistency:** Reduces variability in decision-making
- **Clarity:** Creates a North Star when trade-offs or tensions arise.
- **Credibility:** Builds trust with staff, patients, and community when our actions match our values.

What can we afford
AND
What can we not afford to compromise?

What Mission Integration Looks Like in Practice

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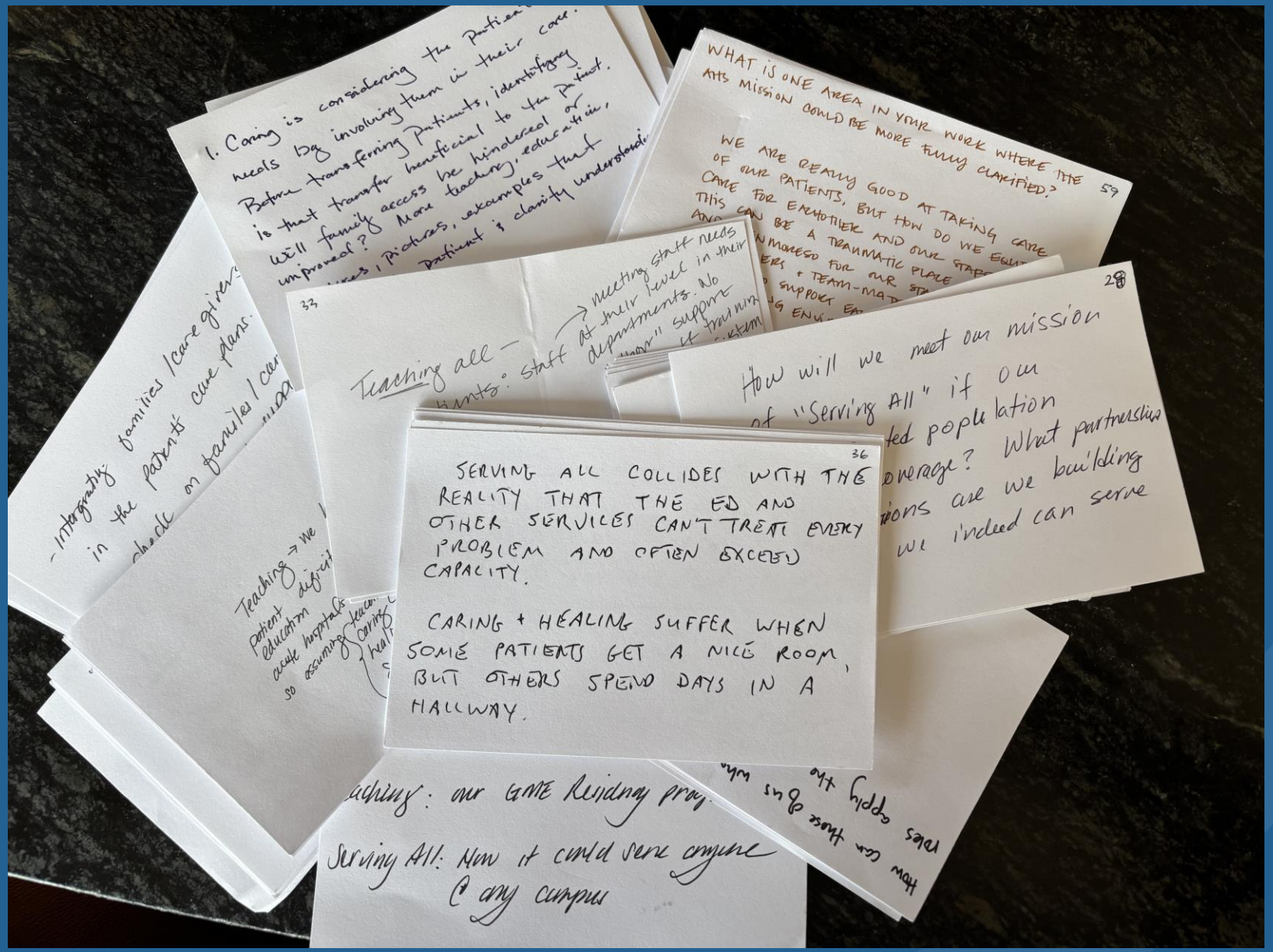
- **In Planning:** Embedded in strategic priorities.
- **In Decisions:** Major initiatives show alignment with mission.
- **In Daily Work:** Performance, policies, and culture reinforce mission value.

Example: Incorporate mission into Board and Executive decision templates.


