BOARD OF DIRECTORS
REGULAR MEETING
Thursday, October 28, 2010

CALL TO ORDER:
Chair Ullyot called the meeting to order at 17:50 hours at the Burlingame Council Chambers, 501 Primrose Road, Burlingame.

ROLL CALL: Present were Dan Ullyot, MD, Chair, Rick Navarro, MD, Vice-Chair Larry Cappel, PhD, Treasurer, and Don Newman, MD, Past Chair.
Also present were: Cheryl A. Fama, Chief Executive Officer, Colin Coffey, General Legal Counsel, and Kelly Molloy, District's Community Outreach Coordinator.
ABSENT: Helen Galligan, Secretary, due to vacation.

CONSENT CALENDAR: The Consent Calendar, consisting of the Treasurer's Report and Un-audited Financial Statements as of September 30, 2010 was presented.

> ***DIRECTOR NEWMAN MOVED AND DIRECTOR NAVARRO SECONDED THE MOTION TO APPROVE THE CONSENT CALENDAR AS PRESENTED. THE MOTION CARRIED UNANIMOUSLY.***

AGENDA REVISION: Chair Ullyot announced a change in the order of the agenda. He acknowledged the number of attendees and moved "Oral Communications" ahead of "Community Education".

ORAL COMMUNICATIONS:

Jane McAteer, Director, CSM Nursing Program informed the Board that CSM has submitted a letter of intent requesting continued District support of her Nursing Program.

Pat Giorni, Burlingame noted that although the work of the Community Health Investment Committee is not public at this point, she wanted to speak against continued funding of Sutter Health's Senior Focus Program, explaining that the intent of the voters support of the Master Agreement between our District and Sutter Health was clear about not giving tax funds to Sutter Health.

She also commented on the recent announcement by MPHS to seek outside operators for its Skilled Nursing Facility and Outpatient Dialysis Program, in addition to the earlier closure of the Acute Rehab Program, and before that, the announcement that there was no room for Outpatient Cardiac Rehab in the new hospital. This pattern of closing services is of major concern to the public. She asked if any space in the new hospital will be leased out, like the Sleep Center is in the current hospital. **Chair Ullyot** answered, based on the discussions at the Building Committee; there is no plan to lease space in the new hospital. She stated this activity

should warrant a convening of the Board's Sutter Oversight Committee and urged to the Board to do so. [It was noted that she serves on this District committee.]

Kim Kubal, Executive Director, Your Strength to Heal, introduced her program and stated that she has submitted a letter of intent to the grants committee. She briefly described the program and her role.

William Holsinger, Burlingame resident and member of the Board for Your Strength to Heal added his support and more information on the value of this new, unique program, and submitted a written statement for distribution to the Board as it was too long to read and would have exceeded the 3 minute limit.

Dr. Dick Gregory introduced his role as Chair of the Senior Focus Community Committee and spoke about the importance of the District's funding support. He asked that the Board increase its FY 2011 grant to the level provided in FY 2009. He noted that Mills-Peninsula provides $1.2M to support the programs, but without the critical District support, services may be limited going forward. He then introduced recipients of Senior Focus services and asked them to comment.

Mary Tesia, Recreations Supervisor from the San Bruno Senior Center stated the Wise and Wellness program has been in effect there since 1998. Prior to that, volunteers did blood pressure screenings. There have been great improvements for the seniors who are able to see nurses at the facility who treat and guide them with their healthcare. Some seniors had high blood pressure and glucose readings, the RN's were able to work with their doctors and prevent more serious problems. The patients are able to see the RN's twice a month for readings as well as more comprehensive examines once a year. She asked the Board to continue funding for the program.

Norma Guliani, a participant in the Senior Focus programs and District resident, stated she was here to tell the Board that this program has changed her life –without it she would be home watching TV alone. She hoped the Board would continue to support Senior Focus.

Cynthia Gurillo, sister of Norma Guliani, Ms. Gurillo stated her sister Norma Guliani has attended Senior Focus for the past four years and the program has been beneficial to her well-being. She is able to get out three days a week and socialize with other people and participate in all the programs they offer. If she needs help, she now has a team of people to help her. Ms. Gurillo stated she could not say enough good things about the program and the people that run it; they are kind and caring. She noted that it not only helps the seniors who are involved, it helps the families who are caring for them. As time goes on, we are going to need more programs like this one and we should never cut back on programs that care for our disabled citizens.

