MIAMI-DADE COUNTY
FINAL OFFICIAL
Meeting Minutes

Board of County Commissioners
Committee of the Whole

Stephen P. Clark Government Center
Commission Chambers
111 N.W. First Street
Miami, Florida 33128

Monday, September 20, 2010
As Advertised

Harvey Ruvin, Clerk
Board of County Commissioners

Diane Collins, Acting Division Chief
Clerk of the Board Division

Jill Thornton, Commission Reporter
(305) 375- 2505

CLERKS SUMMARY AND OFFICIAL MINUTES
BOARD OF COUNTY COMMISSIONERS
COMMITTEE OF THE WHOLE MEETING
SEPTEMBER 20, 2010

The Board of County Commissioners met as a Committee of the Whole in the County Commission Chambers on the Second Floor of the Stephen P. Clark Government Center, 111 NW First Street, Miami, Florida, at 10:00 a.m., September 20, 2010, there being present upon roll call: Chairman Moss, and Commissioners Natacha Seijas, Bruno Barreiro, Rebeca Sosa, Audrey Edmonson, Barbara Jordan, Dorrin Rolle, Katy Sorenson, Javier Souto, and Carlos Gimenez; (Commissioner Sally Heyman was late-excused), (Commissioners Jose "Pepe" Diaz and Joe Martinez were absent). Mayor Carlos Alvarez and the following staff members were also present: County Manager George Burgess, County Attorney Robert Cuevas, First Assistant County Attorney Abigail Price-Williams, Office of Strategic Business Management (OSBM) Director Jennifer Glazer-Moon; and Deputy Clerks Doris Dickens and Jill Thornton.

The Commission convened in a moment of silence, followed by the Pledge of Allegiance.

Chairman Moss called the meeting to order at 10:30 a.m. He noted the purpose of this meeting was to discuss the Public Health Trust (PHT) and the County's proposed Fiscal Year (FY) 2010-11 Budgets, followed by questions and comments from members of the County Commission and the County Administration. He also noted the procedures to be followed today, and asked Commissioner Sorenson to provide an opening statement.

Commissioner Sorenson noted Jackson Memorial Hospital (JMH) and the PHT were extremely important to Miami-Dade County, and should be sustained. She recapped the major issues surrounding JMH with the following questions: Could JMH survive on its current revenues given its responsibilities? What revenues and services could be improved or eliminated? How could the paying patient mix at JMH be improved? Was the right management team in place to resolve the issues? Can management continue to forestall the capital improvement projects and expect to see more paying patients? Should the Board revisit JMH's employee salary structure, which was clearly higher than all other hospitals in the area, even though JMH employees already made concessions? And, was the PHT Board of Trustees acting within their role and fulfilling their responsibilities? Commissioner Sorenson suggested when appointing new trustees to the PHT, the Board of County Commissioners interview the remaining PHT Board members to consider whether or not to retain them in light of the troubling reports submitted by the Inspector General (IG). She noted she believed the Commission was dedicated to the mission of sustaining JMH and the PHT, though it would need to make some tough decisions.

Commissioner Heyman, Chair, Health, Public Safety and Intergovernmental Committee (HPSIC), noted the reports by Dr. Roldan, the IG, the Grand Jury, and dialogues with the PHT have helped the Commission to better understand the challenges that JMH faces. She said she was interested in hearing the substantive, measurable changes made at JMH, specifically, the changes made in its administration, operations and practices. She asked to be educated on the progress the administration was making to overcome the challenges, the shortfalls as a result of

decreased Medicare patients and the limitations of state/federal funding, which would help the Commission to work as a legislative and management body to successfully further these efforts.

Dr. Eneida Roldan, CEO JMH/PHT, introduced Mr. Ted Shaw as the Interim Chief Financial Officer (CFO) of JMH. She noted, on behalf of all JMH staff and PHT members, she was pleased to report the accomplishments made over the past fifteen months at JMH; and though challenging, she was hopeful these changes would move JMH forward in a positive direction.

QUESTIONS BY CHAIRMAN MOSS

Question: Referring to Dr. Roldan's September 3rd, 2010 report, page 3, which announced the strategic action of the University of Florida's Shands Healthcare System to repatriate undocumented patients to their home country and limit non-emergency services access to uninsured patients from outside their 13 county service area, Chairman Moss asked what would be the impact of this action on JMH.

Answer: Dr. Roldan: JMH management implemented a (front-end) utilization program that carefully identified and tracked patients coming to JMH from outside of Miami-Dade County (MDC), and this was done at the front-end of the revenue cycle. When an emergent patient is received at JMH, appropriate steps are taken to contact the respective county(s) to get reimbursement.

Question: What success has JMH had in getting reimbursement from other counties for the care of patients that reside outside of MDC?

Answer: Mr. Shaw: Generally, the best method would be to avoid getting those patients at all; however, JMH has had very little success in getting other counties to pay, other than through Medicaid and federal programs. Patients are closely screened for emergency or non-emergency care.

Question: What brings a patient from outside of MDC to JMH? Do they come to JMH because they feel they can get free care?

Answer: Mr. Shaw: Another hospital will ask to transfer a patient to JMH when it lacks the necessary capabilities to treat the patient; however, at JMH, transferred patients are screened very carefully, and JMH only accepts those it must. If a patient comes to JMH without authorization or from another hospital without a referral, whether undocumented or not, JMH will treat the patient if it is an emergency, and will continue treating the patient throughout the patient's stay of illness, pursuant to County policy.

Question: Was JMH in contact with other medical institutions or counties that request to transfer patients to JMH, in order to get some guarantee of payment? And, was this a big issue for JMH, and what impact did this have on JMH's budget?

Answer: Dr. Roldan: She assigned a Chief Utilization Officer (CUO) at JMH to dialogue with the physicians who transferred patients to JMH to ensure the reason for transferring was because

only JMH could perform the service. If the CUO determined the service needed could be performed at the facility requesting the transfer, the CUO would refuse the transfer. In the case of a transplant or another service performed only by JMH, the CUO works closely with both the Revenue Cycle Manager and Case Management to ensure JMH gets reimbursed for the services.

Question: What was JMH's cost to provide charity care to patients transferred from other medical facilities outside of Miami-Dade County to JMH?

Answer: Mr. Shaw: The cost of the charity care mission was about $700 million annually. As it relates to undocumented patients, the cost was estimated at $64 million annually; however, he had not isolated the cost for caring for transferred patients, but could provide the Commission with that number later.

Request: Chairman Moss asked Mr. Shaw to provide the Commission with JMH's cost to treat patients transferred from other medical facilities outside of Miami-Dade County to JMH.

Question: Referring to page 4 of Dr. Roldan's report, Chairman Moss asked if other hospitals had faired better than JMH through a more beneficial state and federal program or matching funds.

Answer: Mr. Shaw: Some counties had separate waivers and received more direct funding from the Federal government through a matched grant. Essentially, these cities received a larger portion of the pie. However, MDC participated in, and actually funds a large portion of a statewide program that distributes funds across the State.

Question: Referring to page 6 of Dr. Roldan's report, how much funding did JMH receive from the Low Income Pool (LIP) Program?

Answer: Mr. Shaw: JMH received approximately $67 million in funds annually from the Disproportionate Share Hospital (DSH) and LIP programs.

Comment: Chairman Moss recommended that JMH management monitor this funding source since concerns were raised regarding LIP funds being phased out under new Health Care Reform.

Comment: Dr. Roldan noted under new Health Care Reform, a proposal was being discussed to phase out the DSH program and to cover the uninsured patients with an insurance plan similar to Medicaid. She noted if that happened, JMH would no longer have the benefit of the DSH program for those patients that remained uninsured.

Question: Referring to page 7 of Dr. Roldan's report, regarding the issue of a $259.2 million net loss in FY2009, Chairman Moss asked if the PHT's Internal Auditor (IA) had detected anything that indicated there was a problem, and if so, did he/she notify anyone of it?

Answer: Dr. Roldan: She did not receive any direct communication from the IA or personal notification regarding this issue; that it was purely an observation made by her and Mr. Lapciuc

when working with the PHT to evaluate the true Accounts Receivables in September/October of 2009.

Question: Who is the IA for the PHT?

Answer: Dr. Roldan: Ms. Marlane Burg was the IA for the PHT.

Question: Referring to page 9 of Dr. Roldan's report, he asked what plans were being implemented to address the advantages of labor costs when comparing JMH's labor cost structure with other hospitals in the area.

Answer: Dr. Roldan: JMH's salary and benefit packages were much richer than other organizations in the area, and the higher benefits were due to some individuals having been employed by JMH for many years. She noted one proposed initiative was to convert the primary care clinics to Federally Qualified Health Centers (FQHCs), which get higher reimbursements, but have lower salary costs, and why these clinics show a profit or at least break even. Management was currently discussing with JMH union partners how to implement this initiative.

Comments: Mr. Shaw expressed his appreciation to JMH's union partners and JMH employees for contributing 5% of their base pay towards reduction of JMH's deficit. This would help carry JMH through the first part of 2011; however, the entire labor contracts would need to be renegotiated in FY2011/12. Referring to page 10 of Dr. Roldan's report that reflects a 2000 CMS (Centers for Medicare and Medicaid Services) study of cost reports filed by all hospitals, Mr. Shaw noted that JMH's average hourly wage rate, including benefits, was $40.47, which was higher than any other hospital in the area and the highest in the market. He noted management needed to do a better job at negotiating salaries to be more competitive.

Question: According to page 13 of Dr. Roldan's report, 70% of hospital admissions were initiated through the Emergency Room (ER), but only 20% of individuals seen in the ER were actually admitted, Chairman Moss asked what plans were being made to create an environment in the ER that was second to none in order to quickly access, triage and admit these patients into the hospital and capture more of this market.

Answer: Dr. Roldan: When she started as JMH's CEO in 2008, the first department restructured was the ER by: 1) expanding the express care service, 2) opening an observation unit, and 3) improving the triage unit for better patient assessment. She noted JMH was losing 22% of potential patients because patients were leaving the ER without being seen; however, since restructuring the ER, she has seen that percentage drop to 8% and getting smaller. She also has seen a better effort in patient through-put. Since new Healthcare Reform was shifting more to outpatient care due to the high cost of inpatient care, she would rather see Jackson Health System (JSH) focus more on primary care and preventive medicine rather than inpatient care, which cost more. She noted the hospital would still incur some loss when treating inpatients covered with Medicaid because that was an underfunded insurance. One of the growth strategy initiatives was to work towards outpatient care and to work more closely with the FQHCs in the area to get JMH clinics federally qualified.

Question: How does Urgent Care Centers (UCC) work, and can a patient be charged a cost for being seen at a UCC and then charged a further cost if sent to an ER.

Answer: Dr. Roldan: The difference between UCC and the ER was the ER must abide by the Emergency Medical Treatment and Active Labor Act (EMTALA), a federal rule which prohibits an ER staff from questioning a patient's ability to pay or asking a patient if they had insurance, and must treat any patient that comes through the ER. However, a UCC is not required to abide by EMTALA and could ask for a service fee upfront before treating the patient. The delivery system or treatment at a UCC was also different in that it was not considered an emergency, and the UCC could send the patient to an ER if the staff felt they could not treat that patient.

Question: Could a patient be charged twice, once at the UCC and then another cost at the hospital if sent to the ER; and if so, this should be looked at.

Answer: Dr. Roldan: Absolutely. A UCC could ask for a pre-payment and then send a patient to the ER if they could not treat that individual; however, staff at an ER was prohibited from asking for payment until after the patient was treated.

Question: Referring to page 15 of Dr. Roldan's report, the cost of labor and benefits represents 59% of JHS' total expenses; Chairman Moss asked why was the cost of care at Jackson South Health Clinic (JSHC) much greater than the cost of care at Jackson North, about a 10% difference in labor versus operational costs.

Answer: Dr. Roldan: Some services at Jackson North were outsourced, and the outsourced company paid less in salaries; whereas, the revenues at JSHC had dropped due to lower volume. But, JHSC was at the 25–percentile in staffing benchmarks, which was the desired percentage in the staffing model.

Mr. Shaw added that because JSHC has no outsourced departments, the ratio or percentage of salary and benefits to total expenses was higher. That percentage was lower at Jackson North, because some of Jackson North's salary and benefits are included as a Purchase/Service cost.

Question: Which departments were outsourced at Jackson North?

Answer: Mr. Shaw: Dietary, Housekeeping and the Emergency Room. Also, the ERs at JSHC and JMH main were staffed by employees/physicians of JMH, but the ER at Jackson North was staffed by an outsourced company, which was less expensive and captured as a Purchase/Service cost in a separate line-item rather than as a Salary and Benefits cost.

Question: What difference had the marketing outreach efforts made on Jackson North compared with JSHC? He noted he had not heard much or seen the same level of media marketing and outreach efforts for JSHC as he had for Jackson North.

Answer: Dr. Roldan: Outreach was being done for both JSHC and Jackson North, and JSHS has a complete marketing plan that outlines its different services, especially its laparoscopic surgery

and Urology Center of Excellence. She noted once the expansion was completed, more emphasis would be placed on marketing JSHC.

Mr. Shaw added that access to JSHC had been hampered and its parking limited by the construction of the new ER. Since the opening of the new ER, he has seen an increase in census in the last 30 days.

Comment: Chairman Moss noted this was a concern for him because he had not heard the same level of promotion for JSHC in the media as he had heard for Jackson North.

Dr. Roldan noted JSHC's occupancy rate had been in the low 70-percentile, but recently had increased to the low to mid 80-percentile, which was a positive move.

Chairman Moss noted he was glad to hear that JSHC was moving in a positive direction, since there was a proposal to close this hospital.

Question: Referring to page 17 of Dr. Roldan's report, future goals for aged Accounts Receivables, Chairman Moss asked what plan had management devised to collect aging accounts receivables in the future, and what was the prospect of this effort.

Answer: Mr. Shaw: Management invested most of its efforts improving the Revenue Cycle processes from front end to back end, and closing the FY2010 budget gap. Management also plans to work much harder at monitoring more closely the Accounts Receivables (ARs) to prevent them from aging. He noted a large volume of ARs were not monitored appropriately in the past, and were now being analyzed. As ARs begin to age, it becomes less efficient for hospital staff do this task; thus, the aged ARs are outsourced to collecting agencies. Management is in the process of finalizing negotiations and completing new contracts for third party collection agencies. Approximately $86 million in additional revenues would be realized through FY2011 proposed initiatives by improving the front end processes of the Revenue cycle through improved billing, utilization of new technology, and a centralized registration that ensures demographic information is captured more accurately, available insurance coverage is validated, patients are qualified financially, and co-payments are adjusted to be consistent with the FQHCs. Management has improved the back end processes of the revenue cycle for follow-up to ensure a better clean claims rate and everything is done internally before turning an AR over to a collection agency. Additionally, the collection agencies would be managed in a competitive environment to ensure they follow up on the AR accounts.

Dr. Roldan added that management was also trying to improve the front end of the revenue cycle at JMH clinics, where many patients ultimately end up being admitted to JMH main as in-patients. She noted the intent was to process patients and to convert those that qualify for Medicaid quickly at the clinical level before the patient reaches the hospital. Much of the aged accounts receivables consist of patients that were initially classified as self-paid, but were potential Medicaid qualifying patients, and the conversion takes 4 to 6 months to process. Also, management implemented an interim billing process to bill long stay patients in the interim rather than after the patient is discharged, which has been helpful in reducing the aged accounts receivables and increasing collections.

Question: Referring to page 19 of Dr. Roldan's report, what is JMH's cost to provide healthcare services to inmates incarcerated in correctional facilities?

Answer: Dr. Roldan: The total cost for correctional health care was $74 million, of which includes over $40 million for inpatient care and $25 million for outpatient care. Inpatient care costs are included in JMH's total operating costs.

Question: Does Broward County pay for inmate in-patient care costs, or only outpatient care in the correctional facilities?

Answer: Dr. Roldan: She was unaware of Broward County's cost for inmate services, but Jackson Health Services (JHS) provides both inpatient care and outpatient care services at different correctional sites.

Mr. Shaw clarified that Dr. Roldan's reference to outpatient services was services provided by JMH in clinics within a correctional facility. He noted in many cases, inmates are admitted into JMH for various procedures, which are classified as inpatient services, which are not included in the Department of Corrections (DOC) budget, but are included in JMH's budget.

Question: Did the County transferring the cost of correctional healthcare services to JSH include both inpatient and outpatient services? How was inpatient care services handled prior to the County moving the cost of outpatient care services under the auspices of the PHT?

Answer: Dr. Roldan: When she was training as a resident at JMH in the 80's, JMH still used Ward D for inpatient care services. JMH had always provided inpatient care services to inmates, as well as outpatient healthcare services at various correctional sites.

Comment: Commissioner Jordan noted she was confused about the explanation given for inpatient care services versus outpatient care services, and whether inmates were being cared for at clinics outside the jail system.

Response: Dr. Roldan: Inpatient care services is care provided to an inmate admitted into the hospital, in a hospital bed at JMH, and outpatient care services is care provided to an inmate at a clinic or site within a correctional facility or jail.

Chairman Moss clarified the analogy "clinic" given by Dr. Roldan meant healthcare services provided to inmates at a clinic within a correctional facility or jail, and JMH was responsible for that cost.

Dr. Roldan concurred.

Question: Chairman Moss asked the name of the Budget Director at the time the County transferred funding to the PHT for providing healthcare services inside the jails, and had JMH always been responsible for inpatient care services to inmates in the hospital as a routine cost of the hospital.