Equality


Equity


WHAT IS ONE AREA IN YOUR WORK WHERE THE ATIS MISSION COULD BE MORE FULLY CLARIFIED?
WE ARE REALLY GOOD AT TAKING CARE OF OUR PATIENTS, BUT HOW DO WE
CARE FOR EACHOTHER AND OUR
THIS CAN BE A TRAUMATIC PLACE
Teaching all
How will we meet our mission
SERVING ALL COLLIDES WITH THE REALITY THAT THE ED AND OTHER SERVICES CAN'T TREAT EVERY PROBLEM AND OFTEN EXCEED CAPACITY.
CARING + HEALING SUFFER WHEN SOME PATIENTS GET A NICE ROOM, BUT OTHERS SPEND DAYS IN A HALLWAY.
Serving All: How it could serve anyone @ any campus

“Healing definitely means taking into consideration mental and emotional care for all alongside with patients, staff (immediate) family needs to have access to all of the wonderful services.”

“Caring is considering the patient’s needs by involving them in their care.”

“...serving all means that we impact our community's livelihood. Access and visibility to job opportunities as well as visibility about our workforce are key elements to sharing AHS and our overall mission.”

Breakout Session 15 minutes

How Would You Define:

Caring
Healing
Teaching
Serving All

Report Out: 10 minutes

How Would You Define:

Caring
Healing
Teaching
Serving All

“Serve All- Patients are told that our services are free. In my department, we have to tell patients the story, service was not free. It is hard to do this knowing that our mission is to care and serve all.”

“We are really good at taking care of our patients. But how do we equitably care for each other and our staff? This can be a traumatic place to work and even for more for our staff of color. As managers and teammates we are not equipped to support each other and make this a healing environment for our teams.”

02

Equity informed Mission Integration

Proposed Path Forward for AHS

Where are We Today?

- Many programs-different aspects of equity
- Equity, diversity and inclusion are strategic priorities
- BOT and Executive Team have taken time to learn about equity
- Lots of stratified data

Also:

- Does mission guide decisions?
- Equity participation optional
- Limited support for leaders
- Outcome gaps persist
- Future is complex

Where We Want to Be-
A Structure That Is Intentionally Designed

- Mission guides operational decisions
- Equity in standard work.
- Population level gaps closed
- Deeper relationships with community
- Internal consultation services