Laura Caterman, Senior Focus client, stated she was pleased to come and speak about the Senior Focus program. She and her husband live in Belmont; her husband is a World War II Veteran and two years ago he was diagnosed with Parkinson 's disease with dementia. He has been enrolled in the Senior Focus program for about two years now. "It has been a God send for

us. It has enlightened his life and expanded his ever narrowing world and it has given me precious time to keep house and home together. I have found the staff at Senior Focus to be very knowledgeable, efficient, compassionate and patient – Caregiver-oriented." She urged continued District funding support in view of the increasing senior population.

Diane Whitezel whose husband was a Senior Focus participant shared that her husband was diagnosed with dementia in 2000. She had been his primary care giver until 2007, at which time she needed some medical attention herself and she found herself stranded. She began going to classes at MPHS for caregivers; this was extremely helpful in learning what to expect and what is needed. When she could no longer handle everything by herself, Senior Focus was wonderful and a God send. She could not leave her husband home alone and occasionally had to go out and do shopping. This disease not only causes mental deficiencies, but physical problems as well. When she enrolled him in the program, in addition to the socialization, he was getting practice with movement - exercises to keep his body and brain moving. It was a good thing, much better than sitting at home with nothing to do. The other side benefit was the information she got from experts at Senior Focus who were dealing with him on a regular basis; she didn't have to rely on her estimation of his activities when they would go to his doctor, which made it much easier. Please continue to fund this program.

Dr. Dick Gregory thanked the District Board for listening to all of the people who did a better job than he could do in asking the District to continue to fund the program at the 2009 funding level. He then thanked several members of the Senior Focus staff and volunteers who were present.

Chair Ullyot asked for any other comments from the public. Hearing none, Chair Ullyot turned the meeting over to Vice-Chair Navarro.

COMMUNITY EDUCATION:

"Health Care Reform: The Patient Protection and Affordable Care Act of 2010 – A Surgeon's Point of View". **Presenter: Dr. Daniel Ullyot**

Vice-Chair Navarro introduced Dr. Daniel Ullyot, a cardiovascular and thoracic surgeon and former UCSF professor, who came to Mills-Peninsula to start its first Cardiac Surgery Program. He served as President of the American College of Cardiology and President of the Thoracic Surgical Association. He retired from practice in 2001. He was elected to the District Board in 2004 and has served as Chair since January 2009. He will be speaking to us today about health reform and the Affordable Care Act, 2010.

Dr. Daniel Ullyot opened by sharing the personal incident that launched his research into answering the question "What do doctors think about healthcare reform?" In his first paper, published in December 2009, he argued that ***"the key to healthcare reform is the way we use new medical technology. It is a major driver of cost within our system and unless we can get our hands on that, we are going to have non-affordable healthcare in this country which to me is the key reason we need healthcare reform. "***

On the topic of technology in medicine, Dr. Ullyot shared that he led the American College of Cardiology during the Clinton era in 1994 and weighed in on "Hillary-Care". In addition to that experience, he has been working for twenty years on the California Technology Assessment Forum (CTAF) –a professional group that meets three times a year in public session to discuss new medical technologies and their efficacy.

The Patient Protection and Affordable Care Act was signed into law by President Obama in March of 2010. This is a complex piece of legislation, 2000 pages in length, intended to be phased in over several years. This legislation raises a number of questions: What do we mean by Healthcare Reform. Do we need it? What would the ideal look like, and to what extent does the Affordable Care Act meet that ideal.

What is healthcare? Everything we do in medicine has as its goal to diagnose and treat disease. However, as Kenneth Arrow, the Nobel Prize winning economist wrote; "*The causal factors in health are many, and the provision of medical care is only one."* So, our good health is not strictly dependent on our healthcare, although that is one of the factors. That said medical care is a very big deal. It comprises 14% of the GDP of our $1.8 trillion economy; it is basically 1/6th. The fundamental part of the care is the interaction between a patient and their physician, everything else is ancillary to this - all of the drugs, all of the devices, all of the spaces, like hospitals and nursing homes support this basic interaction of a patient and their physician. However, **when we look at healthcare as a delivery system, then we look at it in terms of access, quality and cost -** that is fast, good and cheap. We must keep these three elements in mind when we talk about healthcare and healthcare reform.