Answer: County Manager Burgess: Inpatient care services had always been a cost of JMH. His recollection was that either Steve Shriver or Dr. Morris was the Budget Director and was present with him at a BCC meeting when a commissioner motioned to have approximately $12 million funds transferred to the PHT for correctional healthcare services of inmates within the jails and Ward D, but inpatient care services that occur in the hospital had always been a cost of the hospital.

Question: Who was the County Manager at that time?

Answer: Manager Burgess: He believed Mr. Armando Vidal was the County Manager at that time.

Question: Regarding the current contract and the Cone of Silence, how much discussion could this Board have regarding the RFP process?

Answer: Assistant County Attorney Valda Clark-Christian noted the Board could discuss the RFP process at a public meeting.

Question: Does the RFP cover inpatient care services that occur in both the hospital and in the correctional facilities.

Answer: Ms. Melida Akiti, Vice-President and Chief Administrative Office of Jackson Mental Health, Ambulatory Services and Corrections Health Services, noted the RFP covers both inpatient and outpatient care services.

Question: Will care providers be in both the hospital and inside the jails to provide care to inmates.

Answer: Ms. Akiti: The process is that a sick inmate would be transported to a sick hall or clinic within a jail facility for assessment and treatment. Those inmates that cannot be treated within a jail facility/clinic would be transferred to Ward D; however, inmates that cannot be treated at Ward D, would be transferred further to the Intensive Care Unit (ICU) at JMH. She noted each of these services has a separate cost, and all three costs are covered by the RFP.

Question: Would the company awarded the contract under the RFP be responsible for all three costs, including taking care of inmates in Ward D and the ICU.

Answer: Ms. Akiti noted the company awarded the contract could decide to contract with JMH to provide ICU beds.

Dr. Roldan clarified that several hospitals countywide provide correctional healthcare services to inmates. The company awarded the contract could decide to either bring the patient to JMH or take the patient to another hospital.

Question: Are there contracts with a number of hospitals countywide that specifically provide healthcare services to inmates.

Answer: Ms. Akiti: Yes. This information was presented publicly in the oral presentation of the RFP, and both vendors proffered the possibility of working with two other hospitals to set up a system similar to Ward D and to contract with other hospitals. They also presented a list of hospitals that could provide security and safety while caring for inmates outside the jail system.

Question: Chairman Moss asked Ms. Akita if she was aware of any hospitals in Miami-Dade County that currently provide these services.

Answer: Ms. Akiti: Yes, Larkin Hospital, Kendall Regional and Palmetto General Hospital currently provide these services.

Dr. Roldan added that the RFP covers the total $75 million cost for correctional health care services.

Comments: Chairman Moss noted concerns were previously raised regarding the County shifting some costs to the PHT for inmate care services, but the cost was actually $25 million, not $75 million; and prior to transferring this cost, the County was only responsible for inpatient care costs of $25 million. Chairman Moss pointed out that although other hospital districts such as Broward County pay the total cost of inmate healthcare services, they do not receive funding from their county government to support their health care system; however, Miami-Dade County provides Jackson Health Systems with a $150 million Maintenance of Effort (MOE) payment. He said he wanted to make this distinction clear, should concerns be raised in the future regarding costs shifted to the PHT; that the costs were $25 million rather than $75 million; and to dispel the theory that the MOE funds provided by the County were being eaten up by the costs the County asked the PHT to assume, since the County provides JHS with (MOE) resources to cover those costs.

COMMISSIONER GIMENEZ

Question: Regarding page 1 of the spread sheet, line-item FY 2010 Total Budget, Commissioner Gimenez asked if the $6 million under Total Income or Loss was the budget amount submitted last year.

Answer: Mr. Shaw: Correct.

Question: Is the current Total Operating Loss $125 million.

Answer: Dr. Roldan: That is the total before initiatives.

Question: Is the current Total Operating Loss $76 million after initiatives.

Answer: Dr. Roldan: That is the proposed total.

Question: Under details for FY 2011, is the current Total Operating Loss $232 million.

Answer: Dr. Roldan: Before initiatives.

Question: Is FY 2011's Total Operating Loss $11 million, after $192 and $28 million in initiatives.

Answer: Dr. Roldan: That is the proposed total, after initiatives.

Question: Referring to the details listed on page 2 of the Spreadsheet reflecting the average annual salary and average hourly rate, he asked if this years' average hourly rate was budgeted at $30.92, but proposed at $31.24 before concessions.

Answer: Ms. Roldan: Correct.

Comment: Mr. Shaw clarified the budgeted amount was $30.93.

Question: Regarding the average hourly rate of $31.64 reflected in the detail section of this years' budget , Commissioner Gimenez asked if that rate would come down to $30.95, and did this include the services of PricewaterhouseCoopers (PwC).

Answer: Mr. Shaw: PwC was assisting the PHT and JMH in a joint initiative, and PwC was not working alone.

Question: Which initiatives would bring the proposed average hourly rate of $31.64 down to $30.95?

Answer: Mr. Shaw: one initiative was to improve staffing and bring all hospital departments down to a 25-percentile by the end of FY 2011. Some departments were higher than 50-percent. Another initiative was to better manage labor by reducing utilization of overtime and agencies to a 3-percent level. He noted both initiatives would help bring the costs down.

Question: How realistic were these projections.

Answer: Mr. Shaw: It would not be easy, and JMH would need to meet all proposed levels in order to be a high performance hospital. The nursing units at JMH main were already at the 25-percentile level, and JSHC was within 1 full-time equivalent (FTE) of the 25-percentile, but other areas need work.

Question: Regarding the concerns raised by Chairman Moss regarding the cost differences between JSHC and Jackson North, and the reply given that some of Jackson North's services were outsourced, Commissioner Gimenez asked if outsourcing services was considered to be a 'best practice' and if so, why was it not being done at JSHC.

Answer: Mr. Shaw: He believed that outsourcing was cost effective and a best practice as long as the quality of service was the same. Management was currently exploring whether to outsource services at JSHC in conjunction with the RFPs currently being done.

Question: What is 'Health Plan Revenue' and was it the amount charged to employees enrolled in JMH's Health Plan?

Answer: Mr. Shaw: Health Plan Revenue is the premium charged to members enrolled in JMH's Health Plan.

Question: Referring to the spreadsheet, which reflected a sharp rise and decline in the amounts budgeted for FY's 2007-2010, why was the actual amount budgeted in FY 2011 $288 after $73 million of initiatives.

Answer: Mr. Shaw: Medicare and Exclusive Primary Organization (EPO) were two new products added to JMH's Healthcare Plan; JMH's run rate was approximately $215 million, based on its performance in the first eight months of this year; and FY 2011's initiative to bring all employees into JMH's Healthcare Plan as a single option would help increase gross revenues. He also noted that fixed costs were associated with increased revenues, but spreading the fixed costs over a larger base of people would result in an overall $15 million revenue improvement from year to year.

Comment: Dr. Roldan added that the spreadsheet narrative lists the additional initiatives that would help increase revenues, including a physician network-management service organization (MSO).

Question: How much would JMH's Cash on Hand and Days of Cash on Hand be on October 1, 2010 and by the end of FY 2010/11.

Answer: Mr. Shaw: His estimate of Cash on Hand on October 1, 2010 was $75 million, and the equivalent days to be about 16 days, provided JMH received State funding; Cash on Hand was estimated to be about $72 million by year end of FY2010/11.

Question: Referencing a newspaper article on JMH that states anything less than 20 days Cash on Hand was considered a state of emergency; Commissioner Gimenez asked why JMH was not currently in a state of emergency if it would begin the fiscal year with only 16 days of Cash on Hand and end with less.

Answer: Mr. Shaw: He has stated publicly that JMH was in a critical state of emergency. The proposed budget was not a sustainable budget, but a survival budget that would carry JMH from one year to the next, and JMH would need to meet all projections in order to survive.

Comment: Dr. Roldan added that management submitted a survival budget, not a sustainable budget, and management needed to be diligent in implementing all the initiatives in order to obtain $192 million in State funding. She noted management's major focus was on efficiencies in the Revenue Cycle and implementing better mechanisms for tracking and improving efficiencies in patient throughput. Management has worked on efficiencies for quite some time, but because there are concerns regarding increased charity care and unfunded patients and more options for the self-paid patients under new Healthcare Reform, management needs to focus more on customer service, and on customer, employee and physician satisfaction and loyalty.

Question: Why is management so concerned with Healthcare Reform if JMH had millions of dollars in uncompensated care that would be compensated for under new Healthcare Reform?

Answer: Dr. Roldan: Across Jackson Health System, the payer mix was about 6% Commercial, 29% Managed Care, 17% Medicaid, 15% Medicare, 1% Government, and 33% Self-Paid, of which 75-80% gets converted to Medicaid. A proposal under new Healthcare Reform was to phase out the Disproportionate Share Hospital (DSH) program, which JMH relied on to cover the cost of uninsured patients and the shortfall in Medicaid coverage. Once new Healthcare Reform is fully implemented, about 94% of the uninsured population will be covered under a Medicaid-like insurance The concern was that JMH would be losing $67 million in DSH funds to cover the uninsured and has no information on how the undocumented patients will be addressed under new Healthcare Reform; and since JMH is a safety-net hospital, those patients remaining unfunded and the undocumented patients (about 17% of unfunded care is undocumented) will still come to JMH. Plus, the uninsured patients covered under reform will have the option to go elsewhere, which is a concern. She noted that JMH's cost structure needs to shift from inpatient to outpatient services, which costs less.

Question: Had management estimated a dollar amount that was relevant to the impacts of new Healthcare Reform.

Answer: Dr. Roldan: Management ran several models of the impacts of new Healthcare Reform on JMH's payer mix, and she or Mr. Shaw could share those results with the Commissioners.

Request: Commissioner Gimenez asked that this information be shared with the Commissioners.

Mr. Shaw noted he did not bring that information with him, but could provide it later.

Question: Commissioner Gimenez asked if JMH would be in the red or black, based on the models ran and the resulting figures.

Answer: Mr. Shaw: To the extent that JMH gets funded, any payment would be better than none; however, historically, when a major change was made to Medicaid, and people were given the choice, they usually did not return to a safety net hospital. JMH was now seeing a drop in the volume of Medicaid patients since implementing new successful programs for qualifying patients for Medicaid. He urged the Commission, when setting its legislative agenda, to pursue the State's at-risk or managed care program, which guaranteed safety net hospitals the same members they had before. He noted, currently, patients were being picked-up by 19 different Medicaid programs under managed care, once they are qualified for Medicaid.

Question: If the purpose of Healthcare Reform was to give people more choices and management continues to say that Medicaid is an underfunded insurance, why would management want to keep those patients that cost JMH more?

Answer: Mr. Shaw: Because JMH gets no funding today.

Question: What percentage of the cost is covered by Medicaid?

Answer: Dr. Roldan: Currently, JMH receives $67 million in DSH funding. If this program is phased out under new Healthcare Reform and those dollars shift to insure the uninsured

population, JMH would no longer be able to rely on this fund to cover the costs of unfunded care, including undocumented patients, and cover the gap created by Medicaid for not paying the full cost to treat those patients.

Question: How much would JMH really lose by losing Medicaid patients under new Healthcare reform, if these patients now cost JMH more.

Answer: Dr. Roldan: One initiative in FY 2011 is to develop a Primary Care (PC) Physician Network to improve customer loyalty and capture individuals at the front end of the revenue cycle more efficiently. Another initiative is through JMH's Health Plan. As JMH gains more control at the front end and increases its MSO-physician network, individuals converted to Medicaid can be brought into the managed care plan. Medicaid reform by managed care would be discussed in the next legislative session, and JMH Health plan is a Medicaid HMO plan. She noted initiatives were built into FY 2011's budget to address Healthcare Reform as it becomes fully implemented.

Question: Would these initiatives help decrease the percentage of people that go to the Emergency Room (ER) that really do not need emergency care?

Answer: Dr. Roldan: Correct, and why the PC Physician Network needs to be developed soon.

Comment: Commissioner Gimenez pointed out that sometimes first responders transport people to the ER to avoid a liability; however, those costs could be reduced if a mechanism was in place that would allow first responders to transport patients to another location.

Question: What was Plan B should the assumptions built into this survival budget fail?

Answer: Mr. Shaw: If JMH failed to meet all of its proposed targets, management would then need to take more aggressive action by reducing services, capital and staff; or management could institute some furloughs. Management prepared a budget that tried to maintain all of the safety net services, and may need to narrow some of those services

Question: Does Plan B have a list of items that would trigger it if some of the proposed initiatives in FY 2010/11 budget failed?

Answer: Mr. Shaw: Yes, there is a list of items.

Answer: Ms. Roldan: Absolutely, management has worked on a Gantt chart, an implementation plan and a timeline for measuring progress.

Question: What was Plan C to get JMH back to fiscal solvency and increase its Cash on Hand to an appropriate level to improve its bond ratings?

Answer: Mr. Shaw: Management would need to focus on growth initiatives; bring more services and profitable businesses to JMH's facility; explore the ½ penny sales surtax to help narrow the deficit in funding JMH's mission; and market JMH's salaries and benefits cost more

competitively, which was 60% of JMH's total costs. The only way to grow Cash on Hand to 100 days is to grow business.

Commissioner Gimenez asked Dr. Roldan to provide him with a copy of Plan B and Plan C.

COMMISSIONER HEYMAN

Comment: Commissioner Heyman noted she would remain focused on the proposed "survival" budget, reduced costs and the new initiatives for improving efficiencies, and looked forward to seeing a sustainable budget in the future.

Question: Referring to page 2 of the Spreadsheet, Commissioner Heyman asked what changes were made to JMH's billing practices in order to improve collections.

Answer: Mr. Shaw: The detail section on page 33 of the budget presentation reflects new initiatives for efficiencies in the Revenue Cycle, which are: 1) Patient Access-a centralized registration process to capture demographics and bill/collect more accurately, validate patient insurance coverage with improved technologies, and position better for collections upfront; and is estimated to bring in $31.3 million of additional revenues over the next 12 months; 2) The Chamberlin, Edmonds & Associates Inc (CEA) program- to qualify more patients for Medicaid while training JMH staff in 2010 of these procedures; 3) Health Information Management (HIM)-an initiative that deals with proper coding, level of care decisions and how those items are billed/collected, and is estimated to generate at least $3.1 million in additional revenues; and 4) The Pricing and Charge Master-an initiative to ensure items are priced and captured appropriately, and is estimated to generate about $10 million in revenues, which is a conservative number.

Question: Is there a check and balance to ensure items get paid, inventoried and coded properly, since these issues were raised by management before the Grand Jury. And, were the projected revenues from some of these initiatives just hypothetical or based on a percentage change?

Answer: Mr. Shaw: There are detailed work plans and targets for each of these initiatives with more details than what is listed in this report.

Question: Would it be accurate to assume that the base line in the Cash plan included some of the new initiatives proposed in FY 2010/11?

Answer: Mr. Shaw: The Initiatives built into the base line of the Cash Plan, which management and the Ad Hoc Committee worked on for several weeks, were realized in FY 2010, and included cash acceleration, cash collections, and reviews of the ARs over a 90 day period, etc.... and any impact of them to FY 2011 was built into the base line. Those initiatives were not part of the initiatives proposed for FY 2011/12, which were additional initiatives. The three larger initiatives (capturing demographic information more accurately, creating better opportunities to bill/collect upfront, and qualifying more patients for Medicaid or other coverages) dealt with improvements to the front end of the Revenue Cycle.

Comment: Dr. Roldan added that one initiative implemented in the Revenue Cycle Department, which had been ongoing for the past few months, was training staff of these processes and administering pre/post tests to ensure sustainable processes and the best practices were repeated.

Question: As it relates to collections, is the IBI settlement measured in this spreadsheet?

Answer: Mr. Shaw: The settlement with IBI will have an impact on collections through December of 2010, and is built into the baseline numbers. Management has implemented initiatives to improve the collection methods, and has done a better job at training supervisors and increased the knowledge base from 20% to 80%.

Question: Would that include making an initial effort to collect after a billing statement was sent out, and could the philosophical position that 'uninsured patients have no means to pay' be changed to explore the ability and means by which an uninsured patient could pay?

Answer: Mr. Shaw: Management was doing everything possible to improve collections, and one initiative was to ensure that a financial assessment of a patient included examining the patients' assets, not just their income.

Question: Were any of the (baseline and projected) initiatives calculated as being favorable for recovery, increasing reserves and Cash on Hand, and improving the bond ratings.

Answer: Mr. Shaw: JMH would need to achieve every initiative's targeted level to realize the additional $73 million revenues proposed through these initiatives.

Question: Was part of the $10 million contract with PwC for marketing?

Answer: Dr. Roldan: The PwC contract did not include marketing, but PwC was working with management to improve both internal and external communications. Internal communication was how to disseminate information among the employees so they feel engaged in this process. External communication was how to produce positive communication to the outside and other stakeholders. These efforts are not generally included in a marketing contract.

Question: Was something being done to market the unique services at JMH, such as the Trauma Center and physician skills, and to market the services provided at JSHC.

Dr. Roldan nodded her head in the affirmative.

Comment: Commissioner Heyman noted another area of gross neglect and waste, especially at JMH main, was empty bays, empty retail spaces with old market values, and no RFPs/RFQs for capital improvements or leased space to capture a market that included staff, patients and visitors. JMH is a 24/7 facility, but operates only one restaurant.