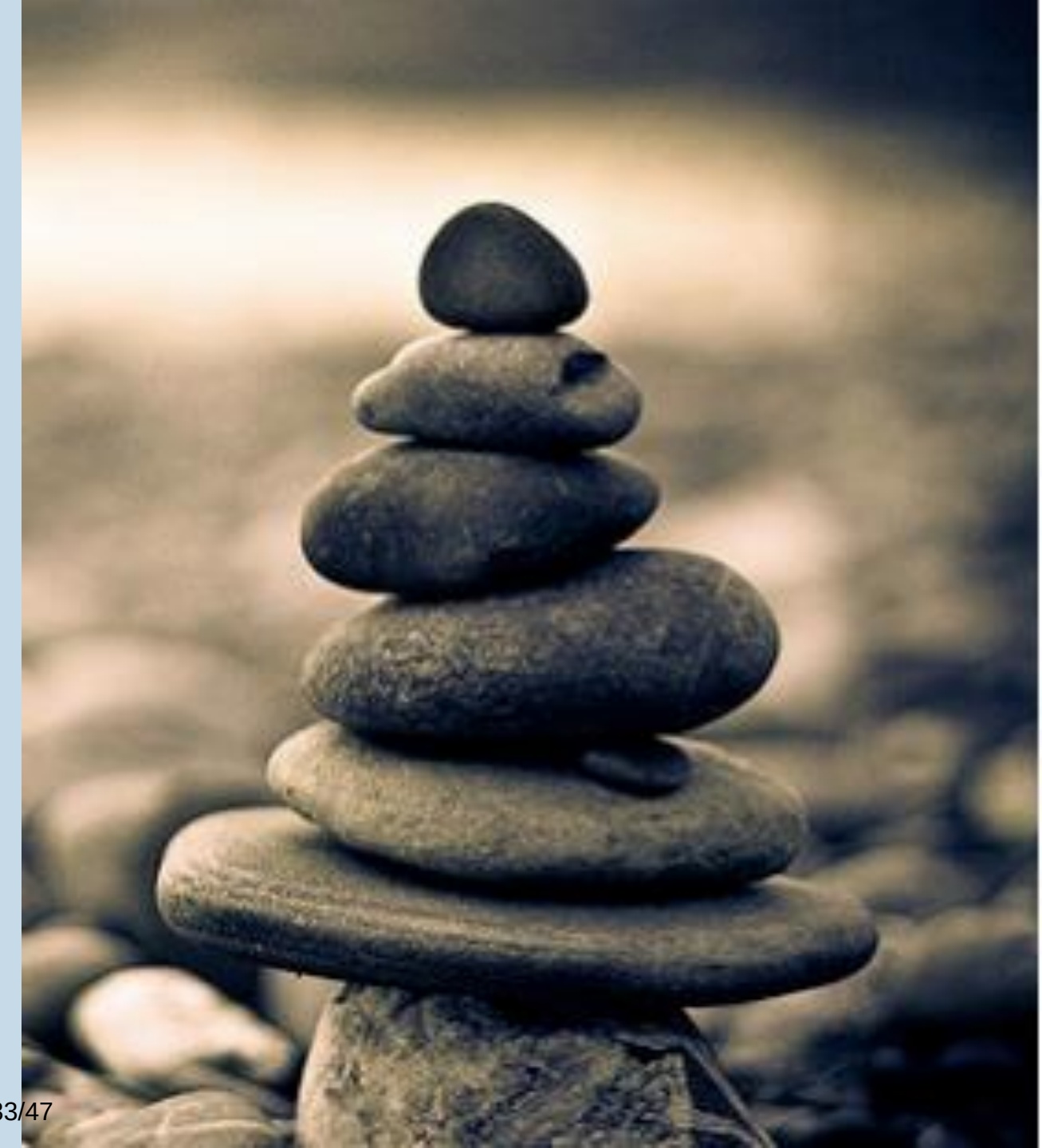
(DRAFT) Big Ideas for Equity 2.0

1. Integrate the mission.
2. Belonging is the equity goal.
3. Equity as an invisible operating system within AHS
4. Increased participation by patients/community
5. Impact on *life trajectories*

Short Term Priorities: Fall 2025

1. Current State Assessment

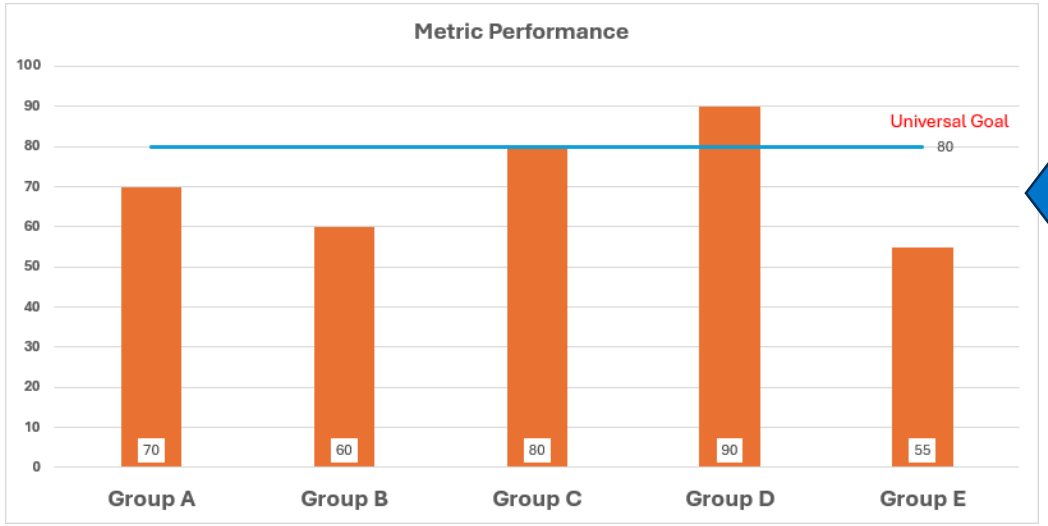
2. Develop a Mission Integration (MI) & Health Equity multi-year plan.



ALAMEDA HEALTH SYSTEM

Plan Components: Solving Population Level Gaps

Standards for selecting populations of focus and designing solutions.



Standards for Gap Analysis/ Interpretation

Standards for data collection and visualization

DRAFT :

Mission Integration and Equity Education

Specific Equity Topics for QI

Equity Topic	Board	Senior Management	Senior Clinicians	Nurse Managers	Admin Managers	QI Team Leaders	QI Experts
Leadership Practices							
Distinguish between complicated & complex problems							
Expand Our Mental Models							
Hold the Problem Space							
Hero vs Host Leadership							
Host Leadership Development							
Leadership Habits of Mind							
Structural Design to Increase Collaboration							
SCARF Summary and Activity							
Six/Seven Circle Model							
Team Leadership Assessment	N/A						
Designing To For System Transformation							
Introduction to Liberatory Design: See/Notice/Act							
Liberatory Design Mindsets							
Liberatory Design Modes							
Co Designing Principles							
Co Designing with Community and Patients							
IHI 3-Part Data Review Tool	N/A	N/A					
Belonging as the next level Equity Strategy							
Organizational Trustworthiness							
Core compons of Belonging							
Targeted Universalism							
Data Design and Interpretation							
We All Count Training							