Do we need healthcare reform in this country? You often hear it said that America has the best healthcare in the world and this is true if you have a complex illness that requires sophisticated technology for diagnosis and treatment – and, I would add, if you are wealthy and insured. Most people in this country are insured through their employer or Medicare. With those limitations, America really does have good care. However, Victor Fuchs, a healthcare economist, offers another perspective. He points out that we are the only high income country without universal health insurance. He poses *"Why do we spend twice as much on healthcare as European countries whose citizens seem to do just as well as we do? Why is there so much over-use, under-use and mis-use of medical technology? Why has healthcare coverage become a flash point for labor management disputes? Why does such a large percentage of the U.S. healthcare dollar go toward administration and marketing, duplication of services and expensive services that are of little or no value to patients?*" His is one voice that demurs a little bit that America has the best healthcare in the world.

What about access? We have 61 million residents who have problems with access to the system. 45 million are un-insured, that includes 9 million children. The definition of un-insured is to be without insurance for all or part of one year. The under-insured are 16 million and these are people who are insured all year, but whose out of pocket costs are more than 10% of income. That is a substantial fraction of American's who have difficulty accessing the system through health insurance and we can debate whether healthcare is a right or a privilege. In Great Brittan, it is a privilege. There will always be some free riders who think they are going to

be safe and not going to buy insurance and there are many who simply cannot afford it. It is important to note that about two-thirds of the un-insured are working American's.

The un-insured do not die in the streets of a treatable disease like appendicitis. They get care because community hospitals are required to treat everyone that enters their emergency departments, but it is done by cost shifting for those who do purchase insurance. So, it is not a completely fair system. Access to healthcare in this country is a problem and is a problem for a significant and growing number.

What about quality? The usual problems with quality are cited as medical errors. In 1999 the Institute of Medicine published a book called "To Err is Human" followed by another publication in 2001 called "Crossing the Quality Chasm" and the upshot of those two very distinguished publications is that there are an estimated 46K – 96K preventable deaths in hospitals every year in the United States. If true, this is a staggering statistic. Hospital acquired infections; high hospital re-admission rates, and unexplained regional variation are all quality issues.

What about costs? The biggest problem of the American system is basic healthcare is becoming increasingly unaffordable for many American's, not just the poor. In 2007 we spent $2.7 trillion on healthcare, 16% of GDP, $7420 per capita, and the really important statistic is on average, for the last 30 or 40 years, healthcare has exceeded the consumer price index by almost 2.5 – 3 times. This is a structural problem.

What are the consequences of these cost increases? Care is un-affordable for many American's, we have lost some competitiveness in the global economy, Medicare is projected to be insolvent by 2017, and by the taxes we are going to be paying for this, we are going to be burdening future generations.

There is a very clear relationship between per capita wealth, per capita income and the amount per capita spent on healthcare. Beginning with Poland, which is the poorest per capita in the comparison graph presented, there is a pretty regular line that goes up through Spain, Portugal, France, Austria, and Switzerland and then you see the United States. We spend $648B a year more than predicted if we were to follow the regular line which describes the amount spent on healthcare by all the other developed countries.

What do we get for our money? The U.S. death rates and conditions that could be averted through medical care are actually higher despite the extra amount of money that we spend. Our infant mortality is higher than so-called wealthy countries, so the conclusion that one would draw from this data is that we are not getting very good value for our healthcare dollar.

Glenn Hubbard, an American economist and Chairmen of the Council of Economic Advisors, who served under George W. Bush, says the big issue for healthcare is high cost relative to the value of healthcare received.

Atul Gawande, a General and Endocrine surgeon at the Brigham and Women's Hospital, is on the Heart faculty and has written a number of articles and is often quoted in the discussion about

healthcare reform. He has a very harsh judgment about our system –*"the most wasteful and least sustainable healthcare system in the world."*

What makes healthcare so expensive? Why do we have this rampant increase in medical cost inflation? ***By far, the most important driver of medical inflation is new medical technology and all healthcare economists agree on this.*** American's love technology and 'newer is always better'. There has been a medicalization of all facets of life; all seems preventable today through medical intervention. Examples: Lasix surgery so you don't have to wear glasses or contact lenses and erectile dysfunction is now treated pharmacologically.