Response: Dr. Roldan: Mr. Charles Parkinson (the County's Budget Coordinator, Office of Strategic Business) was working with management to gather all the leases and develop a master plan, and management would soon be able to provide the Commission with a full report.

Question: Is there a projection of what the leased space was worth, how much was available and would any proposed initiatives for capital improvements be implemented in FY 2010/11?

Answer: Mr. Shaw: There are plans to improve all real estate and retail operations, but additional revenues were not built into the FY 2010-11 Budget from improved retail operations, other than outsourcing the outpatient pharmacy.

Comment: Commissioner Heyman noted she had great concern regarding the correctional health services, and the inpatient/outpatient ratio (40/20). She noted she was seeing the billing and collections on inmate care to be 100% based on a Florida Statute formula passed two years ago.

Question: How were the clinics or sick halls at various correctional sites/facilities staffed?

Answer: Dr. Roldan: Those sites are staffed by JMH employees, nurses and physicians.

Question: Are JMH physicians on call to make specific visits and do assessments at those sites?

Answer: Dr. Roldan: The JMH physicians at those sites are in-house physicians.

Comments: Commissioner Heyman noted other state/county correctional facilities were no longer transporting inmates to major medical facilities, except in an emergency and those inmates are treated in a contained environment or facility similar to the County's Ward D. Her concerns were the costs of transporting inmates not being captured under the Medicaid rates, and inmates were being sent to various places in the hospital as if on a fieldtrip. Another concern was sending some of these patients to other hospitals or outside vendors rather than redirecting them to JMH and keeping the monies in-house, based on the State's 100% collection formula. She expressed concern with JMH trying to bill/collect for services that were uncollectible.

Response: Ms. Akiti noted this information was discussed during the oral presentations of the RFP; therefore, not prohibited for discussion under the Cone of Silence. She noted the goal was utilization and to work in partnership with the Department of Corrections (DOC) to transform some areas inside the jail into a housing clinic where the vendor could provide more services/treatment. She noted JMH management had already considered this initiative, but delayed it because they knew it would be discussed with the vendors. Regarding the concern of inmates transported to facilities outside of the DOC, Ms. Akiti noted management was working with the vendors to ensure in their best and final offers that the monies stay within the JHS.

Question: Commissioner Heyman asked if JMH had reduced its contribution to the Jackson Memorial Foundation (Foundation) from $9 million to $7.2 million.

Answer: Dr. Roldan: Yes, to $7.2 million.

Question: Commissioner Heyman asked if the PHT had reviewed and compared line-items to determine the best return, and if the amount of international patients drawn to JMH by the Foundation was real and collectible. She also asked if the PHT had the ability to ask these questions and require accountability of the Foundation, or just the Commission.

Answer: Dr. Roldan: The PHT has the right to make requests, ask questions and audit the Foundation regarding line-items. She noted the patient revenues that were documented and reported were in the line-item entitled "International Patients."

Comment: Commissioner Heyman noted she was interested in knowing the return on JMH's $7.2 million contribution to the Foundation, and whether the number of international patients drawn to JMH by the Foundation was a real number.

Response: Dr. Roldan: It would be important to elaborate on the marketing efforts being done in the international countries. She advised that management would soon be able to provide the Commission with information on whether the international patients were coming to JMH on their own or being driven there by the marketing efforts.

Questions: Referring to page 2 of the spreadsheet regarding JMH Health Plan Revenues, Commissioner Heyman asked what steps had management taken to improve JMH's Health Plan and keep it in-house. Does JMH have the ability to reduce the co-payments as an incentive to draw its employees or others to its health plan, or does this need to be a legislative change? Is this an initiative proposed in FY 2011/12 budget, and what kind of return would JMH get by contracting out to AvMed, Blue Cross/Blue Shield or other insurance companies?

Answer: Dr. Roldan: Management was working on several incentives such as reduced co-payments or prescriptions to increase the membership base, which were included as initiatives in the proposed budget.

Question: Will these incentives be extended beyond the 11,000 plus JMH employees and their dependents to the other 30,000 plus County employees and their dependents.

Answer: Dr. Roldan: JMH management would need to bring back the attrition rate of its own employees first; then, provide employees a level of comfort that JMH has the ability and infrastructure to sustain its membership base, before extending membership to its neighbors. She noted JMH would be able to extend membership enrollment in year two, but would first try with its own employees in year one.

Question: Referring to the Annual Operating Agreement (AOA) with UM, on page 2, Commissioner Heyman expressed concern with the continual increase in the cost of JMH's relationship to UM while the revenues, patient loyalty and referrals by UM doctors to JMH decreased. She asked what had been done to protect JMH's partnership with UM and what was JMH's return?

Answer: The AOA is defined as five payments made to UM for: 1) providing charity care to the unfunded; 2) teaching medical students in residency at JMH-this payment is based on a formula and part of JMH's academic mission; 3) maintaining programs at the clerical level; 4) purchase services and programmatic services that have been paid by JMH for many years; and 5) some pass-through transfer agreements, such as grants. Regarding job descriptions of the UM faculty, she assigned JMH's new Chief Medical Officer to meet with UM staff to delineate job

descriptions. JMH is prohibited from delineating the number of patients or volume, but can delineate job descriptions that UM should be delivering.

Question: Commissioner Heyman said she tends to agree with her colleague regarding JMH being in a state of emergency, based on the low number of days of Cash on Hand. She asked if some of the existing contractual agreements with JMH's partners could be reassessed to determine their economic reality. She noted it seemed that JMH was the losing partner.

Answer: Dr. Roldan: UM is a real partner to JMH and has deferred some of JMH payments during its restructuring, which helped JMH's cash flow. She also noted that JMH renegotiates the AOA annually, and UM understood JMH's fiscal realties and challenges, and was willing to work with and help JMH.

Question: Is the projected $77 million loss for FY 2010 a realistic number.

Answer: Mr. Shaw: JMH's current loss is $90 million, and may not get any better before the end of the fiscal year, even if JMH was successful at holding the line.

Question: What was being done at the federal level to address compensation for the undocumented patients?

Answer: Dr. Roldan: Early this year, she testified before Congress about this issue in MDC, and could only continue with the lobbying efforts. She will be traveling to D.C. next week to visit with the County's delegation about this issue, which is at the forefront, and she had been very vocal about it at the federal level. In addition, she was chosen by the American Hospital Association as a panel member to discuss Healthcare Reform, specifically undocumented care, and the panel would be meeting tomorrow and joined by representatives from several states.

Comments: Commissioner Heyman noted much of the information shared today was requested by the members of the Commission and shared at the committee level. She felt comfortable that the changes made over the last year were significant and positive, though some initiatives are still in the planning stages. She felt it was important to have everyone's concerns noted on the record, and the Commission be provided with periodical updates on the implementation of these initiatives. She felt the services at JMH are unparalleled, but most important, the JMH facilities and services should be marketed. She said she had hoped to be provided with information on the progress of these efforts, but obviously progress had been made.

Comment: Dr. Roldan echoed Chairman Moss' words regarding the need to look at JMH positively. She noted although faced with many challenges, JMH was a great institution that had done a lot of good over the past 92 years.

CHAIRMAN MOSS

Question: Chairman Moss asked if the PHT had ever audited the International Contract.

Answer: Dr. Roldan: The PHT received an audit of the International Contract from the Foundation, and one of the initiatives was to have the PHT question more and audit the Contract themselves.

Comment: Chairman Moss noted his concern was the Foundation claiming credit for international patients driven to JMH by its efforts, yet no one had audited the International Contracts to see if patients were coming to JMH through the Foundation or by other marketing efforts.

Response: Mr. Shaw: Management has improved the process for identifying the sources and followed up to see whether the contracts with the cruise ships, international insurances or others were negotiated by the Foundation. He noted the growth of the program over the past five years was proof that the Foundation had been successful in its efforts; however, he concurred that the PHT should not be precluded from asking tougher questions.

Question: Does the Foundation provide a budget that delineates line items for the salary structure, those who get paid, how much, and their responsibilities?

Answer: Mr. Shaw: The last budget presented to the PHT by the Foundation was in September 2009, and they proposed another budget for next year.

Question: Prior to that time, did the Foundation have a line-item budget that delineated this information.

Answer: Mr. Shaw: Unfortunately, he was not at JMH at that time, and could not answer this question.

COMMISSIONER SOUTO

Comments: Commissioner Souto said he felt today's discussion was very healthy for informing the community of JMH's issues. He noted JMH was a very important asset and a jewel of this community. He noted its history as follows: JMH was created in 1899; entered into an agreement with UM's medical school in 1952; operated as a department of the (Metro-Dade) County from 1956 to 1973; and its administration was taken over by the PHT in 1973 when the PHT was created. He pointed out that the Commission was charged to provide the citizens a public health care system pursuant to the Charter, but lost some of that supervision when the PHT was created. Commissioner Souto noted, since 1984, he was a participant of the Legislature, both House and Senate, and has dealt with many issues involving JMH. He noted that getting the ½ penny surtax passed to sustain JMH was not easy. He also noted he and other senators were patients at JMH and that several senators/congressmen kept JMH afloat by bringing it much money. JMH had always managed to survive, but now it faces more difficult problems. He said he felt it was very important for the survival of JMH that the Commission be fully engaged in this process, and to continue to closely supervise the PHT. Commissioner Souto urged Chairman Moss to continue this exercise of dialogue periodically, and to ensure that JMH and its mission never failed. He encouraged his colleagues to be involved with JMH, and take their charge by the Charter very seriously.

Chairman Moss agreed with the comments of Commissioner Souto, noting the Commission needed to pay closer attention to the PHT. He also noted, since he was sworn-in as a County Commissioner in 1993, the Commission has not had much significant discussion regarding JMH/PHT budgets, other than some services shifted from the County to the PHT, but largely relied on the PHT's recommendations for approving those budgets. He noted his reason for saying this was because the Commission was accused of micro-managing the PHT, which was not true. He noted the review and scrutiny by the Commission today were due to the concerns raised and wanting to ensure JMH was moving in the right direction. Chairman Moss asked the County Manager which year did the County transfer services to the PHT.

County Manager Burgess corrected the record regarding previous statements he made of who the County Manager was at that time. He noted the budget hearing was in 1999, not 1997, when the County transferred medical services to the PHT; and Merrett Steirheim was the County Manager, David Morris was the Budget Director and Alex Penelas was the County Mayor.

COMMISSIONER ROLLE

Question: Commissioner Rolle noted he was aware that Mr. Lapciuc was conducting an in-depth study on JMH's Revenue Cycle (Accounts Receivables and Billing) Department. He asked that he be provided with an update on the issues and the initiatives involving this department.

Answer: Mr. Shaw: JMH management expended an enormous effort in the last 9 months re-training staff members in the Revenue Cycle Department on the use of systems, to understand the organizational structure and do their jobs appropriately. Management also worked to reorganize the new patient access function, implemented new technologies to acquire better information, etc...which resulted in a $60 million gain to JMH since March 1, 2010 to help reduce its deficit. Plans are in place to finalize the centralized registration next year; as well as improve coding and planning, how to integrate those functions, and how to bill and collect payments. The intent is to impact next year's budget by the same store basis of $86 million, which does not include the impact of growth initiatives. Management continues to focus on collecting every dollar, adjusting the amount of dollars collected upfront by adjusting the co-payments and deductibles to be consistent with the federally qualified health centers (FQHCs) requirements; and to make more of an effort to request and collect those dollars.

Question: Commissioner Rolle: So, it is not business as usual anymore, in terms of billing and accounts receivable?

Answer: Mr. Shaw: It is definitely not the same as it was.

Question: Referring to the memorandum dated September 3, 2010, page 27, that states "plans are underway to convert primary care locations to FQHCs, resulting in $6 million in revenue enhancement," Commissioner Rolle asked how management planned to fill the void in the intercity (Liberty City), since closing down the Liberty City Health Clinic, the Juanita Mann Center in Northside, and the clinic in North Miami?

Answer: Dr. Roldan: The reason for JMH shifting to FQHCs was to increase reimbursement, to enable it to connect with its federally qualified partners, to draw down more funds from the Federal Government under new Healthcare reform because more funds would be allocated to FQHC's under new Healthcare reform, and to federally qualify teaching centers (JMH is an academic system) as an incentive. In order to become a FQHC, JMH needs the support of all its neighboring FQHCs. She proposed to other FQHCs in the community that they evaluate the delivery of primary health care services in the County and determine where the needs are unmet so that we can collaborate to provide services in those areas. This is a work in progress.

Question: How can clinics in the inner city, which were already closed, be converted to FQHCs?

Answer: Dr. Roldan: Once a clinic becomes "federally qualified" it is under a healthcare network, but in order to open a "federally qualified" clinic in Liberty City, we need the collaboration of all FQHCs in the community. We have conducted a community needs assessment to determine the voids in the County, and once the voids are determined, we can open new clinics in the inner city that are "federally qualified."

Ms. Akiti added that management has worked with the executive directors and staff of the Department of Health, the OCHI (phonetic), and the FQHC Health Choice Network to develop a comprehensive review of the health care needs in the County. We looked at hotspots and disproportionate healthcare countywide. Our other partners have funding and opportunities to open new clinics, and we think a medical health care facility will be developed in Liberty City.

Question: What department have you collaborated with regarding the areas served by the three clinics- Liberty City Health Clinic, Juanita Mann Center in Northside, and the clinic in North Miami?

Response: Ms. Akiti: The strategy was to ensure that all FQHCs were able to work together and expand their services. We will be working with the network in addition to the four primary health centers. Our goal is to ensure that all County residents receive health care.

Comments: Commissioner Rolle noted he never liked that the three centers in the intercity were closed without the Commissioners knowing management's plans. He was concerned that the residents of Liberty City and North Dade would lack good access to health care services while plans were being implemented for converting clinics to FQHCs. He was further concerned that the Liberty City Clinic, which was located across from Liberty Square and probably the busiest, low-income project in the County, was closed before being modernized to a certain degree. Referencing page 27 of the report, it seemed to him that an array of services was being offered at Jackson South that was not being offered at Jackson North.

Response: Dr. Roldan: The specialties at community hospitals are determined by the physicians that bring those services to the hospitals. Management was looking at the available services to determine what needs to be enhanced at Jackson North and South, and working on a strategy to bring in more doctors specializing in those areas. Community hospitals are physician driven, and not like Jackson Main, which is an academic center where all specialties are practiced.

Comment: Commissioner Rolle noted although he was supportive of JMH and believed in its mission, he was disappointed in the way the poor had been treated, particularly those in Commission Districts 2 and 3, where services were terminated, especially where a center was closed that was located across from one of the most impoverished locations in the County. He said he would try to support JMH, but was not convinced that the current Administration had developed specific plans to fill the voids existing in the intercity, particularly Liberty City.

Response: Ms. Akiti: Management was working in collaboration with the representatives of the Jessie Trice Community Health Center, which is part of that area, to enhance services with specialty care.

Comment: Commissioner Rolle: The collaboration you are referencing is not helping the people in Commission District 2.

Response: Ms. Akiti: This is an opportunity for management to reassess what they were doing, and if more services are needed, we will include them.

Comment: Chairman Moss: His impression was the effort to convert centers to FQHC was wavering. He suggested a specific plan be developed for that area to seriously address the actual needs, not just the Liberty Square housing project, but the concentrated poverty in the area; and to engage the District Commissioners of those areas in the process. He noted he has voiced the same concerns before, regarding this area.

Comment: Commissioner Rolle: He was concern that the reports he had received from the administration/professionals did not align with the comments he was hearing in the streets of District 2. Because Jackson North lacked services, many people in the community still felt that Jackson North would soon be closed again, which he hoped was not the case.

Comment: Chairman Moss: Based on the feedback from the community and what he had heard on the radio, he perceived that Jackson North was fine and that Jackson South was in trouble. He had heard much positive feedback regarding the people's experiences at Jackson North, but had not heard the same about Jackson South.

Response: Mr. Abraham Galbut, PHT Board member and Chairman of the Ad Hoc Sustainability Committee for Jackson North noted the Ad Hoc Committee meets monthly and has worked diligently with JMH union partners, Administration and physicians to create the best medical system at Jackson North. Jackson North has the infrastructure and the ability to deliver services, but needs to build a better system by recruiting more physicians and patients. We have a $4.2 million capital budget to improve Jackson's physical structure. Though the process has been slow, Jackson North is operating in the black, which has been the case almost every month, even if the government removed funding for indigent care. We have aggressively pursed public advertisement, and Jackson North is a contributing member to the Jackson Health System.

Comment: Commissioner Jordan: I think that past discussions about closing Jackson North was still lingering in the minds of the public; however, television commercials about Jackson North has help the public to see it as a true hospital, and not a place of last resort.

Comment: Commissioner Rolle: He has attended a number of the Ad Hoc Sustainability Committee meetings, and as the Commissioner of District 2, he has seen some progress, but was not hearing or seeing positive feedback about Jackson North in his community.

COMMISSIONER JORDAN

Question: Commissioner Jordan asked how many safety net hospitals, nationwide, currently operate with 20 days of Cash on Hand.

Answer: Mr. Shaw: He was unsure, but not many and almost all public safety net hospitals are having a difficult time now.

Comments/Question: Commissioner Jordan noted she would like to see which hospitals operating with 20 days Cash on Hand to use as a model. Referring to page 3 of the Presentation entitled Strategic Actions to Attain Sustainability, she noted many other safety net hospitals are challenged the way JMH was, including Broward, which has a special taxing district. Commissioner Jordan noted she would like to see information on the safety net hospitals that were not challenged.

