# FINAL OFFICIAL MEETING MINUTES
# Miami-Dade County Hospital Governance Taskforce (HGT)

Beacon Council Offices
80 S.W. 8th Street, Suite 2400
Miami, Florida

April 21, 2011
As Advertised

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Board of County Commissioners

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CLERK'S FINAL OFFICIAL MEETING MINUTES
MIAMI-DADE COUNTY HOSPITAL GOVERNANCE TASKFORCE
APRIL 21, 2011

The Miami-Dade County Hospital Governance Taskforce (HGT) convened a meeting at the Offices of The Beacon Council, 80 S.W. 8th Street, Suite 2400, Miami, Florida, on Thursday, April 21, 2011, at 3:00 p.m., there being present Chairperson Juan Carlos Zapata and Members: Martha Baker, Michael Barron, Jose Cancela, Ed Feller, Robert Johnson, M. Narendra Kini, Marisel Losa, Steven Marcus, Ana Mederos, Steven Pinkert, Linda Quick, Sharon Pontious, Lillian Rivera, Donna Shalala, Steven Sonenreich, and Alternate member George Foyo representing Brian Keeley; (Vice Chairperson Susan Dechovitz and Members Manuel P. Anton III, Lee Chaykin, and Brian Keeley were absent).

I. ROLL CALL:
The following staff members were present: Assistant County Attorneys Eugene Shy, Karon Coleman, and Laura Llorente; Gary Collins, S. Donna Palmer, and Antonio Crawford, Office of Commission Auditor; and Deputy Clerk Mary Smith-York.

Chairman Juan Zapata called the meeting to order at 3:10 p.m.

II. OPENING REMARKS
Chairperson Zapata referenced points from last weeks meeting and addressed the issue of the Board of County Commissioners (BCC) proposing the establishment of a seven-member board to oversee the Public Health Trust. Pursuant to his concerns of how the seven-member board would impact the work of the HGT, Mr. Zapata, in speaking with County Commission Chair Joe Martinez, understood this to be a temporary measure.

Assistant County Attorney Karon Coleman advised that the subject board was the Financial Recovery Board (FRB), that it was in place for a period of 24 months pursuant to resolution by the BCC, and that it would not lead to overall governance.

In response to Mr. Cancela's question of whether there was an item on the BCC agenda providing that the ordinance be amended to stipulate that a 2/3 vote could overturn the seven-member board, Assistant County Attorney Karon Coleman explained that there were two potentials: that an amendment to the ordinance to put 2/3 vote in the 25A language; and, in the resolution that would establish the FRB.

Dr. Pinkert suggested Public Health Trust members should be heard and recommended former Trustee Dr. Mark Rogers, followed by other past and present PHT and BCC members, be asked to make presentations. Dr. Pinker explained this would allow the HGT to attest that its recommendations were evidence-based.

Discussion ensued among members regarding presentations done by PHT and BCC members versus representatives of healthcare centers that had undergone governance change, and experts' opinions versus evidence-based recommendations.

Dr. Shalala pointed out that the presentations given thus far all said their governance change made them more competitive and provided them flexibility and control over the most important elements in management, including contracts and personnel. She emphasized the point that the driving force behind most of the changes in governance was independence, the ability to make tough decisions in a competitive market.

Ms. Baker suggested there be a debriefing session following each presentation to identify points that addressed key problems being targeted by the HGT, i.e. smaller board size.

Chairperson Zapata advised that he met with the Dr. Eneida Roldan, Chief Executive Officer, JMH, and spoke with BCC Chairman Joe Martinez regarding the HGT's working draft document. He highlighted several components of the case study done on four hospitals reflected in the Kaiser Study of 1999, including operational, labor unions, political, accountability, etc. that would be helpful to the efforts of the HGT. Chairperson Zapata noted he was receptive to Dr. Rogers making a presentation, but pointed out that the HGT must reach a consensus on the type of recommendations it wished to present to the BCC. He stressed the importance of putting some ideas together as a foundation.

Dr. Sonenreich suggested the HGT consider looking at the Center for Healthcare Governance (CHG), an institution that provided information and resources to hospitals' boards. He recommended Dr. James E. Orlikoff, Senior Consultant, be contacted for direction regarding governance issues.

Ms. Quick volunteered to invite Dr. John Combes, President and Chief Operating Officer at the CHG in Chicago, IL, to participate in a teleconference presentation at the next HGT meeting.

Chairperson Zapata requested Commission Auditor representative Donna Palmer to coordinate presentations by Dr. Combes and Mr. Carlos Migoya, President Elect, Jackson Memorial Hospital, for the HGT meeting on April 28, 2011.

Dr. Feller urged the HGT to move quickly in amassing and analyzing the Task Force members' opinions to determine whether therein lay a quick answer.

III. APPROVAL OF MINUTES (April 7, 2011)

The following corrections to the April 7, 2011, minutes were requested:

- On page 3, paragraph 2, include "L.A. County" in the list of medical centers.

It was moved by Dr. Kini that the April 7, 2011, meeting minutes be approved as amended with the foregoing requested change. This motion was seconded by Dr. Shalala, and upon being put to a vote, passed by a unanimous vote of those members present.