The innovations that are developed in this country every year are in the thousands. We have come to believe that any new technology showing any improvement is accepted, irrespective of cost. The analogy given to illustrate this is a drug that the FDA approved last year, Terceva. It is a drug for people with end stage pancreatic cancer. It costs $3500 per month. In a very good study the data show that it prolongs life twelve days. So, we have a very expensive medication that on average can prolong life twelve days and we wonder if that is a good use of our money? The desire for healthcare is infinite and ultimately unaffordable. Therefore, I think we can agree that maybe our system could benefit from reform.

What would ideal reform look like? To me, it would look like access to at least a basic set of essential medical services for all American's. There would be an emphasis on continuous healthcare and an emphasis on good patient outcomes. "Bending the cost curve" means limiting the adoption of new technologies to those whose safety and effectiveness are evidence-based and whose benefits are in some reasonable proportion to cost. That would be a big jump and we are not there yet.

Quoted from Victor Fuchs, New England Medical Journal, "***The role of new medical technology deserves special attention in thinking about future healthcare spending because biomedical innovations as a whole have been the primary source of both improvements in health and increasing expenditures. On the one hand, it is fiscally irresponsible to continue to accept innovations regardless of cost, even if they pass tests of safety and efficacy-and it is particularly irresponsible when the interventions are provided at public expense. On the other hand, we must avoid an innovation policy that cuts off new interventions prematurely. Some interventions that are not cost-effective at first may prove to be so over time and with greater experience in implementing them."***

If we could develop a culture in this country where we insisted on evidence-based medicine and had some reasonable sense of what we can and cannot afford then we would have meaningful reform. It is really asking a lot and really depends on rationing. As soon as you start talking about limits, people start talking about managed care, so it is a big political issue. I wish I had a better answer. **The way we handle new medical technology is the key to bending the cost curve, and cost control is really the essence of health care reform in this country.**

Does the Affordable Care Act approach this ideal? This is a very complicated bill, it is phased in and many of the changes will not occur until 2014, some not until 2018, and a lot of the

language is termed "the Secretary of HHS shall do this, she shall do that" and there is a lot of authority given to the Secretary of Health and Human Services, Kathleen Sebelius. She is going to begin this process and her successors will have a tremendous amount of flexibility in applying the Affordable Care Act.

How does the Affordable Care Act deal with access? By 2014, there will be 32M new American's insured. By American's, I mean citizens of the United States; there is no provision for un-documented residents. 83% of American's are now insured. As of this legislation in 2019, 93% will be. Of the 32M new insureds, half of them will get their coverage through an expansion of Medicaid. What the legislation does is it increases the coverage for Medicaid up to 133% of the Federal poverty level which is about $10K per individual and $21K per family. The other 16M will be asked to purchase insurance through an individual mandate. They will purchase through state-based insurance exchanges, which will make it easier to purchase insurance for individuals.

There have also been changes to the insurance industry itself. The one that stuck in my mind is the *medical loss ratio*, which is the amount of premium dollars that insurance companies must spend on healthcare. It is mandated to be 85% for group policies and 80% for individual plans. Today, some of the companies who are doing very well financially can have administrative costs as high as 30%. So the Federal government is telling private companies what they must spend-that is going to be an interesting battle.

What does the Affordable Care Act do about quality? They are putting a great deal of stock in Information Technology (IT). The stimulus package passed in 2009 approved approximately $20B to increase health information technology and the Electronic Health Record (EHR). Quality is said to improve through greater technology, fewer drug reactions, greater transparency, better dissemination in the physician community regarding best practices, and more accountability. It is thought that updated IT in this sector of the economy will improve quality.

The other provision in the legislation that is supposed to lead to better quality is the improved coordination of care. Accountable Care Organizations (ACO), such as the Mayo Clinic and the Cleveland Clinic are models. In our community, physicians are interested in the foundation model which also improves the coordination of care. By improving the coordination of care the quality will improve.