Question: How much is JMH contributing towards the Low Income Pool (LIP)?

Answer: Mr. Shaw: JMH funded $321 million in 2010, and we got back approximately $387 million from the LIP.

Question: Who else contributes monies to the LIP?

Answer: Mr. Shaw: Other safety net hospitals contribute to the LIP, but not nearly as much as JMH (Jackson) does. All contributions are sent to Washington, D.C., where it is matched and then sent to the State and placed into the LIP. The State distributes the LIP monies across the State, based on a formula.

Comment: Dr. Roldan: JMH is the largest contributor.

Question: I understand that the share distributed to other safety net hospitals is disproportionate, based on what Jackson contributes. Have we ever explored distributing the funds in proportionate shares?

Answer: Dr. Roldan: She has discussed the idea of proportionate shares with members of the Safety Net Alliance, and continues to do so.

Question: If Jackson should decide to contribute monies to the LIP in proportion to the amount that it receives from the LIP, how would that affect other safety net hospitals?

Answer: Mr. Shaw: That is a very technical question, and he was not sure he could answer it. The State has always relied on Jackson because it is the largest provider of indigent care. The waiver under which the State of Florida operates is different from waivers of other States,

because those States do not have an LIP. The formula is very complicated and was decided years ago pursuant to State statutes.

Comment: Dr. Roldan noted she could provide the Commission with the formula and the spreadsheets that reflect what other safety net hospitals contribute versus what they receive from the LIP.

Comment: Commissioner Jordan noted she would like that information to come back to this Commission because as JMH continues in its financial crisis, the ability to keep bankrolling that disproportionate share becomes more difficult; and proportionate share should be explored.

Response: Dr. Roldan: A number of those safety net hospitals are concerned, and you are correct.

Question: Regarding the comment that the $67 million disproportionate share used along with LIP funds to pay for the uninsured patients may negatively impact the County's ability to receive the $67 million; Commissioner Jordan asked does that not shift some of the uninsured so that they become able to pay.

Answer: Dr. Roldan: Yes, but the issues are: JMH may no longer receive the LIP funds, the uninsured that will be covered will have the option to go elsewhere, plus, JMH will be responsible for covering the undocumented patients and unfunded care.

Comment/Question: Commissioner Jordan noted we should be able to use advertisement, public relations, community outreach and recruitment of community doctors to address the fact that uninsured patients could go elsewhere. What is the status of recruiting community doctors at Jackson Main and the issues related to the University of Miami?

Answer: Dr. Roldan: JMH has an ongoing joint Task Force with the University of Miami that is developing initiatives and proposals for encouraging community doctors to come to Jackson Main.

Comment/Question: Commissioner Jordan noted she thought the larger impact was JMH's ability to attract patients when the referrals come from the physicians. How much say did JMH representatives have in these proposals, because she understood the Task Force primarily consisted of UM representatives.

Answer: Dr. Roldan: Credentialing was currently done by the UM's faculty, but this will be a joint effort.

Comment/Question: Commissioner Jordan noted she thought this was currently tied to a sovereign immunity, and should not be. When will the revenue cycle be brought back in-house?

Answer: Mr. Shaw: The Revenue Cycle was currently in-house, except the portion pertaining to Medicaid eligibility, which had been outsourced. We are in the third month of that contract; we committed to bring back a report to the Commission after 90 days of the contract being

completed, and have almost reached the end of 90 days. A proposal to bring that portion of the revenue cycle back in-house at the end of the third quarter of next year is reflected in the budget.

Questions: Commissioner Jordan: What was the cost escalation of healthcare services that were shifted to the PHT in 1999? Are the clinics and other healthcare programs/services that were shifted still in existence; what changes were made to them and were these clinics/services included in this budget?

Answer: Dr. Roldan: The clinics that we currently have are included in the budget. As she previously explained, an initiative exists to convert clinics to FQHCs under Jackson Main.

Question: Is the Request for Proposals (RFP) provision that allows applicants to identify other hospitals that provide the same services, based on conditions? Why would we encourage them to take the patients elsewhere? Please clarify.

Answer: Dr. Roldan: She could provide the details about what was discussed in committee. We are not encouraging them to take the patient elsewhere, but giving them the option; however, we want them to continue doing services with JMH.

Ms. Akiti added that each vendor will present their best and final offer; however, management did not want to tie the vendors' hands with regards to services and limit their contracts solely to Jackson. The vendors will have the opportunity to use Ward D, which automatically makes that patient part of Jackson's Health System. The reason why the RFP was written with the option was to give the vendors the opportunity to look at cost effectiveness. As a result, vendors are stating they would like to use Jackson's services.

Comment: Dr. Roldan: When comparing other hospitals and their infrastructures, Ward D is very safe, accessible, and well-liked by the Department of Corrections, and this will encourage the vendors to continue bringing the patients to Jackson.

Question: Commissioner Jordan asked to get more information on the amount JMH pays to UM through the Annual Operating Agreement (AOA), and does UM also pay JMH?

Answer: Mr. Shaw: Yes; the UM pays JMH rent for leasing properties/buildings and office space within JMH facilities. Part of the restructuring was an acceleration of a lease that allowed us to defer some payments.

Questions: Does the UM pay JMH for the use of its operating rooms and other services when training their students? She noted she asked the Commission Auditor to gather information on what type of financial arrangements existed at other teaching hospitals, because it seemed like JMH and UM have a reciprocity relation. She noted he is still gathering that information. She noted she had information regarding the Cook County Health and Hospitals, Advocate Crisis Medical Centers, Northwestern Memorial Hospital and Northwestern University, and it seemed that this University was charged for certain educational items. Do we report any payments we make to the UM and seek credit or reimbursement from the Federal Government?

Answer: Mr. Shaw: Yes. We seek credit for Medicaid and Medicare through the cost reports for costs related to graduate education and indirect medical education, and we get reimbursed for the costs through the cost reports. He pointed out that students are not UM students, but residency students of JMH.

Dr. Roldan added that the residency program is owned by JMH, and through a national matching program, Jackson recruits students in residency from around the nation and other medical schools.

Concern: Chairman Moss: We need to ensure that paying patients are not being directed to other hospitals, while non-paying patients end up at Jackson as a result of the Correctional Health Services RFP, because there will always be the 'cherry picking' factor, and he was concern with JMH not getting some of the pickings.

COMMISSIONER SEIJAS

Question: How many times does Jackson allow an urgent care patient to be seen at JMH before it collects payment from that patient?

Answer: Dr. Roldan: We do not have urgent care centers, but if we did, we would try to triage the patient and direct them to urgent care. One initiative is to have patients directed to a Primary Care Clinic. However, we always collect from urgent care patients that are sent to us.

Question: Other hospitals operate differently. At another hospital where she was an urgent care patient, the hospital collected for the first and the fourth visits, but not the two visits in between, and that cycle was repeated, thereafter. She suggested JMH administration please research this process so that JMH could become more competitive. How many Primary Care centers have been closed in the last three years?

Answer: Dr. Roldan: Two Primary Care Centers have been closed.

Comment: Commissioner Seijas noted those were major centers, and she concurred with Commissioner Rolle's concerns regarding the centers chosen to be closed, served areas that had a lot of needs. She said she felt that experience should have equipped them to find more people because a great need exists. She preferred to call JMH a County hospital rather than a safety net hospital. She commended Dr. Roldan for providing the Commissioners with the reports and timely spreadsheets.

Comment/Question: Commissioner Seijas noted it needed to be known that the people of MDC have transferred $137 million in property tax funding and $163 million in sales taxes to assist JMH with its operating costs, but that did not mean JMH's budget was balanced. She noted the Commission was presented with a PowerPoint presentation saying that Jackson would lose $11.9 million. She asked will Jackson be in the red by $11.9 million even if the proposed initiatives were successful.

Answer: Mr. Shaw: JMH submitted a balanced budget, which is a cash basis budget as opposed to an accrual basis budget. When members of Jackson's staff calculated the $11.9 million, they included approximately $65 million in non-cash expenses (depreciation). When you add this back, Jackson is in a positive cash flow position, except that it will spend all of that on capital, which it needs to do. When that is spent, the budget will be balanced down to zero (0).

Question: Will the County Commission be voting on a balanced budget for Jackson?

Answer: Ms. Glazer-Moon: The PHT and JMH Administration submitted a balanced budget, with revenues equaling expenditures, and it is included as Item F in the Budget Ordinance. It makes the adjustments for a cash basis budget, such as different revenues and cash carryovers to support this year's operations, and differs from what is in the County's Budget Book, which only includes the MOE and Sales Tax revenues. Many things will need to happen for Jackson to adhere to its plan, but their plan is a balanced budget.

Question: So we will be voting on a plan for a balanced budget?

Answer: Ms. Glazer-Moon: Yes.

Comment/Question: Commissioner Seijas noted she was okay with the fact that Jackson's capital for 2011 is more than $117 million; however, she wanted the public to know this information. Referring to Dr. Roldan's comment that $1.1 million will be added to Community Health Center of South Dade Inc. (CHI) by reducing the capital budget, she asked what impact would this have on JMH.

Answer: Mr. Shaw: With the help of Mr. Parkinson, we identified a duplication of monies in the CC (Capital) of the budget that would be funded by the IRP bonds, therefore, some CC funds were freed to be used to fund this, in addition to the MOE; and this was identified subsequent to the PHT submitting the budget.

Question: Where did the $600,000 designated for the Community Health Center of South Dade Inc. (CHI) come from?

Answer: Ms. Glazer-Moon: The County Manager's change memorandum presented at the County Commission's First Budget Hearing on September 13, 2010 reflects additional carryovers, which are additional revenues available for allocation this year. A formula was applied to that revenue, which determined that additional funding of $600,000 was available in the PHT's MOE and the PHT chose to direct that $600,000 towards the CHI.

Comments: Commissioner Seijas noted, on page 9 of JMH's budget narrative, you argue that Jackson's cost to deliver services is excessive because "Jackson still competes with local competitors who have significant advantages in labor costs;" however, she met with the PHT Board to discuss these facts and correct this fallacy using the comparisons recommended by the State of Florida Agency for Health Care Administration. The information used by Jackson does not take into account the specialized services such as the Trauma Center, transplant units, etc.... The fair comparison of operating expenses per adjusted patient day shows that it costs more per

day at other hospitals than at Jackson, and makes it clear that Jackson does not have the highest operating costs. She noted she would appreciate it, that when you adjust your budget pursuant to comments made by members of the County Commission, you correct it to reflect that this is not the case; that Jackson does not have the highest operating costs of local hospitals. She also noted she supports the initiative for a single option Health Care Plan.

Question: What is the percentage of patients leaving the Emergency Room without being seen? Is it currently eight-percent?

Answer: Dr. Roldan: Currently, it is eight-percent and still decreasing. We are aiming for three to four percent.

Question: Referring to Page 13 of the presentation that says the Emergency Departments (EDs), both adult and pediatrics, were so busy that a number of patients arriving by ambulance were diverted to other hospitals, and that number decreased by 53 percent, she asked what number decrease by 53-percent?

Answer: Dr. Roldan: I do not have that number at this time, but I can provide you the baseline. The diversion was due to JMH not having enough patient through-put. That number had decreased by half, and has been decreasing for the past 2 years.

Question: What is JMH's review process for all non-county residents who come to the Emergency Room for stabilization?

Answer: Dr. Roldan: We check to ensure that they do not come from outside of the County. There is a much more stringent review at the front end of the process to classify the patient by using whatever information or documentation they give us.

Question: Have we thought of establishing some type of process, a set of rules requiring certain documents be presented that are acceptable as proof the patient lives in the County?

Answer: Mr. Shaw: JMH currently has a list of acceptable documents, but many who arrive at the ER are not coherent, so we subsequently go after ID and try to obtain a minimum of two sources, using technology to validate the address is correct.

Ms. Carmen Pla, Vice President, JMH Revenue Cycle, added that we changed our policies to accept only valid State of Florida identifications. Regarding financial assessment of the patient, we changed our policies to accept signed letters of support, and provide paperwork for the patient to sign attesting they understand that JMH will press criminal charges against them for providing false information. Also, instead of qualifying patients based solely on their income, we run credit reports to ensure their assets match their incomes.

Question: Referring to page 17 of the presentation that says JMH has made a substantial effort in FY2009-10 to collect old accounts that were not processed effectively in prior years, and has reduced the ARs by $50.5 million. Were those accounts sent to a collection agency?

Answer: Mr. Shaw: Those accounts were excluded from the dollars we turned over to the collection agency, because we were required by court order to only submit to the agency the accounts that were never billed.

Question: Regarding a strategy to support revenues, noted on page 26 of the presentation, and to affiliate with the physicians in the community in order to bring funded patients to JMH, Commissioner Seijas asked if the physicians who come to JMH were covered under sovereign immunity.

Answer: Dr. Roldan: No. The physicians that we identified at Jackson North and Jackson South are basically community physicians. If they are not under an agency-type model, they rely on their own credentials to bring in patients, and have their own malpractice insurance.

Comment: Commissioner Seijas: JMH needs more people from the community to understand that Jackson North is a big hospital. Regarding language on page 26 of the report that says community physician strategies are underway for both cardiology and general medicine; this puts JMH in competition with UM. I think JMH can not survive without UM and needs to join with UM, instead of compete with it. I hope the joint task force of UM representatives and JMH staff can address the immediate issues, and develop a strategy to gain support in Tallahassee for sovereign immunity of UM doctors. Mr. Rosenberg, Dean of Florida International University (FIU), supports sovereign immunity as well.

Response: Dr. Roldan noted she proposed that UM's Dean and Jackson work together to define an indigent patient at JMH, and work towards sovereign immunity.

Comment: Commissioner Seijas suggested the task force discuss this issue. If we try to help UM's doctors acquire sovereign immunity, we might become better partners with them. Jackson will still have to continue treating the undocumented patients.

Question: Is JMH recruiting surgeons for Jackson North and Jackson South? Is FIU recruiting surgeons mostly at Jackson North?

Answer: Dr. Roldan: Yes, at both Jackson North and South. And yes; we are helping FIU with their initiative to recruit surgeons for Jackson North.

Comments: Commissioner Seijas noted management really needed to concentrate on Jackson South, and noted she was glad that the Obstetrics (OB) unit was reinstated there. She also noted she was not excited about the proposal for Bariatrics, but agree that certain services were needed, particularly Orthopedics, Obstetrics, Gynecology (OB-GYN), and Emergency Room services. She noted, before the County Commission votes on the County's budget on Thursday September 23, 2010, she would like the Jackson Memorial Foundation to identify the 31 contractors they referenced; the nature of business between the contractors and the County; why they are doing business with the County; what business were they supposed to do; how long they have been with the County; and how long they will stay with the County. If not, she would suggest we freeze JMH's contribution to the Foundation until the Foundation finds its way back. As the task force works, we need to remember that UM also has international services, and should not

duplicate our services. She said she hoped the economist speaking on the radio this morning was wrong about this crisis lasting another five years, and maybe we should look at the long term.

CHAIRMAN MOSS

Comments: Chairman Moss noted he felt that providing UM doctors with sovereign immunity could make JMH extremely competitive in the future under the new environment created by Healthcare Reform. We need to make a concerted effort to move the sovereign immunity issue forward. The more the County Commission understood the process of acquiring sovereign immunity, the more prepared they would be to advocate for it in the future.

Chairman Moss suggested that JMH employee's salary structure needs to be reviewed to ensure a fair comparison of its rates with those of similar hospitals doing similar activities; maybe to pull out the specialization services, and just look at the general hospital costs.

COMMISSIONER SOSA

Comment: Commissioner Sosa thanked the County Attorney's Office for clarifying the jurisdictions between the County and the PHT concerning JMH; for the memorandum that says the County owns Jackson, but transferred possession and control of operating its facilities to the PHT; and defined what the PHT could not do

Question: Based on the County Manager's memorandum dated September 20, 2010, what would the estimated fiscal impact be to the County if all Jackson employees switched to the JMH Health Plan from AvMed? She asked if they were suggesting that all County employees do the same or just the JMH employees.

Answer: County Manager Burgess noted the PHT members and the County Administration have discussed how the JMH Health Plan could capture all JMH employees. We are not adverse to that, but there is a cost and a lot of issues the need to be resolved to accomplish this. He was not sure whether the PHT could meet the target dates. The PHT's budget assumes that Jackson would gain approximately $8 million if all its employees used the JMH Health Plan, but he was not convinced that $8 million was the correct number.

Request: Sosa asked County Manager Burgess to please determine and report to the County Commission on whether he agreed with the $8 million, before the Second Budget Hearing scheduled on Thursday (9/23).

Response: County Manager Burgess noted he could share his thoughts with the Board before Thursday. But his thoughts were that many steps need to be taken to achieve those savings. The plan has to be marketed, cleared of misconceptions that it is not limited to just Jackson, but part of a broader plan. In the long run, the JMH Health Plan is an opportunity that has great potentially for the hospital, the County and beyond the County, but he could not say with confidence that JMH will be able to hit the $8 million target in the upcoming budget. He noted Dr. Roldan can expound.

Response: Dr. Roldan: One of our priorities is to bring back those employees who left the JMH Health Plan. Currently, 46-percent of JMH employees are enrolled in this plan. We need the infrastructure to bring them back and retain them. Even if they decide to keep the AvMed plan, it will help if they use JMH or the hospitals affiliated with JMH.