IV. TELECONFERENCE INTERVIEWS

A. Cook County Health & Hospitals System

Ms. Elizabeth Reidy, General Counsel, Cook County Health & Hospital System, Chicago, IL, greeted HGT members and explained that she was representing Chief Executive Officer William Foley and Board Chairperson Warren Batts, who were unable to participate due to schedule conflicts. She advised that her responses would be limited due to her role as General Counsel, as opposed to Director/CEO. Ms. Reidy advised that a second brief call that included the CEO or Chairperson was recommended in order to answer in depth questions. She provided a brief introduction and historical background regarding Cook County Bureau of Health Services, renamed Cook County Health & Hospital System (CCHHS) in its governance change process.

Following Ms. Reidy's overview, she provided the following responses to the HGT's questions presented by Drs. Barron, Kini, and Pontious:

**1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?**

The CCHHS Board consisted of eleven directors, ten of which are healthcare oriented and one an ex-officio member, who was Chairman of the CCHHS Commission. The CEO looked at staffing issues, hired experts in performance improvements and did significant staff reductions, which included vacant and filled positions. Specific governance-related questions should be made to the Director for a more appropriate response. The turnaround expert was guided by a core of professionals who knew about the health industry. Key issue was reimbursement and whether the dollars owed were being captured and the governance and policy experts began working from that perspective as soon as possible.

**2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?**

The hospital went from being governed on a direct hands-on basis by elected officials to being governed at a Board level by a group of experts. Brought the centralized human resources and purchasing functions in-house. The Board consisted of one director who was head of another hospital, and two other members were from neighboring hospitals.

**3. What impact did the governance change have on your mission and how is that measured?**

The mission has remained unchanged. One of the largest projects of board was to manage a five-plan entitled "Strategic Plan Vision 2016" which entailed a significant reallocation of resources to the system. Trying to reallocate limited resources to focus on outpatient specialty care, primary care, and immediate care.

**4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?**

New governance structure evaluates effectiveness through an Operational Ops (phonetic) Plan for benchmarking, as well as traditional red light, yellow light, green light system, and performance improvement benchmarking.

**5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?**

Ms. Reidy advised that she was unable to answer the foregoing question. She stated the Board of Directors approved bargaining agreements, but the County Board of Commissioners negotiated them. She advised she was not sure as to whether they were civil or healthcare service. Ms. Reidy was also unable to answer the question regarding what percentage of the $630 million total healthcare revenues came from outpatient clinics. Ms. Reidy asked that the HGT provide her with a copy of its final report once completed.

Discussion ensued among members highlighting the differences between the Cook County Board and the PHT, including the smaller size and the objective of strategic planning and personnel issues.

Regarding the issue of "conflict of interest" among board members, Chairperson Zapata advised that he was awaiting a response from the Ethics Commission and the Inspector General regarding this subject. He stated he would recommend creating a system that incorporated an open setting wherein the CEO could communicate with the governing body.

B. L.A. County Department of Health Services

Mr. John Schunhoff, Chief Deputy Director, Los Angeles County Department of Health Services (LACDHS), provided the following responses to questions by Drs. Barron, Kini, and Pontious:

**1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?**

The governance structure was described as a department of the County of Los Angeles, governed by the five members of the Board of Supervisors, who were County Commissioners. There was uncertainty as to whether a direct link existed between the change in governance and the strides they made in terms of patient care and finance. California law gives counties responsibility for providing indigent care. The majority of the counties did not operate public hospitals and clinics, rather contracted those services to private hospitals and community clinics. LA County has a history of having public hospitals and clinics and provides indigent care through its facilities; and in the past 15

years, funding has been provided to the LA County Community Clinics to provide indigent primary care, while the hospital provided more specialty care.

**2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?**

There was significant increase in the number of patients coming to the emergency rooms and some of this increase was attributed to a change to one of the facilities. The system recently opened the L.A. County Medical Center that was a 600-bed facility. Pursuing a different model of governance relative to the new Martin Luther King Hospital scheduled to open in 2013. Rather than opening a new County Hospital, a county facility was being built, whereby the LACDHS and the University of California (UC) jointly formed a non-profit corporation that would contract with the County to lease the facility and operate the hospital. The UC would provide the medical oversight and quality oversight board with regard to the core physician services. This was a different approach compared to the other four hospitals in the system that were County-owned and operated.

**3. What impact did the governance change have on your mission and how is that measured?**

The Board of Supervisors had a strong commitment to low-income and indigent care and over the years put significant amounts of County dollars into the health care system. This Board has essentially taken off the Department of Health Services from the general fund problems, particularly those related to the extension. There were three types of budgets in the County: the general fund, special districts, and health department. Have not had to encounter the same source of reductions that the general fund departments had.

**4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?**

Each facility measures quality of care by objective measures; periodically, the chiefs meet with the medical staff to go over issues. Unsure whether there was a systematic method of measuring effectiveness and have not evaluated the role of the Board in governing the health system.

**5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?**

The governance structure has not had an impact on the financial viability of the health system; however, with the new County governance structure has cross collaboration and communication. This was evidenced in the health services to juveniles through the Probation Department and the department of Children and Family Services, having to report to the Board through the CEO.