How does the Affordable Care Act affect cost? There are two elements to cost reduction: lower individual costs and change to the whole system. Most people criticize the Affordable Care Act and say it is an *access* act. It does provide increased access to care, but does nothing about cost. Or, it is an insurance bill? It makes insurance more available, but it does not do anything about cost. That has been the criticism of the Affordable Care Act. Peter Road, head of the government Office of Management and Budget and Ezekiel Manual, an oncologist, who was assigned to the Office of Management and Budget, recently published an article in the New England Journal of Medicine in which they took this on and decided the Affordable Care Act *does* cause cost reductions. Over 10 years, the legislation hopes to reduce costs by:

- $7B from fraud and abuse

- $20B from paperwork
- $7B from generic medications
- $135B from changes to Medicare Advantage Plans (25% of seniors are in these plans)
- Additional savings by revising payment mechanisms to physicians and hospitals. An example is the plan to revise the payment structure for complex imaging services, such as MRI's, CT scans, and PET scans, requiring that existing machines will need to generate enough revenue to cover their costs. This will reduce unnecessary duplication of technology purchases.

There are a number of other changes that will drive down costs:

- Beginning in 2018, there will be a 40% excise tax on insurance plans costing more than $27,500 for families and $10K for individuals.
- After 2020, insurance premium increase threshold will be limited by CPI. If Medical inflation rises 2.5 times CPI, it will be capped.
- Employers will be offering plans with lower premiums and workers will benefit from higher wages. Government tax revenues will benefit two ways: through "Cadillac" plan excise taxes and income tax on increased wages.
- Proposed "incentives" for hospitals to reduce costs which are simply payment penalties. If your readmission rate within 30 days of hospital discharge is in the higher tiers of hospitals, your reimbursement is going to fall. If the hospital acquired infections are on the upper tier, you are going to be penalized.

There are three new agencies that you really must know about:
1 – PCORI – Patient-Centered Outcomes Research Institute
2 – CMS – Centers for Medicare & Medicaid services
3 – IPAB - Independent Payment Advisory Board

PCORI has already appointed 23 agents to this new body, which is a public/private/non-profit agency. It will be funded through a Medicare trust fund and private insurance company. This is to ensure that decisions are made and Congress does not strip it of its money. Its purpose is to fund new research, new technology, and rigorous scientific studies and disseminate the results from this research. At some point we have to get to the stage of risk/benefit analysis and place a value on this - Is this new innovation going to be worth it and can we afford it? The quality of life vs. years of live (QUALY'S) is a very well excepted methodology for putting a dollar sign on the value of the quality of life by the intervention. This legislation explicitly forbids the use of QUALY's in any recommendation from PCORI.

CMS' Innovation Center refers to bundled payment systems and allows the Secretary of HHS to promote pilot programs on innovative ways to pay for medical care. The Secretary of HHS can have pilot programs and expand them without going back to Congress for approval and they think this may be one of the ways they can get control of medical costs.

The IPAB will take the amount of money spent in Medicare per capita and will have formulae to develop thresholds. By 2018 that threshold will be 1% above CPI; that is a draconian cap on the growth of Medicare spending given the medical inflation trend at 2.5 times CPI. The Secretary of

HHS must, by law, implement the payment polices developed by the IPAB or the Congress may enact legislation XXXXXXXXXXXXXXX

"In summary, the American health care system at its best is very good; it is however desperately in need of reform. We must find ways to contain the rate of rising costs and get better value for our healthcare dollar because Americans' expectations are boundless. Any reduction on money spent on healthcare is viewed as rationing. Some combination of public education and coercion will be required to turn the ship around. Every dollar we save is someone's salary – politically, it is very difficult to restrain. It remains to be seen if the Affordable Care Act will be able to lead us out of the unsustainable position we find ourselves in. As George H. W. Bush used to say, stay tuned."
(The presentation is appended to and made part of the minutes.)

Treasurer Cappel thanked Dr. Ullyot for synthesizing the thousands of pages of legislation. He also found it important and informative as it relates to the District and its role in healthcare delivery. The District is now forced, if not mandated and morally obligated, to look at services that are being spun out of our healthcare organizations to see if those services can be provided in an alternative fashion to ensure our constituents do not lose the options of a full healthcare delivery system, not just medical care. Thank you for the opportunity to listen.