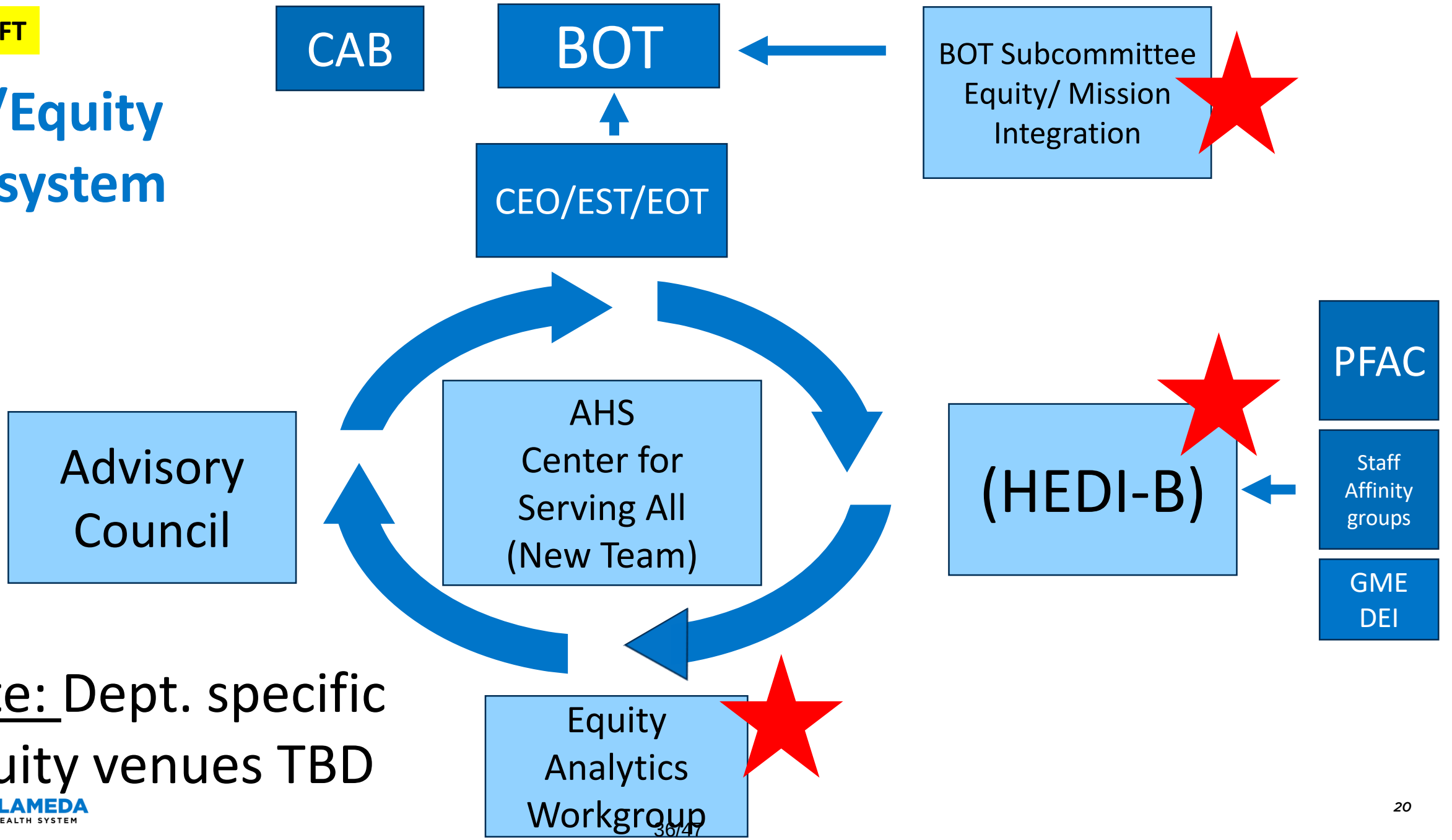
Role

Darker= Deeper Expertise

ALAMEDA HEALTH SYSTEM

DRAFT

MI/Equity Ecosystem



Note: Dept. specific equity venues TBD

03

How might we lead differently if mission was our first filter?