Question: Commissioner Sosa asked if management included in this budget, the $8 million savings as a result of this initiative.

Answer: Dr. Roldan: Yes, the budget currently included all JMH employees.

Question: But how can management include the approximate $8 million additional revenues in your budget if they did not have the infrastructure in place or know when it will be put in place?

Answer: Mr. Shaw: Management was in the process of creating and completing that infrastructure with new systems, new leadership and a new network of providers negotiated. He said he was confident that this could be achieved.

Commissioner Sosa noted before the Commission votes to support this budget, we need to see something more tangible demonstrating that the $8 million savings can be achieved. Please expand your explanation of the line-item amount that is being targeted in your budget, and what steps are being taken to achieve that amount based on the County Manager's suggestions.

Response: Dr. Roldan: Management can itemize the initiatives that would achieve that amount, but more important, we need to go through open enrollment to achieve it, which will not occur until after the budget is approved.

Comment: Commissioner Sosa suggested they be very conservative in the amount they put in the budget; otherwise, unrealized projections could result in an additional deficit next year. Regarding Sovereign Immunity, she said she felt it was important that the Commissioners meet with the legislatures in Tallahassee to convey how important sovereign immunity was for Jackson right now. She had the impression that they do not think it is necessary, and suggested maybe Chairman Moss could arrange a roundtable discussion with them on this issue.

Question: Is the PHT requesting an increase in funding from the General Fund to balance JMH's budget, other than what is stated in the formula?

Answer: County Manager Burgess: Their budget assumes the ½ penny sales tax receipt and the calculated MOE, which was $600,000 more than what we estimated. This was not a request of the PHT, but was their calculated entitlement. When formulating their budgets, the PHT and the County agreed that the County would assume approximately $300,000 in costs associated with the Office of the Countywide Healthcare Planning and Air Rescue for the north end of the County. They have not asked for anything in addition to those two items.

Question: Can management provide a comparison of the operating costs for Jackson Main, North, and South that compares the operating costs, losses and expenses for each of these facilities?

Answer: Dr. Roldan: Yes. It is reflected in the County's Budget Book, separated by units.

Question: What had been done and what could be done to ensure that Jackson receives reimbursement for uninsured patients who qualify for Medicaid? Commissioner Sosa noted JMH employees were taking care of this, but due to the change in software at Jackson, some information became inaccessible; therefore JMH was losing Medicaid refunds. She said she was concerned about how much was lost.

Answer: Mr. Shaw: We were using the best of our employees who worked with in-patient information to work on the outpatient side and capture that information at the front end. We employed Chamberlin, Edmonds & Associates, Inc. (CEA) system to handle the inpatient side and manage the hospital's uninsured patient base. We also engaged the Social Security Administration to fill out all the disability applications for both federal and State services. He noted he would report on these efforts to the County Commission at the end of 90 days as promised, which would be up this month. The monthly reports reflect that the amount of pending Medicaid being captured had increased.

Comment: Commissioner Sosa noted we need to try and do a lot more in that area. Regarding the International Program, she could not emphasize enough the importance of this program to JMH because it markets JMH to other communities, brings in paying patients, and creates more revenues for JMH. After the County Commission approved its budget, she would like the PHT to create a plan to enhance this program.

Question: Do you have a written plan to create efficiencies in JMH's Administration to minimize losses at Jackson Main, North, and South?

Answer: Dr. Roldan: Yes. The proposed budget has listed those initiatives by line-item for Jackson, Main, North and South facilities.

Request: Commissioner Sosa noted she would like to see some specific numbers regarding those initiatives.

Question: What percentage of insured patients stay admitted in JMH for more time than the insurance covered? She noted she was aware that losses had incurred as a result of this issue, and something needed to be done in this area to save money.

Answer: Dr. Roldan: One initiative under case management and utilization that management will be implementing was to reduce the length of stay. In the Revenue Cycle, we are working on insurance claims that are denied due to patients staying too long, and on the clinical side, we are also working to reduce the length of stay so that the days of inpatients are covered by insurance. Managed Care will only allow a certain amount of days for patients with specific pathologies or diseases.

Comment/Question: Under the line-item for physicians, Commissioner Sosa suggested establishing a pay review to improve that area. What percentage of patients with insurance that leaves the ER without being treated because they had waited a long time to be seen?

Answer: Dr. Roldan: We are permitted to discuss the patients who left the ER without being seen; however, since the patient left without being seen, it is unknown whether the patient had insurance or not. Also, the number of patients that leave without being seen has been reduced. It can be assumed that they left because they had insurance or other options and could go elsewhere to receive care, or, they just left, and eventually will return to Jackson for treatment. We are trying to capture as many patients as possible.

Question: Do people sign in when they enter the ER?

Answer: Dr. Roldan: Yes, but at that point, Jackson's staff is not allowed to ask them if they have insurance.

Request: Commissioner Sosa asked Dr. Roldan to please give her an idea of that percentage. She said she thinks this area needed to be improved for the hospital to attract more paying patients and to convince them to stay.

Response: Dr. Roldan noted management has increased JMH's express care, improved triage, and established an observation unit in order to capture more ER visitors. When she was restructuring the ER at Jackson Main, she did a Sigma Insurance project to show the amount of patients being lost and what we would assume if they had a different payer mix. She said she could share that information with the Commissioners.

Request: Commissioner Sosa said she would like to see that information.

Comment/Question: Commissioner Sosa noted the County Commission approved a resolution on September 1, 2009, directing Dr. Roldan to update the feasibility study that evaluated the cost saving alternatives for providing healthcare services to inmates; to prepare a Request for Proposals (RFP); and to compare what was done in Broward County and other counties nationwide in order to determine the best options for providing these services. What are the options? This process has been delayed too much, and now the County Commission faces approving this budget without having the options or alternatives for realistic savings in this area. When can the alternatives be determined without interfering with the RFP?

Answer: Dr. Shaw: We have completed the RFP, and are in the process of negotiating the terms.

Question: Is the PHT/JMH budget balanced?

Answer: Dr. Roldan and Mr. Shaw: Yes.

Question: Mr. Manager, is the PHT/JMH budget balanced?

Answer: County Manager Burgess: Based on all the assumptions in the budget, it is balanced.

Question: Did the PHT already approve this budget?

Answer: Dr. Roldan: Yes

COMMISSIONER SORENSON

Comment: Commissioner Sorenson noted it was fair to assume that although this is a balance budget, it is an optimistic budget. She said she understood that the County Manager will remain engaged with the PHT to monitor this budget on a monthly basis to ensure the goals/projections were being met, and to make needed adjustments.

Question: In reference to a letter from Mr. Dickenson (a concerned civic leader) regarding unrealistic assumptions caused by the County's mandate for a balanced budget; is it the State or the County that mandates a balanced budget? She said she understood that it was a State mandate that we have a balanced budget.

Answer: Assistant County Attorney Valda Christian: That is correct for a countywide budget.

Comments: In the letter, Mr. Dickenson referred to unfunded mandates. A decision was made in 1999 to take $12 million from Jackson's budget to fund items that were previously paid for from the General Fund. She said she wanted taxpayers to understand that those items have to be funded, and if not taken from the County's budget, then we have to cut from somewhere else, at a time when the County is hemorrhaging money as well.

Comment: Commissioner Sorenson said she felt that Commissioner Seijas' memorandum regarding a comparison of labor costs at all county hospitals should be looked at to see if we are doing a true, equitable comparison of the costs and if the costs were realistic. Mr. Dickenson's letter says that conservatively, $150 million in labor costs could be saved annually, while the County's Budget Staff estimates $50 million at best could be saved, and would require opening up all the labor contracts.

Comments: Commissioner Sorenson noted she agreed that Jackson needs to cultivate/improve its relationship with UM, since UM has a lot more going for it than Jackson, but Jackson has a lot more to gain from this relationship; therefore we need to ensure that both the UM and Jackson were cooperating and reciprocating from this relationship. It looks as though management is moving in a positive direction and will need to keep working hard to ensure the proposed goals are met. If Jackson cannot reach its goals, an assessment might be needed to see what services could be cut. Certainly, moving towards primary care is a good idea because we know that prevention is less expensive than emergency care, but doing so would be a long-term solution.

CHAIRMAN MOSS

Comment: Chairman Moss expressed appreciation to all JMH staff members and PHT members present today (09/20) for providing their input in this discussion. He said he wanted to stay positive in overcoming Jackson's issues, and receive some help from the media to stay positive or balanced when identifying problems or future issues at JMH. Regarding unfunded mandates, Broward County may pay for its correctional services, but it does not contribute monies to its health district for those services. Yes, costs were shifted from the County to the PHT, but money was also provided to cover some of those costs. He noted not many counties outside of Miami-Dade County provided funding to their public safety net hospitals. Chairman Moss also thanked

his colleagues, the County Attorney and the County Administration for assisting the Commission. He said he felt they needed to meet on a monthly basis to review the PHT's progress in addressing these issues, and be prepared to make necessary changes. As Commissioner Gimenez requested, we all want to see plans B and C and to discuss them in advance of hearing about any issues concerning Jackson in the media.

As a point of order, Chairman Moss closed this session and moved into discussing the County's Proposed Fiscal Year 2010-2011 Budget.

DISCUSSION OF THE COUNTY'S PROPOSED FISCAL YEAR 2010-2011 BUDGET

Chairman Moss noted the Non-Mayoral Budget Recommendations report presented by the Commission Auditor, along with other outstanding budget issues, need to be addressed today. He asked that today's budget discussion be conducted in a positively focused manner.

Chairman Moss expressed the need to maintain safety net services and use rainy day reserves during bad economic times. He presented six (6) basic areas of concern to him and his recommendations for addressing them:

1) Head Start – needs to be maintained as it is currently structured and the number of service days needs to be reduced as necessary, based upon available resources. The funding source for Head Start would remain as it currently is.

2) Office of Community Advocacy –the four (4) staff positions that are currently paid for by the Office of the Chair needs to be restored, and funding added for a Director's position. While providing oversight of this Office, it became evident that it required dynamic full-time leadership by somebody who could interface with the community, address diverse community issues and crisis situations, and supervise staff.

3) Community Based Organizations (CBO) – funding for CBOs needs to be restored to the FY 2009-10 levels. CBO budgets were reduced by 30 percent in last year's budget, and another 25 percent reduction this year would severely limit access to essential community services.

4) Small Business Development (SBD) – needs to be maintained to its current staffing levels; the certification process needs to be moved back to this Department; and the appropriate staffing was necessary to carry out SBD's mission.

5) Housing and Community Development (HCD) – this department and its funding needs to be restored. HCD's primary funding source was a Community Development Block Grant. Splitting up this Department would impact the delivery of services, which were already scarce in the neediest neighborhoods. The level as well as the overall focus of funding

for HCD had decreased; the 15 percent set aside for public services placed in the General Fund needs to be re-evaluated; and the 15-percent cap needs to be maintained. The benefit of this process was that it targeted the Neighborhood Revitalization Strategy Areas (NRSA), the poorest areas in the County. Three (3) NRSAs and over twelve (12) public housing developments exist in District 9 alone and the County's NRSAs need an overall direction, which would not happen if the HCD department was split up.

6) Greater Miami Service Corp (GMSC) – needs to be maintained. GMSC has made a positive difference in the lives of many young people in the community. Alternative and safety net services need to be offered to the youth to keep them out of trouble and off the streets so that the neighborhoods remain safe for everyone.

Regarding the Government Obligation Bonds (GOB) Program, Chairman Moss noted he was prepared to support the GOB budget; however, he expressed his desire for the community neighborhood projects to come to fruition. In conclusion, Chairman Moss expressed his frustration over major County projects, which were envisioned to create jobs and bring about other positive opportunities/outcomes for the entire community. He noted he was tired of the commitments made to the community not being honored by contractors, and promised job opportunities not materializing, especially in District 9.

Commissioner Heyman noted the importance of maintaining a balanced budget. She questioned whether costs had been projected and funding sources were available for Chairman Moss' recommendations.

Chairman Moss responded that he did not have a projection of the costs; however, he envisioned using the reserves as a funding source.

Commissioner Sorenson noted even a rollback budget would require reducing a number of county services and a reduction of 600 county employees, which would not be good for the employees or the economy. She pointed out that the Stimulus Program was successful, but it did not receive enough funding. She noted the County had its own Stimulus Program that could create additional projects and jobs in the community by maximizing the GOB millage rate. Commissioner Sorenson suggested a millage rate adjustment was needed to restore public libraries service hours and days, since libraries were akin to the CBOs and excellent community resources. She said she was opposed to most of the Commission Auditor's suggestions; that she believed the Board should reduce each Commissioner's District Budget by $100,000, and that the Legislative Analyst positions in both the Commissioner's and Commission Auditor's offices were a duplication of services. Commissioner Sorenson noted the County Attorney's Office and its function was necessary since they compete with major law firms for the best and brightest lawyers, and their budget should be increased. She said the moneys saved from her suggested reductions to the Commission's budget should be directed to CBO's and the Parks programs. Commissioner Sorenson expressed concern with utilizing reserve funds to the extent that any of the County's bond ratings would be jeopardized; that a threshold and clear direction were needed

from the County Manager and the Budget Director to ensure appropriate bond rating levels were maintained and acceptable to the rating agencies.

Commissioner Barreiro concurred with Commissioner Sorenson's suggestion to restore library services to a 100 percent level. He supported a higher millage rate to support the GOB program and to ensure community projects were funded; however, suggested a mechanism be established that expedites those projects and immediately puts work into the community, even if it means waiving the procurement rules or adding language to the GOB ordinance.

County Manager George Burgess responded that the Board had already established an expedited program for GOB projects, which was working. He said those projects that are shovel ready could be added to the expedite list and included in the next two bond sales.

Commissioner Barreiro asked the County Attorney to evaluate other alternatives and whether the language in the GOB ordinance could be streamlined to facilitate or further expedite the process. Commissioner Barreiro noted he would support a reduction in the County Commissioner's budgets by cutting Commissioners $6,000 salary and benefits in order to send a message to the community that they were making personal sacrifices to help the budget; however, he would oppose cutting their health insurance benefits.

Commissioner Seijas noted, although she voted to establish District offices, she did not have a District office as a cost saving measure. She spoke about the positive outcome of the Stimulus Program, specifically in her district where a contractor working on NW 67th Avenue, worked during the night in order to not disrupt traffic and forfeited his profit to keep 100 laborers employed.

In response to Commissioner Seijas inquiry regarding whether staff had identified funding to restore the Children's Advocate Program, Ms. Jennifer Glazer-Moon, Budget Director, Office of Strategic Business Management, noted that staff found a way to restore the Guardian Ad Litem Program positions.

Commissioner Seijas expressed concern regarding an increase in the budget of the Commission on Ethics and Public Trust (COE) and inquired whether this Commission would be hiring additional staff.

Ms. Ines Beecher, Budget Coordinator, Office of the Commission Auditor (OCA), responded that when she met with Mr. Robert Meyers, Executive Director, COE, there was some disagreement between him and the Administration concerning the COE's budget. She noted the COE budget for FY2009/10 was $1.892 million, but after adding carryovers, was adusted to $2.132 million. Ms. Beecher said that Mr. Myers requested a $2.391 million budget for FY 2010-11 due to an increased work-load. She noted a compromise was met to freeze one investigator position, rather than eliminate it as proposed by the Manager, and Mr. Meyers proposed to freeze a second (vacant) investigator position for 3 months, and keep the part-time intern, plus various other payroll adjustments were made. Ms. Beecher said that after making these adjustments, a $94,000 gap remained in the budget, and the OCA was recommeding this difference come from the Non-Departmental reserves.

Commissioner Seijas noted she did not agree with the request for additional funds, that it was inappropriate and this exception should not be approved when 600 County employees positions were being eliminated. She said she did not have any problem with freezing the investigator positions for one-year, keeping the intern position, and the negotiated payroll adjustments. She asked Mr. Meyers to explain the rationale behind him requesting an increase in the COE budget.

Mr. Meyers explained that the County Manager recommended the COE cut three (3) positions in its FY2009-10 budget; however, the Commission authorized the COE to keep its carry-over funds, which allowed the buy-back of those postions. He noted he agreed with the OCA's proposal to freeze the one vacant investigator position for one-year and accepted today's recommendation to freeze the other investigator position for one-year instead of 3 months, since the net affect would be the same because one person was retiring this year. Mr. Meyers said the COE would not be taking any salary or cost of living (COLA) increases, but asked that the part-time intern position, which was traded-off, be restored in consideration of this concession. He also noted that the County increased the COE's responsibility and workload by asking it to investigate part-time and contractual employees as well.

Commissioner Edmonson noted she would address her concerns regarding Housing and Community Development and Small Business Certification later today with County Manager Burgess. She agreed that days and hours should remain with the libraries and that funding for the CBOs and Parks should remain intact. She also concurred with Commissioner Barreiro's recommendation to eliminate the Commissioner's $6,000 salary. Commissioner Edmonson said the Hampton House, a County-owned property which was declared an historial site, was an eyesore and needed to be adequately funded. She supported funding the Greater Miami Service Corp because these kids were the future of our community, and it was the County's responsibility to help them. She expressed concern with banking County reserves rather than use them at a time when county employees were losing jobs and unemployment was increasing in the community. Commissioner Edmonson supported funding the Office of Community Relations for additional positions and concurred with Commissioner Barreiro's proposal to go above and beyond to further expedite the GOB projects and put local residents back to work in the community.