D. Truman Medical Centers

Mr. Gerard Grimaldi, Vice President, Health, Policy & Government Relations, Truman Medical Centers (TMC), introduced Chief of Staff Cheryl Washington, and President/CEO John Bluford. Following a brief historical overview of the organization's governance structure, he provided the following responses to questions prepared by the HGT members:

**1. How did your change in governance lead to improved patient care, increased patient satisfaction, and increased market share and revenue? Any impact on access to healthcare services?**

A key governance problem was addressed by the downsizing the Board from 50 members. TMC was a 501(C)3 organization and the City and County each had three members on the Board of Directors.

**2. What turnaround efforts did your hospital/health system go through before consideration of governance changes? Describe the success or lack thereof of these efforts and why?**

**3. What impact did the governance change have on your mission and how is that measured?**

The governance has allowed the operational structure to be innovative and entrepreneurial in terms of providing best quality care and services to patients to meet the organization's mission.

**4. How did the old governance structure evaluate its effectiveness? How does the new governance structure do the same?**

The Board Development Committee was charged with recruiting and retaining, as appropriate, the Community Directors, as well as evaluating the Board's effectiveness and making recommendations for future improvements.

**5. What was the direct correlation between the change in governance and improved financial viability? Could the same result have been achieved under the existing governance structure? Why or Why not?**

TMC received approximately 8 ½ percent of its operating revenues directly from the City and the County, in terms of the operating subsidies for the care provided, which was a key component, due to the financial strength of the safety net institutions. Truman was one of the first hospitals to go to the non-profit models in the 1960s.

Responding to the question of whether the flexibility and freedom that fostered an entrepreneurial spirit resulted from the governance structure or autonomy in the city and

county governments, Mr. Grimaldi stated it was a combination of several factors, including autonomy, strong leadership, and a strong team.

Pertaining to the kind of labor contracts were in place and whether the government engaged in negotiations, Mr. Grimaldi explained that the contracts were with Truman Medical Centers and were with two separate organizations handled by the management staff. He noted the Board approved what was in those contracts, particularly the financial items. Additionally, he stated the Appropriations Authority of the City and County governments monitored whether TMC stayed true to the mission through annual evaluations.

Regarding whether the financial relationship with the City and County was built into the ordinance that permitted TMC to become a nonprofit corporation, Mr. Grimaldi noted a contract with the City ensured the funds were provided for indigent care and the original covenant or operating agreement with the County bound TMC to operate what use to be Jackson County Public Hospital.

Mr. Grimaldi stated there was a clear distinction between the functions management was empowered to do without Board approval and those functions that required the Board's approval.

Regarding what the amount of funding from the City and County was prior to becoming a 501(C)3 corporation, Mr. Grimaldi stated it was funding through a separate levy for health related purposes adopted by the City and County respectively. He added, at that time, there were not as robust Medicaid or Medicare programs as today; and half of the volume and revenue was generated from the outpatient versus inpatient services.

Regarding the new governance structure at TMC, Mr. Grimaldi stated the size of the Board was reduced from 50 to 33 members and added more accountable governance structure through committees. He agreed to research whether reports describing the governance changes existed, and if so, would submit copies to the HGT.

V. OVERVIEW

A. Comparison of Federal, State, and Local Hospital Funding Sources

Ms. Linda Quick provided a description of the figures reflected in the spreadsheet entitled "South Florida Acute Care Hospital Medicaid-related Financial Data" included in today's agenda package.

Chairperson Zapata noted the HGT should focus on determining what type of structure would work best for the PHT: modify the current structure, change to nonprofit corporation, or change to a special taxing district. He encouraged members to present their recommendations.

Discussion ensued among members regarding what type of governance structure would best serve all aspects of the Jackson Health System.

Mr. Cancela explained his reason for requesting Mr. Rogers' resignation letter be placed on last week's agenda was to recommend that this Task Force develop a two-step recommendation process. These two steps include: 1) a short-term recommendation to amend 25A to create a buffer for the PHT as it currently stands; and 2) a long-term governance structure change that would take up to two years to enact.

VI. WORKING ITEM

A. Discuss/Draft Preliminary Recommendations

Discussion ensued regarding the composition of the proposed new board, the need to ensure members were qualified to serve, and what the level of County Commission control over the hospital board should be. A consensus was reached that short-term recommendation ideas should be dealt with next week and that a copy of the Charter should be available during discussion of possible changes. HGT members also contemplated what number of members would be right for the new board and whether the first step in formatting the recommendations would be amend 25A to reflect the change in membership. HGT members agreed to revisit the referendum language pertaining to the half-penny sales tax and address the conflict of interest aspect of board members.

VII. ADJOURNMENT

The next meeting was scheduled for April 28, 2011, at the State Attorney's Office, 1350 N.W. 12th Avenue, Miami, Florida, at 3:00 p.m.

There being no further business to come before the Hospital Governance Task Force, the meeting adjourned at 6:09 p.m.

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Juan C. Zapata, Chairperson
Miami-Dade Hospital Governance Task Force