"How does Mission Integration get factored in when we make difficult decisions like budget cuts?"

"How will we meet our mission of "serving all" if our undocumented population loses coverage? What partnerships or coalitions are we building to ensure that we can indeed serve all?"

How are going to continue the mission driven work of serving all when there are major Medicaid budget cuts that we are facing on both the federal (and thus) the state level. Governor Newsom has already posed budget cuts for undocumented people with the Medi-Cal program. Will we continue to support these (and others) patients even without State funding?

Mission Integration Decision Lens

Imagine:

If we had to reduce spending by $X million, how would our mission shape **what gets protected first**?

Mission Clarity Begins Here

An invitation to co-design a new tool

PDSA: Test Out This MI Protocol Today!

Mission	Mission Integration and Equity Lens
Caring	• How do we preserve human dignity? • Are we centering compassion in ways that respect *all* identities and lived experiences? • What does caring look like when resources are scarce?
Healing	• Which services or roles are essential to our healing mission? • Are we prioritizing healing for communities historically denied access
Teaching	• Who do we teach –and why does this matter to our identity? • Who gets to learn? • Who gets to teach? • Are our education efforts liberating or gatekeeping?
Serving All	• Who is included in "all"? • What populations rely on us most? • What inequities must we resist reinforcing? • Who is left out in our decisions? • Are we perpetuating structural inequities in service delivery?

Mission Integration means knowing what we must protect ----------even when we can't protect everything.

Questions?

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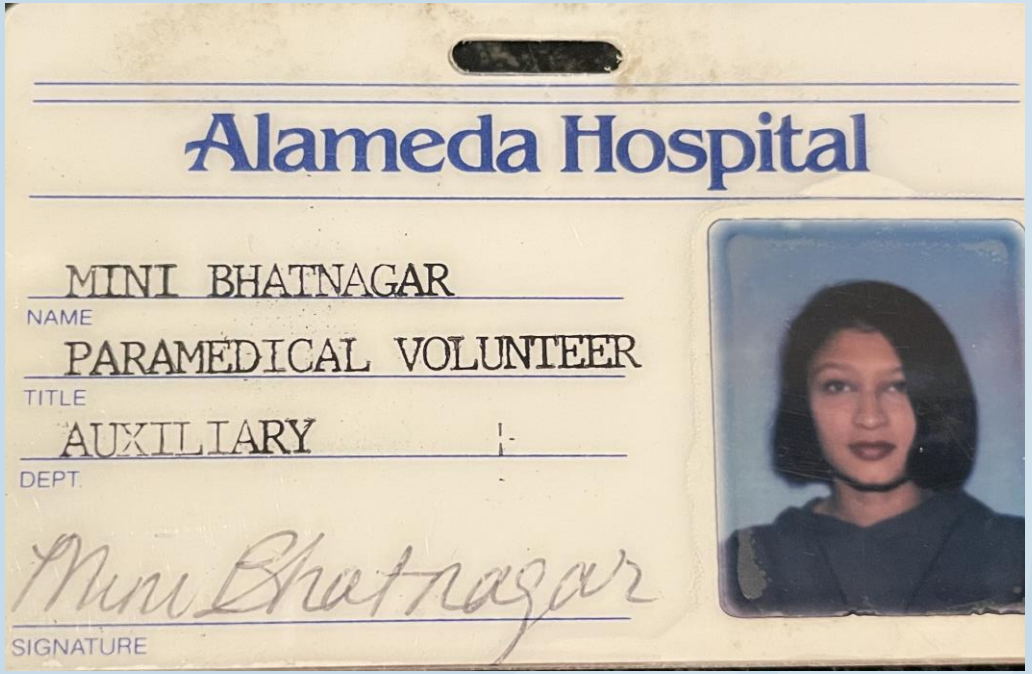

Thank You!

Ana Torres
Angela Ng MD
Annette Johnson
Ankita Kalraiya
Arlene Gomez
Ashley Smith
Bryan Toral
Lilly Macrae
Mark Fratzke
Mario Harding
Lilly Macrae

1999 Medical Student

2000-2003 Intern/Resident

ALAMEDA HEALTH SYSTEM

Appendix

What is the role of the Chief Mission Integration Officer (CMI)?

Collaborates for mission/equity in all operational areas

Wears many hats:

Architect, weaver, navigator, guide. collaborator

ALAMEDA HEALTH SYSTEM

Mission Listening Tour Kick-Off :
Caring, Healing, Teaching, Serving All

What's one area in your work where the AHS mission could be more fully clarified?

Please write it down on the index cards at your table

REFLECTION

When was the last time our mission directly shaped a hard decision?