Vice-Chair Navarro turned the chair back over to Dr. Ullyot.

COMMITTEE REPORTS

A. **Long Term Planning Committee: Chair Ullyot,** Committee Chair, reported there have not been any meetings since the last District Board meeting.

B. **Sutter Health Oversight- Building Committee, Director Newman,** Committee Chair
Director Newman reported the new hospital is getting ready for move-in. The construction of the POB is essentially complete except for the lobby. The hospital construction should be done at the end of this next month with move-in scheduled for February. It will probably be the only new facility in the Bay Area for some time.

C. **Community Health Investment, Director Navarro** stated he was unable to make the last Community meeting and asked Ms. Fama to speak on behalf of committee. **Ms. Fama** reported the grant process has started. The District's health priorities were reviewed and, given the information collected through our environmental scan phase of the strategic planning process, the committee recommends no change. Therefore, the FY 2011 priorities will be: primary care access, childhood obesity, senior services with a focus on promoting independence and keeping people in their homes as long as possible, health education to children, seniors, adolescents with the intention of reducing high risk behaviors, and training and recruitment of healthcare professionals. The grant budget was reviewed; there is $1.3M of the budget available for new grants. Thirty-three letters of intent have been received. Site visits are being scheduled. The committee has two more meetings scheduled and is on track to have recommendations ready for the December 9, Board meeting.

CEO Report

A. **Office Staffing Changes:** Ms. Fama reported that the fulltime Administrative Assistant position will be eliminated effective 11/12/10 and a part time Community Outreach Coordinator position has been

created. This new position has been filled by Kelly Molloy, who worked previously for the District before relocating across the Bay. She brings a wide range of talent and skills to the position and is familiar with office operations.

B. Community Activities: Participation on the Board of Supervisors sub-committee on Healthcare Workforce Needs has been helpful in obtaining the most current research and thinking on the impact of the Affordable Care Act on workforce demands. This information will be important as we look at our fifth health priority on education and recruitment of healthcare workforce.

C. Facebook: With Ms. Molloy's help, we will be bringing the development and expansion of our social networking tools in-house. We are already up to 30 Facebook friends!

D. Strategic Planning Activities: We are making good progress on the planning process outlined and presented to the Board in March. To assist in the next phase - Emily Hall and her team from Olive Grove Consulting have been retained. **Chair Ullyot** requested a copy of Ms. Hall's resume to understand her background. **Ms. Fama** stated the next steps are to have Emily and her associate, interview each of the Directors individually prior to a planning retreat and to schedule that retreat in February. District staff will be surveying Directors on preference of dates and times.

OLD BUSINESS

Fiscal Year 2010 Audit Status

Treasurer Cappel stated the audit is in draft form at this point and we are waiting on clarification on the current status of District assets that may or may not still be at the hospital. Basically the assets have either been disposed of or are unaccounted for. We hope to have needed information within the next 30 – 60 days. Preliminary numbers for FY 2010: current assets increased $4.0M; net capital assets decreased about $4.5M; current liabilities decreased about $9.4 thousand, and our fund balance is up about $4.M. We are starting to do better on our San Mateo County pooled fund returns with the interest rate up from about .8% to about 1.3%. However, LAIF is not performing that well and is getting only 0.50% return. Hopefully, some of the recent changes put forth by the Board will stimulate that growth and we will do better. The other important note from a financial perspective is our tax revenues are going to drop a bit this year from approximately $4.4M to approximately $4.2M.

NEW BUSINESS

Report Out from Closed Session prior to Meeting; If any reportable actions taken.

Chair Ullyot reported there was nothing to report out to the public from the Closed Session Meeting prior to the Board meeting.

Mills-Peninsula Announced Plans to Outsource Service Operations: SNF & Dialysis

Chair Ullyot asked for any thoughts or questions about this. **Chair Newman** stated, as Chairmen of the Oversight Committee, the Committee will need to focus on what is going on with respect to the two programs that are being outsourced. He asked for guidance from the Board in terms of the role the Directors would like to see the Oversight Committee play. He stated that, from the Mills Peninsula perspective, the District has no role, but in terms of the lease agreement between the District and MPHS, there is a role in terms of programs. He stated that outsourcing should not diminish quality, only diminish costs to the organization.