Commissioner Jordan asked Mayor Alvarez whether the Commission on Ethics and Public Trust (COE) received a 5-percent salary adjustment as the other County employees had.

Mayor Alvarez responded that he submitted a memorandum to the Office of the Chair during a budget meeting, explaining that the COE was the only department that had not taken the 5-percent salary reduction. He further explained that Mr. Meyers insinuated that his memorandum was prompted by an ethics investigation which the COE conducted on members of the Mayor's office and that it was a conspiracy. Mayor Alvarez noted it was not a conspiracy, and it was Mr. Meyers' contention that taking the reduction would put a cloud over the COE's independent status.

Commissioner Jordan noted she recalled a previous conversation where it was explained that internal controls were put into place in order to realize the savings. She asked Mr. Meyers whether the COE budget ever reduced its budget by 5-percent similar to the rest of the County.

Mr. Meyers responded that the COE was directed to reduce its budget, but not told to take a 5-percent salary reduction because the County Mayor did not have authority to cut the COE by 5-percent.

Commissioner Jordan said the Commission adopted a policy giving flexibility to all County Departments to reduce their budget by 5-percent using either furloughs or pay cuts, based upon negotiations with the various unions. She questioned whether the COE adhered to this policy.

Mr. Meyers responded that he took this matter to the Independent Ethics Commission who concluded that it would be acceptable to utilize other means to reduce the budget by 5-percent without reducing salaries. He noted their employees took furlough days; however, this reduction only amounted to approximately 2.5 percent of their salaries, not 5-percent. Mr. Meyers said he re-submitted this issue to the Independent Ethics Commission in light of additional concerns expressed by several Commissioners, and the Ethics Commission concluded that the 5-percent reduction was not warranted because other savings were achieved and past raises of COE employees did not equal the raises received by other County employees.

Commissioner Jordan noted an inequity existed concerning COE employees, since all other county employees had forgone receiving raises and also had assumed increased workloads without receiving additional compensation.

In response to Commissioner Jordan's inquiry regarding the dollar amount realized had the COE taken the 5-percent reduction, Ms. Glazer-Moon responded that based upon salaries only, the amount was approximately $78,000.

Mr. Myers pointed out that the COE had already taken a 2.5 percent reduction so that amount would actually be half or approximately $40,000.

Ms. Glazer-Moon commented that at last year's second budget hearing, two positions were restored and added to the COE's budget, and the Department's budget was amended as needed using the $310,000 carryovers. She noted because their carryovers were exhausted, the General Fund subsidy was increased by almost $200,000 in order to keep this Department close to the same subsidy level this year without having to make reductions, and the two restored positions were allowed to remain in-place. Ms. Glazer-Moon said the COE would have received a reduced General Fund subsidy of about $100,000 if they took a 5-percent reduction similar to other entities or about a $78,000 reduction if they took a 5-percent salary reduction.

Commissioner Jordan noted in order to be fair, she would be recommending a 5% salary reduction in this area in order to fund other programs such as the Office of Community Advocacy.

Mr. Meyers expressed concern that the COE would actually be taking a 7.5 percent reduction if a 5-percent salary reduction was imposed since a 2.5 percent furlough reduction was already taken and previously approved by the Independent Ethics Commission. He pointed out that the COE Budget for FY2010/11 did not anticipate any employee raises in an attempt to avoid a layoff of any employees, and he would need to lay off an employee in order to come up with the $100,000

difference. Mr. Meyers indicated that the COE needed an alternative budgeting mechanism because it was uncomfortable for the COE to go through the current process due to its independent responsibilities under the County Charter.

Commissioner Jordan noted the oddity of considering the COE an independent entity when it relied on County resources. She expressed her desire for this area to be further evaluated to ensure resources remained consistent with other County Departments.

In response to Commissioner Jordan's inquiry regarding other positions that had been restored, County Manager Burgess explained that the Administration was in the process of making its rounds to personally meet with each Commissioner and address their concerns. He noted this process would be completed by Thursday, September 23, 2010, and the concerns heard today were not new, but consistent with those already expressed in earlier meetings. County Manager Burgess said he felt very comfortable that the concerns being expressed by the Commissioners could be accommodated.

Commissioner Jordan indicated her support for the items mentioned by Chairman Moss, especially the recommendations concerning the Office of Community Advocacy (OCA). She noted the OCA Director voluntarily relinquished his position last year, which allowed the OCA to move under the Office of the Chair and freed up resources that helped provide the OCA with additional financial support. She said the OCA serves four very distinct communities (Hispanic Affairs, Office of the Commission on the Status of Women, Black Affairs and Asian Affairs) which require leadership to be sensitive to their needs and to coordinate their efforts.

Commissioner Rolle commented that he was awaiting an explanation from the Administration on Head Start's funding. He noted his concern with funding for CBO's, particularly for after-school programming; the decision to dismantle the Office of Housing and Community Development; and the Small Business Development (SBD) certification and recertification process. He said he believed the SBD should not have been merged with the Department of Procurement Management. He supported expediting GOB funds to promote infrastructure projects; however, he was concern that jobs were not being created within the District where the projects were being built. He asked the County Manager to provide a report highlighting the impact of the County Mayor's recommendations on District 2 parks. Commissioner Rolle expressed concern regarding the Cultural Arts Center on NW 62nd Street/22nd Avenue, the Farm Share, and the lighting in District 2. He noted his desire for the County Attorney's Office budget to be restored, the libraries to be made whole, and asked for a list of CBO's being recommended for funding. In conclusion, Commissioner Rolle asked the County Manger to meet with him at his earliest convenience to provide answers to these questions.

Commissioner Heyman noted her concerns regarding the budget gap and whether it could be filled. She asked the County Manager to state the current amount in the County's reserves and whether the funds in those accounts would be adequate to satisfy additional services being requested by the Commission.

County Manager Burgess responded that there were several kinds of reserve accounts, including: Specifically Designated Special Purpose Reserves that specifically designate for items like

energy costs changes, employee separation costs after years of services, etc...; Emergency Contingency Reserves, which were difficult to access and need to be guarded to strengthen the bond ratings to a level acceptable to the rating agencies; Contingency Reserves, which are for emergencies and include stipulations on how to access them; and Future Services Reserves, which was approximately $8 million and would address the additional service needs being requested by the Board. Responding further, County Manager Burgess noted the Administration contemplated the Board would have concerns; therefore, at the proposed budget rate levels, sufficient funds were available in these reserve accounts to address the concerns raised by the Board, plus some which had not been expressed yet, without any additional impact on County services or further employee layoffs. He said that all enhancements could be addressed without eroding the contingency reserve levels needed to strengthen the County's financial and bond ratings.

Commissioner Heyman noted the Commission should lead by example, and noted she did not support adding additional funds to the BCC, the Office of the Chair or other Office account budgets, while County departments were reducing their budgets. She supported the Office of Community Advocacy; however, expressed concern that the salaries for the five positions on this advisory board were each between $124,000 and $145,000, which should be reduced to fund a Director's position. Commissioner Heyman requested the Volunteer Coordinator position be reinstated in the Animal Services Department and that similar positions in the Parks Department and Libraries be considered as well. She noted that one fire rescue boat located at the Port of Miami should either be eliminated or relocated to North Dade where it could be docked for free and more readily available. Commissioner Heyman noted her conservative approach in managing the District 4 Office and its expenditures of funds. She suggested the Administration's car allowances be evaluated, along with the potential of reducing perk/benefits and use these funds to return direct services back to the community. In conclusion, Commissioner Heyman noted the rollback rate would result in a substantial tax increase for a large portion of the community during bad economic times, and cautioned the use of a wish list approach just to meet the rate cap. As an alternative, she suggested placing funds in reserves or rehiring employees that were laid off to maintain a level of service.

Commissioner Sosa noted she had questions on behalf of her constituents even though she voted against the rollback budget. She proceeded to ask the County Manager a series of questions pertaining to whether 1,224 employees were hired in FY 2009/10 and terminations were proposed in the FY 2010/11 budget.

County Manager Burgess responded that he had not reviewed the documentation referenced by Commissioner Sosa. He noted the quoted figure was possible and the majority of those positions were probably internal placements, which are recruitments of County employees. He noted the requisitions for hiring are only for filling positions that were in the proposed budgeted, and that both he and the Budget Director personally approved personnel requisitions. He noted approximately 600 filled positions where currently slated for termination in this proposed budget and efforts would be made to pipeline them.

Commissioner Sosa expressed concern with the County hiring 1,224 employees and then firing 600 employees. She asked the County Manager to provide her with a report depicting the

number of these 1,224 employees that were hired from within the County or lateral transfers from other departments and the number that were hired from outside the County.

In response to Commissioner Sosa's inquiry regarding how much control the County Manager's Office had over the Property Appraiser's Office (PAO), County Manager Burgess responded that the County Manager's Office had none; that the PAO was governed by the State of Florida-Department of Revenue (DOR) in terms of requirements/methods for assessing property values. He noted the PAO meets with the Administration regarding their budget and to present their needs/requests in order to be compliant with the DOR regulations for an accurate property tax roll. County Manager Burgess explained the possibility existed for the DOR to find the County 'not in compliance' with the DOR requirements, if the PAO resources were inadequate. He said that additional resources were required to handle the unprecedented increase in volume of property tax appeals filed last year. Responding further to Commissioner Sosa's inquiries, County Manager Burgess noted the Property Appraiser's Office salaries were supported by the General Fund.

Commissioner Sosa commented that the PAO hired 41 additional employees last year. She noted although she supported the creation of this office, she never anticipated it would grow so much that it would take away from other essential community services. She expressed concern that the DOR regulates this office, and determines its staff needs; however, the County's taxpayer dollars are responsible to fund it.

In response to Commissioner Sosa's inquiry about the PAO's initial and current budgets, Ms. Glazer-Moon responded that in FY 2008/09, expenditures were $25.988 million, the budget for FY 2009/10 was $30.472 million and the proposed budget for FY 2010/11 was $34.225 million. She noted a substantial portion of this growth was associated with the increased demand for Value Adjustment Board reviews. Ms. Glazer-Moon noted the budget was submitted to the DOR in early summer for review to ensure the resources were sufficient to accomplish the PAO's mission. She said the County was restricted from making amendments to the budget after it was certified by the DOR on August 15th. Ms. Glazer-Moon noted the County could potentially loose its State Revenue Sharing, and could be imposed with other costly fines/punishments should the County be found in violation of the DOR requirements.

Commissioner Sosa concurred with Chairman Moss about funding the Office of Community Advocacy, and agreed that a review of the executive benefits and packages would be appropriate. Commissioner Sosa noted the Commissioner's $55,000 salary and benefits package included retirement funding and could not be compared to the Administrative salaries and executive benefits.

Commissioner Jordan noted she was not one to be swayed by the opinion of the media and would not support giving up her $6,000 salary and other benefits. She noted this Commission conceded to a larger percentage of cuts in last year's budget than all other County departments.

Chairman Moss noted his support for funding the public libraries and parks. He said it was important that Public Safety be kept intact; noting the tremendous jobs that County police and fire departments had performed. Chairman Moss noted there were 5,200 sworn police officers

and 3,400 firefighters in Miami-Dade County (including municipalities), compared to 14,000 sworn police officers and 5,000 firefighters in Chicago (not including Cook County). He said Miami-Dade County was "doing more with less."

Chairman Moss expressed his appreciation to everyone in attendance for their participation in today's Committee of the Whole meeting. He said that a Regular Board of County Commission meeting would be held tomorrow and if any issues were unresolved, another Committee of the Whole meeting could be convened. In the interim, the Administration should continue making its rounds and meeting with each Commissioner. Chairman Moss noted he looked forward to having a completed budget by the upcoming Budget Hearing scheduled for Thursday, September 23, 2010.

There being no further business, the Committee of the Whole meeting was adjourned at 4:01 p.m.

Dennis C. Moss, Chairman
Board of County Commissioners

COMMITTEE OF THE WHOLE MEETING

Board of County Commissioners
September 20, 2010

Prepared by: Jill Thornton

EXHIBITS LIST

NO.	DATE	ITEM #	DESCRIPTION
1	09/20/2010		Attendance Sheet-Roll Call Sheet
2	09/20/2010		Memo from Commissioner Martinez explaining his absence from today's BCC Committee of the Whole meeting
3	09/20/2010		Memo from Commissioner Heyman explaining that she would be a little late to today's BCC Committee of the Whole meeting
4	09/20/2010		Memo re: 2010-2011 Board of Directors for JMH and the Foundation Health Services Board
5	09/20/2010		Report by Dr. Eneida O. Roldan, MD- Re: Jackson Health System's FY 2010-11 Proposed Budget for review
6	09/20/2010		Memorandum from Mr. Charles Anderson, Commission Auditor, dated September 15, 2010, Re: FY 2010-11 BCC/Non-Mayoral Budget Recommendations
7			
8			
9			
10			
11			
12			
13			
14			

Board of County Commissioners
Roll Call Sheet for 9/20/2010

MEMBER	PRESENT	LATE	ABSENT
Commissioner Barreiro		✓	
Commissioner Edmonson	✓		
Commissioner Gimenez	✓		
Commissioner Heyman	✓		
Commissioner Jordan		✓	
Commissioner Martinez	—	—	✓memo
Commissioner Rolle	✓		
Commissioner Seijas	✓		
Commissioner Sorenson	✓		
Commissioner Sosa	✓		
Commissioner Souto	✓		
Vice Chairman Diaz	—	—	—
Chairman Moss	✓		

Others:
CA Cuevas
FACA A. Price-Williams

NOTE: *7 members constitute a quorum*

JOE A. MARTINEZ
MIAMI DADE COUNTY COMMISSIONER
DISTRICT 11

Memorandum

To: The Honorable Dennis C. Moss, Chair and
Members of the Board of County Commissioners

From: Joe A. Martinez, Commissioner JM

Date: September 15, 2010

Re: September 20, 2010 Committee of the Whole Meeting

I will be unable to attend the September 20, 2010, Committee of the Whole meeting as I have meetings scheduled at the District Office. I apologize for any inconvenience this may cause.

Should you have any questions, please do not hesitate to contact my office at (305) 375-5511.

JM/mm

cc: Honorable Mayor Carlos Alvarez
George M. Burgess, County Manager
R. A. Cuevas, County Attorney
Dianne Collins, Clerk of the Board

Collins, Diane (COC)

From: Ferreiro, Maria (DIST4)
Sent: Monday, September 20, 2010 9:50 AM
To: Moss, Dennis C. (Office of the Chair)
Cc: Diaz, Fara (COC); Collins, Diane (COC); Bido, Carline (Office of the Chair); Bannerman, Wayman G. (Office of the Chair); Michaels, Bonnie S. (DIST4); Mejia, Lorna (DIST4)
Subject: Tardy
Importance: High

Please be advised that Commissioner Heyman will be a little late to the Committee of the Whole meeting scheduled for today, September 20, 2010. She has a previously scheduled doctor's appointment.

Thank you for your attention in this matter.

Mary Ferreiro
Office Manager
Office of Commissioner Sally A. Heyman
111 NW 1st Street, #220
Miami, Florida 33128
Tel: (305) 375-5128
Fax: (305) 372-6179
mary4@miamidade.gov

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"Bringing Government Closer to the People"

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Steven R. Poliakoff, M.D.
Physician

Shirley Press, M.D.
Physician

Norma Quintero
Social Affairs Magazine

Chris Riley
Miami Heat Charitable Fund

Eneida O. Roldan, M.D
Jackson Memorial Hospital

Manny J. Rodriguez
Florida Power & Light Co.

Robert S. Schwartz
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Patricia Wallace
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Conese Enterprises, LTD.

Eneida O. Roldan, M.D.
Jackson Health System

**until new Chair takes office November 1, 2010*

Jackson HEALTH SYSTEM
PUBLIC HEALTH TRUST

Eneida O. Roldan, M.D., M.P.H., M.B.A.
President & C.E.O.

Executive Office
1611 N.W. 12th Avenue
Miami, Florida 33136-1096
305-585-6754

To: Honorable Mayor Carlos Alvarez
Honorable Chair Dennis Moss
Members Board of County Commissioners

Date: September 3, 2010

From: Eneida O. Roldan, MD, MPH, MBA
President and Chief Executive Officer, Public Health Trust

Re: Public Health Trust Budget

Copies to: John Copeland and Members, Public Health Trust
George Burgess, County Manager
Alina Hudak, Assistant County Manager
Jennifer Glazer-Moon, Director, Office of Strategic Business Management
Daniel Alfonso, Assistant Director, GSA, Miami-Dade County

Pursuant to your request, we are respectfully submitting Jackson Health System's FY 2010-11 Proposed Budget for your review.