Director Cappel responded that he believes our current agreement precludes us from being actively involved in this; however, there are two major services that are being eliminated at the hospital. Dialysis and SNF are two very critical programs for this community and they are two programs that are going to become increasingly important. They are clearly money loosing industries. The District Board's role then becomes to ensure these services are still provided in our community. The worst thing that could happen

would be sending SNF patients out of their community. The Board can provide input, whether it is used or not. It is important for the District to give suggestions and influences.

Director Navarro stated it is not part of the core services as outlined by the lease, however, the Board can request that Sutter provide a forum for the community to ask any of the questions they have in relation to these closures. Employees can also ask their questions.

Chair Ullyot stated he agrees with both Directors Navarro and Cappel and noted the importance of understanding that the Affordable Care Act is squeezing the entire industry and must. This is not the only hospital that is cutting back. Sutter has smart people who are looking at national trends. If they get a 20% reduction in Medicare reimbursement, which is half of the healthcare in this country, Medicare is the price leader upon which insurance companies will base their prices and compensation. The irony is Mr. Merwin comes at quarterly intervals and elaborates on the profits that are being made at MPHS and how successful they are. That is good to hear, but in the next breath we can't afford Dialysis and SNF. I think it is important to document the basis for their decisions and how those decisions were announced to their employees and the public. Whether the services will remain here or disappear, it is always interesting to understand if these are money loosing industries, who is going to be beating the path to the door to run these money loosing services. Apparently, they have already had a pretty good response to request for proposals because the Dialysis entities use fewer RN's than the hospital does and does not have to employ union workers, so there are cost saving opportunities. If the services are going to stay here and we can continue to keep an eye on quality, then that is about all we can do.

Ms. Fama offered that as the Board does its strategic planning, it will have to come up with a mechanism to look at trends within the Sutter system, as well as the state, concerning further cost reductions relative to the Affordable Care Act. One has to wonder, even though thus far MPHS has only nibbled on non-core services, how real and how soon might there be some shortfall that triggers the language in the master agreement whereby MPHS can come to the District to help fund those services. As observed in the last year, acute rehab, skilled nursing and dialysis suggest that it might be just a matter of time before a core service is involved. This will directly impact the Board's strategic targets and uses of reserves for paramount default.

Chair Ullyot noted that the Sutter Oversight Committee positions us well to gather information. He then commented on two items. First, the recent discussion about closing Acute Rehab and the commitment to relocate Dr. Aftonomos and all his wonderful staff to the SNF - hat seemed to pacify everyone and now the SNF is going. In our conversations with Mr. Merwin we asked if this means these folks are going to disappear. He answered - the request for proposals requires that responders give Dr. Aftonomos first right of refusal to remain involved with the SNF. The second comment noted that the hospital will be experiencing an increase in capital expenditures of $30M /year to pay for the new hospital which gives them no capital for any improvements. **Director Newman** stated that we might want to look at the impact of the new health reform legislation on our hospital. We may very well find ourselves paying for part of the funding.

Treasurer Cappel stated if the healthcare act does proceed forward, then it would behoove all hospitals to look at services that are not making money and get rid of them quickly. The primary role of an Accountable Care Organization (ACO) is to buy ancillary support services as inexpensively as possible. It will be the ACO's role in life to squeeze those costs out. The hospital of the future will be for the very acutely ill with few if any other types of programs. Everyone will be taken care of by alternative, non-hospital based programs. I agree with Cheryl, I think we have a whole string coming down the pike. We can't blame the hospital; it is a business. **Chair Ullyot** stated he was glad to have Treasurer Cappel there

to hear the discussion and stated that this is exactly what our strategic plan must encompass. Our oversight of the hospital is very important to our community.

Chair Ullyot asked if there were any other comments from the public. There were none.

ADJOURNMENT:
The meeting was adjourned by **Chair Ullyot** at 19:20 hours.

By:

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Kelly Molloy, Community Outreach Coordinator

Approved:

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Helen C. Galligan, Secretary

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Daniel J. Ullyot, M.D., Chair