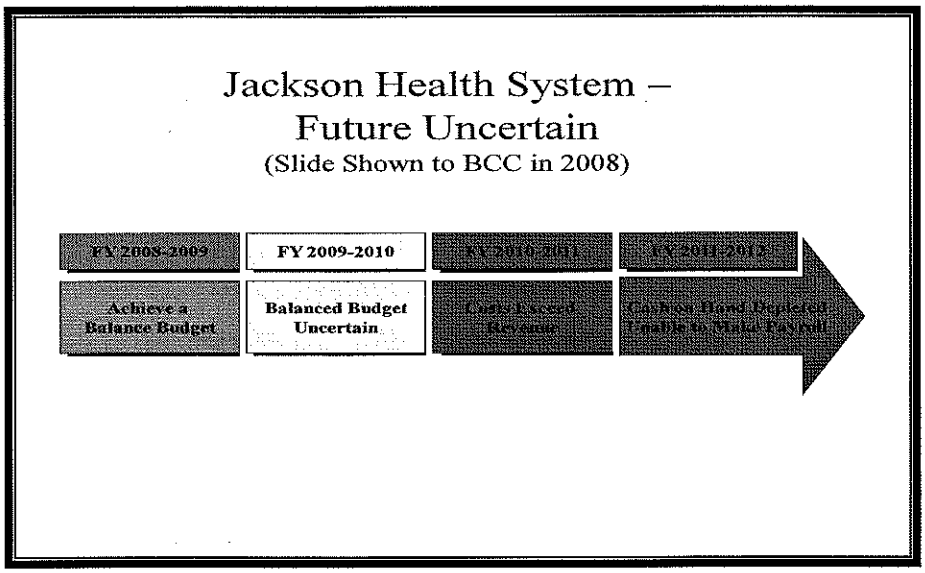
Executive Summary

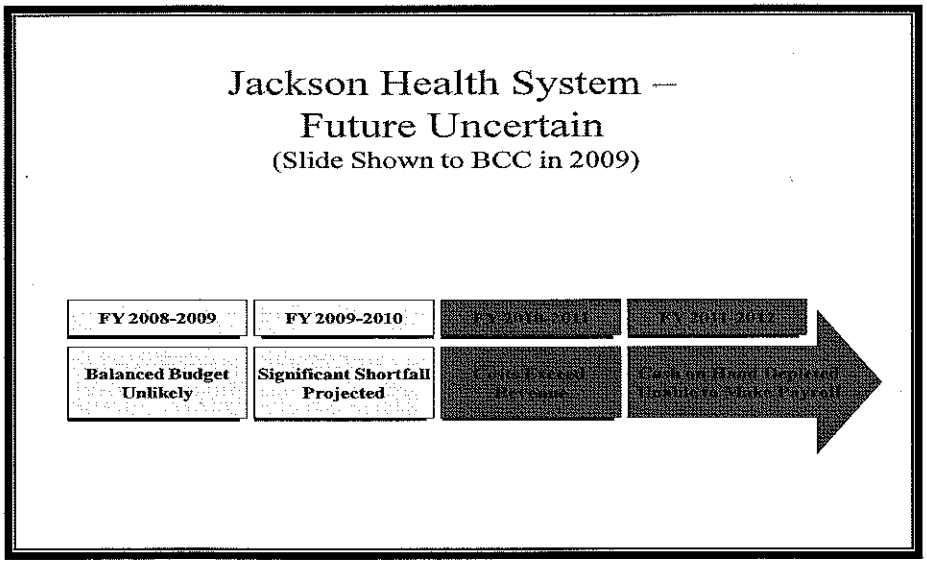
In recent months, Jackson Health System (JHS) has been on the minds of many in the community – as well as the commission – as we have faced one of the most challenging financial situations in Jackson's 92-year history. The increased levels of charity care that Jackson continues to provide have been greatly exacerbated by the severe economic downturn, increasing needs of the community, significantly rising costs and reductions in funding support among other driving forces. To fully comprehend the FY 2010-11 proposed budget, it is essential to first understand the industry trends and factors that have driven JHS to its current operating situation.

Jackson simply cannot afford to continue to operate as it has in recent years, providing expanding services to the community with limited revenue to cover costs. This leaves our public health system at a crossroads and our executive leadership team facing critical decisions. We understand that there are infinite healthcare needs within our community, but Jackson cannot continue to meet all of them without additional revenue and funding sources. Despite our best efforts at streamlining operations, reducing costs and improving efficiencies, these changes alone do not balance our budget. We must

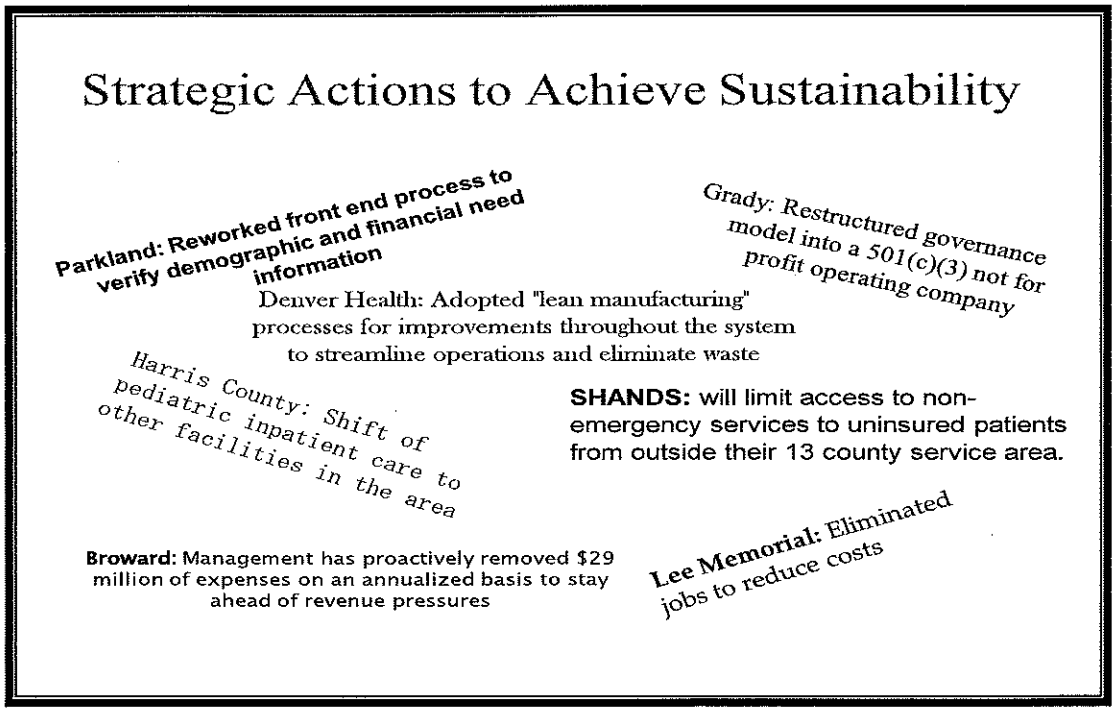
reevaluate and transform our operations if we hope to become financially sustainable and continue to fund our mission of building the health of the community by providing a single, high standard of quality care for our residents.

It is important to note that Jackson is not alone in its financial struggles. Safety net hospitals nationwide have been impacted by similar issues. Each is implementing different strategies specific to the needs of their communities and the preferences of their key stakeholders. In the end, each organization has to find the balance between services it provides, available resources and market share and growth to continue to fund its mission.





Some systems have attempted to survive these negative trends by eliminating services, transferring operations to other providers and executing substantial reductions in workforce through both layoffs and early retirement programs. In each of these instances the organization and its mission have been redefined. For example, Grady Health System in Atlanta, Georgia, significantly reduced their head count, divested outpatient dialysis services and repatriated undocumented patients to their home countries. Shands at the University of Florida announced in July that they will limit access to non-emergency services to uninsured patients from outside their 13-county service area. Broward Health has proactively removed $29 million of expenses on an annualized basis to stay ahead of revenue pressures. Jackson has continued to provide all services, even in the face of unprecedented financial challenges. Instead of reducing services, as an organization we have been able to provide current service levels by delaying much-needed capital expenditures.



Strategic Actions to Achieve Sustainability

	Operational Efficiency	Growth Strategies	Governance	Reduction/ Divestiture of Services
Parkland	X	x		
Grady	x	x	x	x
Denver Health	x	x	x	
Harris County	x	x		x
Shands				x
Broward	x	x		
Lee Memorial	x	x		

Source: Review of public literature

In other markets, communities have worked together to make structural changes to create sustainable safety net health systems that represent the uniqueness of each community. Strategic changes include refining the mission, narrowing the service offerings, revamping governance, aggressively competing for market share through acquisitions, and redefining extensive outpatient and primary care strategies. Still others have worked with their communities to create or designate new tax revenues to fund the mission. Harris County Hospital District in Houston, Texas, is shifting focus to a prevention and wellness culture through strategically located community health centers. Lee Memorial has cultivated a 95 percent market share of its primary service area following the 2007 acquisitions of Southwest Florida Regional Hospital and Gulf Coast Hospital. And Parkland Health and Hospital System in Dallas, Texas, has pursued an ambulatory-based expansion strategy with a focus on community-oriented primary care clinics. Additionally, Dallas voters approved funding to support a new acute care facility.

An evaluation of high-performing safety net systems that in recent years have consistently reported a positive operating margin shows that each began a strategic transformation five to ten years ago building financial reserves and solidifying market share through both physician alignment and primary care strategies to drive waste and inefficiency out of the cost base. Others have fared better through a more beneficial program of state and federal matching funds.

Jackson Health System

Executive Summary

	FY 2010 Projection	FY 2011 Projection
Projected Loss Post Final Audit (Feb. 2010)	$ (227,000)	$ (346,000)
Actions Taken		
Cash Acceleration	35,500	4,600
UM Payable Restructuring	54,000	6,000
Federal/State accelerated payments	42,100	
Management and Supervisory Reductions	4,800	8,600
Reduction in Force	19,600	47,100
Union Benefit Contributions	17,800	52,800
Non-Union Benefit Contributions	2,300	5,400
Process Improvements	14,900	86,000
Health Plan Operating Improvements	4,600	16,000
Operating Performnce Improvements	15,210	92,604
CBO Reductions		2,100
Growth Initiatives		7,900
Foundation Contributions		6,000
	210,810	335,104
Capital Investment Deferral	16,700	
	$ 227,510	$ 335,104

Dollars in Millions

Jackson Health System

FY 2011 Budget
Survivability versus Sustainability

Is the Job Done? – No!

- **Severe Lack of Capital**
- **Concessions Agreed Upon Need Renegotiation**
- **Economy in Slow Recovery**
- **Cost of Charity versus Funding – Gap Growing**
- **Must Find Strategy to Compete – Not Just Survive (Healthcare Reform Impact)**

Healthcare Reform and Jackson

When planning for Jackson's future sustainability, another component to take into consideration is the historic healthcare reform legislation that was passed this year and how it could change the delivery of healthcare services in the United States. It is indeed complex and many of the specifics with regard to operational changes and its effects on institutions like ours are still uncertain. We continue to stay informed, and have participated in discussions and shared our challenges at Jackson with our national representatives.

A major component of healthcare reform is universal health coverage, which could result in many of the uninsured or underinsured patients that we serve today having medical coverage. But once they have insurance, there is no guarantee that they will continue to seek care at our facilities. Historically, when there were major coverage expansions for Medicaid, there have been significant shifts in market share based on consumer preferences. So when unfunded patients have insurance coverage, Jackson will be competing with other institutions in South Florida to be the "provider of choice" for their care.

Another important consideration is that while more citizens will have coverage for care under healthcare reform, the payment rates for services are likely to be reduced to more closely reflect today's Medicaid rates. Currently, these rates only cover a portion of what it costs Jackson to provide the care. With the advent of the new program, other reimbursements — such as the disproportionate share program and the Low Income Pool (LIP) — may be phased out. If you would like to learn more about how safety net providers, including Jackson, may be affected by healthcare reform, please refer to Attachment A.

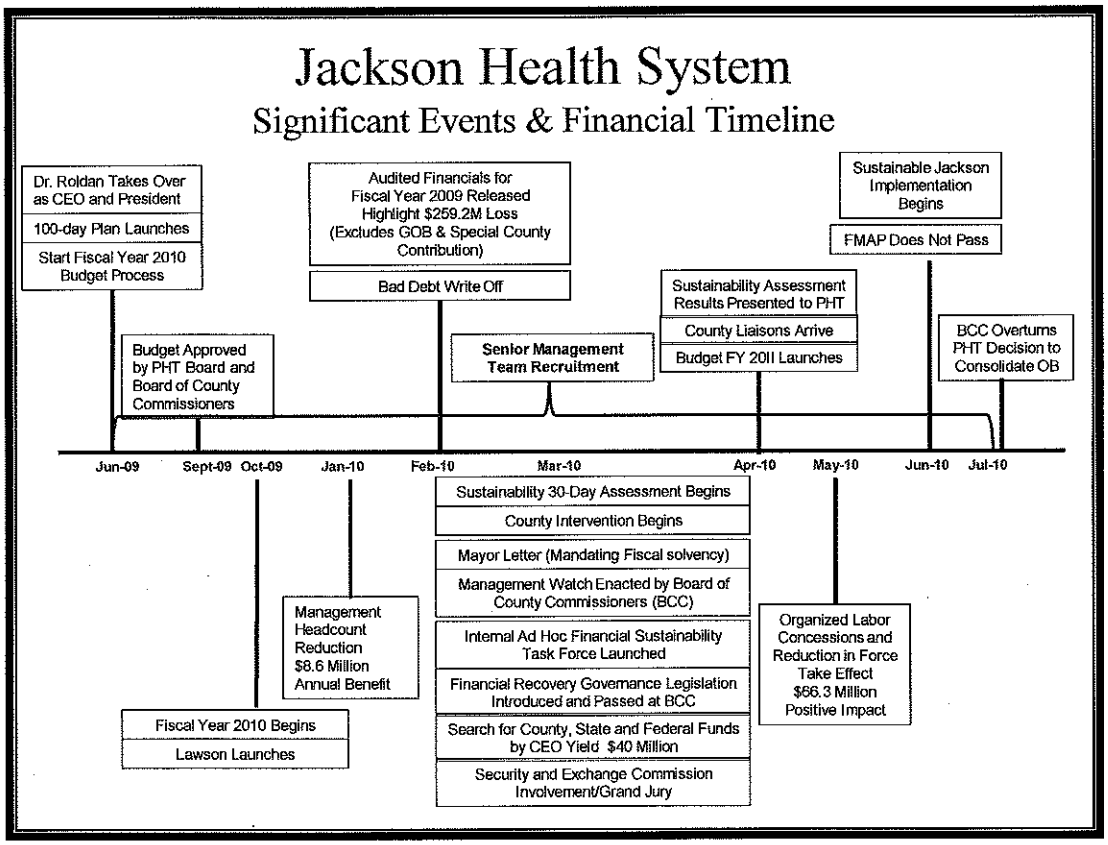
But again, with the specifics of healthcare reform not yet agreed upon or finalized by lawmakers, Jackson and other institutions are still unsure of the specific impact. Therefore, Jackson cannot, and should not, rely on these changes to provide the health system with long-term sustainability. Jackson continues to improve sustainability initiatives in order to cope with any changes that reform might bring.

Jackson's Unique Financial Challenges

In addition to the obstacles similar safety net institutions are facing, Jackson has additional unique challenges. You are well aware that the South Florida economy has been one of the hardest hit in our nation. Unemployment continues to plague our community, property values have declined, the number of foreclosures is at an all-time high, sales taxes have diminished, costs continue to rise, private and government funding support has decreased, and we are home to one of the largest populations of uninsured and underinsured in our area. Our proximity to our neighboring Caribbean nations and the large undocumented population provide distractive challenges. These factors have all led to increased financial difficulties for Jackson's already-taxed public health services.

It is also important to note that within the last two decades, services included in the "mission" of JHS have grown through county policy decisions to consolidate all healthcare-related services in Miami-Dade County within the scope of the Public Health Trust. JHS operates under community expectations that the reduction of any safety net services is unacceptable. The financial impact of these factors was exacerbated by the impact of the severe economic downturn on tax-based revenue and the related increase in unemployment beginning in 2008. Also, the economic downturn has caused people to delay needed medical services, thus reducing patient activity in physician offices that results in fewer referrals to hospitals and increased competition among hospitals to attract physician referrals and patients for elective procedures. The year-end audit uncovered a material shortfall in the allowances for uncollectable accounts resulting in a net loss in FY 2009 of $259.2 million (excludes GOB).

For a historical context of our initiatives please refer to Attachment B.



The proposed FY 2010-11 budget is the first step in an action plan necessary for Jackson's survival. It will also lay the foundation necessary to launch longer-range changes to achieve financial sustainability. JHS faced huge challenges in FY 2009-10, including declining volumes, an increasing unfunded patient load, and rising costs and decreasing public funding resulting from a declining real estate market and lower revenues from sales taxes.

Significant financial shortfalls became apparent as a result of the FY 2009 audited financial statements. The primary drivers of declining performance were steady decreases in patient volumes and a decline in the percentage of charges collected from patients and third party insurers.

What We Have Accomplished

Jackson Health System

Fiscal Years 2009 and 2010 - Budget to Actual Comparison

(Excludes GOB & Special County Capital Contributions)

	FY 2009 Budget	FY 2009 Actual	FY 2010 Approved Budget	FY 2010 Projection
Net Patient Revenue	$ 1,312.6	$ 1,063.2	$ 1,270.5	$ 1,152.3
Other Operating Revenue	278.2	249.6	320.1	256.5
Total Operating Expense	1,968.6	1,944.9	1,944.7	1,836.1
Net Operating Results	(377.8)	(632.1)	(354.0)	(427.3)
Total Non Operating Items	388.4	372.9	347.5	349.7
Total Net Income (Loss)	$ 10.6	$ (259.2)	$ (6.5)	$ (77.6)

Dollars in Millions

A new direction was charted with a change in leadership including an entirely new management team. Together with the Public Health Trust board, the new leadership team organized to quickly address the financial crisis and develop numerous cash sustainability initiatives. The PHT board and JHS management began the transformation process with dramatic improvements in operational efficiency starting in June 2009, under my leadership. In a short time frame, we were able to implement drastic changes in our operations.

One of our first priorities was to restructure and strengthen the executive leadership team. While the number of overall executives was reduced, critical senior executives were recruited who are experienced in driving change in public teaching hospitals. This has led to the creation of a new administrative leadership team, which includes a new chief medical officer; new chief operating officer; an interim chief financial officer; a new chief information officer; a new chief nursing officer; new corporate directors in strategic planning, government relations, revenue cycle and public

relations; and a new chief administrative officer for Jackson Memorial Hospital. The team is committed to working cohesively to implement the changes that are needed for Jackson to continue to serve its mission, maintain its medical excellence and improve the overall patient experience.

One of our first sustainability initiatives was to examine all of Jackson's current expenses and eliminate waste, resulting in reducing administrative and management positions by more than 100 FTEs to improve efficiencies and cut costs. In addition, intense efforts are underway to reduce agency and overtime costs, improve inventory controls and other creative ways to cut unnecessary spending. While examining our expenses, we also engaged our entire employee base to re-examine the inner workings of the health system. We reevaluated existing processes and procedures to find ways to become more efficient and perfect our operations from the ground up. This is likely to yield additional cost savings in the near future. We are committed to improvements in our charge capture, billing and collection systems. We anticipate these improvements will generate additional funds in 2010, and have the most significant impact in FY 2011.

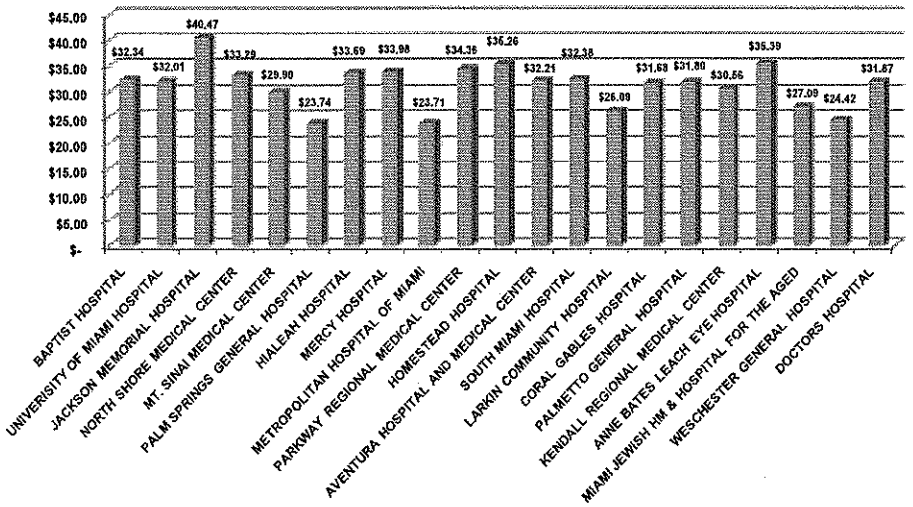
Throughout this process, we have strengthened our relationship with our primary academic partner, the University of Miami Leonard M. Miller School of Medicine, and continue to appreciate their support. Through renegotiations and restructuring of our agreements with them, we deferred approximately $56 million of our current debt to future years. We have also continued to grow our relationship with the Florida International University Herbert Wertheim College of Medicine.

Contributions from our employees were also tremendously important. Last year, we implemented salary and/or benefit reductions for executives, leadership and management groups. This year, successful negotiations with our labor unions resulted in contributions to the cost of our health insurance program equal to five percent of employees' base salary, among other savings. Longevity, merit pay and bonuses were also suspended. Similar contributions were made by non-union employees. Our labor partners have also been engaged in our sustainability efforts, helping to reduce costs through an innovative approach for employees to identify and implement improvements.

In streamlining our operations, we lost many members of our Jackson family as part of our workforce reduction initiative, beginning with management positions. This included the reduction of high-level senior vice presidents. This initiative generated savings of $4.8 million in FY 2010.

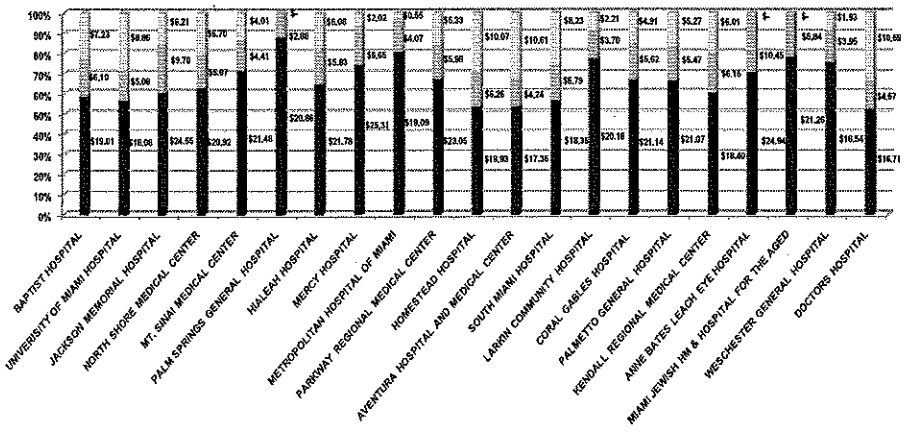
With these drastic changes, we are building a culture of accountability and transparency. This will be achieved, in part, by increasing employee communication and involvement through regular e-mail updates, town hall meetings, direct-mail access to our executive leaders and the implementation of various task forces. We intend to involve all employees in this process as change needs to occur at all levels of the organization. As seen in the following charts, JHS still competes with local competitors who have significant advantages in labor costs.

FFY 2010 Final Rule Medicare Wage Index Public Use File
Average Hourly Wage



Source: Average hourly wage data derived from Table 2 (Hospital Case-Mix Indexes for Discharges Occurring in Federal Fiscal Year 2008; Hospital Wage Indexes for Federal Fiscal Year 2010; Hospital Average Hourly Wages for Federal Fiscal Years 2008, 2009, and 2010; and 3-Year Average of Hospital Average Hourly Wages) included within the Centers for Medicare & Medicaid Services FY 2010 final rule changes to the acute care hospital IPPS and LTCH PPS (Federal Register Volume 74, Number 165).

FFY 2010 Final Rule Medicare Wage Index Public Use File
Average Hourly Wage Allocation



Source: Average hourly wage data breakdown derived from the Centers for Medicare and Medicaid Services FY 2010 Final Rule Wage Index PUF (Public Use File) obtained via www.cms.gov.

We have also increased the community's awareness of Jackson's critical role in caring in South Florida through media stories and editorials, speeches and appearances, outreach events, and greater involvement of elected officials and community leaders.

While managing such a large transformation, we felt it prudent to bring in expert assistance by engaging PricewaterhouseCoopers and utilizing SEIU's contract with the Sibery Group to assist in developing efficiencies with patient throughput.

Throughout this time of financial uncertainty, we have continued to provide top-notch medical care, attract talented physicians and experts, and engage in the national healthcare reform movement. As a testament to our continued success, Jackson Memorial Hospital was once again named one of "America's Best Hospitals" by *U.S. News & World Report*, a very high honor. Jackson Health System was also honored by the National Association of Public Hospitals (NAPH) for its work in providing much-needed medical services for the injured after the January earthquake that devastated Haiti. Jackson cared for approximately 205 patients at five of its hospitals (Jackson Memorial Hospital, Holtz Children's Hospital, Jackson North Medical Center, Jackson South Community Hospital and Jackson Rehabilitation Hospital).

Unfortunately, strides to improve efficiencies, streamline processes and procedures, and cost-cutting measures were not enough, and additional projects have been identified to bridge an even larger financial gap in FY 2010-11, initially estimated at a shortfall of $346 million. Working with the PHT board, JHS employees and Miami-Dade County leadership, the plan for FY 2010-11 continues cash sustainability measures to drive improvements totalling approximately $177 million.

Additionally, JHS leadership has developed other cost-cutting and revenue-enhancing initiatives for FY 2010-11 that focus on improving processes, staffing to volumes, re-evaluating supplier arrangements, and growing volume throughout the system. This includes implementing labor and productivity measures to bring JHS to a performance level that is at the top 25 percent of productivity for similar high-performing healthcare organizations by the end of FY 2011, centralizing patient registration to improve the data captured to bill and collect properly, and renegotiating both supplier and payer contracts.

In addition to these overall institutional changes, improvements, and plans for 2011, each of our JHS divisions have specialized implementation plans for strategic initiatives and increased efficiencies. Our nine overarching entities are: the Jackson Memorial main campus, Jackson North Medical Center, Jackson South Community Hospital, Jackson Towers, Community Medical Practices, Nursing Homes, JMH Health Plan, Corrections Health Services, and Primary Care Centers.

Jackson Memorial Main Campus

The Jackson Memorial main campus encompasses all of our downtown medical facilities including the system's flagship hospital, Jackson Memorial Hospital (JMH). Also included are Holtz Children's Hospital, Women's Hospital Center, Jackson Rehabilitation Hospital, Jackson Mental Health

Hospital and the Ambulatory Care Centers. As the system's centerpiece, Jackson Memorial Hospital is home to a majority of the system's staff and is a teaching hospital for the University of Miami Leonard M. Miller School of Medicine. It has long been a focal point for operational improvement initiatives.

JMH Nursing Services have continually made adjustments to service capacity to match patient demands. JMH increased service capacity with a 15-bed Palliative Care Unit that opened in the summer of 2009 and eight private rooms for orthopaedic/neurology/spine services. During the same time, inpatient acute care beds were consolidated, closing two units to maximize bed utilization. Through the restructuring of nursing services between October 2008 and 2010, JMH has achieved a 40 percent reduction in the cost of temporary nurse staffing and overtime. To create a culture of continuous improvement, nursing staff involvement in Unit Practice Councils has resulted in implementation of cost-saving measures and quality improvement measures at the unit level. There are currently 83 active Unit Practice Councils throughout the health system.

JMH Pharmacy Services achieved improvements in "charge capture," resulting in $26.5 million in increased gross patient charges. By focusing on eliminating unnecessary utilization while improving quality of care and utilization of discounted pricing, drug costs have been reduced by $14 million this fiscal year. A reduction in work force of 26 FTEs resulted from schedule modifications to optimize productivity, shared workload among the three campuses (Jackson Memorial, Jackson North and Jackson South) via our electronic order management system, and reduction of management positions by the redesign and redistribution of job responsibilities.

Radiology and Imaging Services at JMH have eliminated 45 FTEs since 2009 by increasing the expected technical productivity levels from the 25th percentile to the median and close management of overtime costs. An additional $1 million in revenue enhancement has been achieved through enrolling in additional funding sources for screening mammography and increasing staffing for second- and third-shift emergency OB/GYN ultrasounds and increases in outpatient pediatric procedures.

JMH Laboratory Services support the main campus operations as well as Jackson North Specialty and Diagnostic Center, North Dade Health Center, Jefferson Reaves Sr. Health Center, South Florida AIDS Network, Prevention Education & Treatment Center (PET), Dr. Rafael A. Peñalver Clinic, South Dade Homeless Assistance Center Clinic, and Corrections Health Services. The laboratory is also the reference laboratory for Jackson North Medical Center and Jackson South Community Hospital, providing all microbiology and immunology testing for all facilities. Since 2009, FTEs have been reduced by 26, and overtime utilization was reduced to less than 2 percent of the total worked hours. Tests previously outsourced were brought in-house at a savings of $400,000.

Through implementation of value analysis and engaging stakeholders, JMH has reduced the cost of medical implants (which is one of the most significant costs of many procedures) by standardizing care and reducing the number of vendors. For example, in total joint replacements, we have been able to reduce the cost from $2,700 to $1,500 per implant. In addition, we have engaged medical device vendors to provide funding for uninsured patients who require implants.

During FY 2009-10, improvements in surgical services have been a result of consolidation of services, reorganization of management functions and increased efficiency. In total, 37 FTEs were eliminated since 2009. In the two major measures of operating room efficiency, JMH has made substantial improvements. Prior to this fiscal year, the first surgical case of the day started on time only 47 percent of the time. Today, as a result of focused improvement efforts, 80 percent of "first cases" start on time. Another indicator — the length of time it takes to prepare a room for the next surgery — has improved by nearly 30 percent. These efficiencies result in an annual savings of $2.8 million. While increasing efficiency in surgical services, JMH also increased capacity and expanded services. During FY 2009-10, two operating rooms for minimally invasive surgeries and one pediatric catheterization lab were opened.

The emergency departments (ED) in Jackson Health System are the primary portal of entry for inpatient services, with 70 percent of hospital admissions initiated through the EDs. But patients admitted to a hospital represent only 20 percent of the total ED volume. For FY 2008-09, the emergency departments in Jackson Health System evaluated 225,000 patients.

The Jackson Memorial Emergency Department was a logical starting point for aggressive performance improvement efforts. These included streamlining the patient experience to reduce the amount of time a patient spends both waiting for and receiving the care they need. In FY 2008-09, we opened an observation unit and expanded our express care services. As a result, patients requiring inpatient services were admitted 17 percent more quickly, and those able to be treated and discharged stayed in the ED nearly two hours less than in prior years. The same improvements that are so beneficial to the patient also create capacity for others who need the care that only JMH can provide. The number of patients who came to the ED, but left without being seen, declined by 21 percent. Also, the number of hours when the JMH EDs (adult and pediatric) were so busy that patients arriving by ambulance were diverted to other hospitals decreased by 53 percent. As a result of these concentrated efforts, labor costs were reduced by $3.3 million and gross revenue was increased by $11 million.

The Support Services Division (SSD) includes Nutrition Services, Engineering Services, Environmental Services, Capital Projects Administration and Property Management. Although headquartered at JMH, Support Services covers the entire health system. Primary focus points of the Support Services budget to reduce expenses have been to reduce and eliminate overtime, reduce and consolidate system-wide service contracts, and minimize supplies throughout departments without jeopardizing patient safety. Overtime has been drastically reduced from an actual expense of $1.6 million in FY 2008-09 to a projected actual expense of $600,000 in FY 2009-10 and will continue to be reduced in FY 2010-11. SSD will focus on filling mission-critical vacant positions to reduce overtime costs, and will implement a plan to evaluate staffing patterns throughout the division. This fiscal year, staff numbers are being reduced by an estimated 30 FTEs to a projected reduction of actual salaries and benefits of $1.5 million from the FY 2009-10 budget. Supplies have been reduced within SSD by $1.6 million from the FY 2009-10 supplies budget. SSD currently is working on a consolidation of maintenance contracts for a projected reduction in purchased services of $1.7 million during this fiscal year.

Holtz Children's Hospital and the Women's Hospital Center have focused on increasing efficiency through service consolidation and improved productivity. As a result, total FTEs declined by 123 during FY 2009-10. Labor and delivery operating rooms were consolidated with the JMH surgery department to improve quality and efficiency. At the same time, two new pediatric operating rooms were opened. During FY 2009-10, half of the comprehensive consolidation effort for Holtz was completed. The balance will be completed in FY 2010-11. Women's and Children's have implemented unit scorecards to drive performance and accountability to the unit level. This has enabled identification of opportunities in charges, revenue mapping, increased unit competition and involvement of staff in financial metrics.

The groundbreaking Fetal Surgery Program was also launched in this fiscal year. This unique service provides intrauterine interventions saving fetal lives, which in most cases would be otherwise unviable. The program exceeded planned volume projections in its first year and generated $8.5 million in charges.

The new 30-bed Pediatric Intensive Care Unit and dedicated pediatric cardiac catheterization lab opened this year.

It is also exciting to note that for the second consecutive year, *U.S. News and World Report* officially ranked Holtz as one of the "Best Children's Hospitals" in the country based on clinical outcomes. Holtz was ranked 24th on the specialties list for diabetes and endocrine disorders and 25th for neonatal care.

The Ambulatory Care division consists of outpatient clinics housed on the main campus, four Primary Care Clinics and five specialty care clinics located throughout Miami-Dade County. The main focus of operations in FY 2009-10 has been centered on improving operational efficiencies in preparation for healthcare reform and, therefore, improving our customer satisfaction to be the preferred choice for outpatient care. Particular attention was given to unit environments and securing the facilities after hours to address safety concerns. Steadily decreasing volumes and the establishment of other community-based organizations (CBOs) resulted in the suspension of some services of the division and right-sizing the organization. Service suspension included the Care-A–Van program and both North Miami and Juanita Mann health centers. Both centers required major capital expenditures and had steadily decreasing volumes. A thorough review showed available services to serve our community through other free clinics and CBOs in close proximity. Additionally, the Ambulatory Care Division streamlined middle-management positions, reducing labor costs by approximately $1.5 million. Further Primary Care Center (PCC) and main campus Ambulatory Care Center (ACC) clinic restructuring occurred after a review of ACGME training requirements/utilization and volumes. This resulted in an additional reduction in workforce of more than 100 FTEs, reducing labor expenses by approximately $10.5 million.

In spite of the declining volumes, both the ACC clinics and PCCs collaborated with our Revenue Cycle division and instituted point-of-service collection of co-payments generating more than $500,000 in additional income through the end of July 2010, with projections of more than $1

million by the end of the fiscal year. Further operational efficiencies were gained by integrating the PCC dental department into the clinic dental department at JMH.

One of the keys to sustainability in this area of care is the provision of services with the least cost. Several new initiatives were instituted in FY 2010. For example, Ambulatory Care now oversees the follow-up of newborns with hyperbilirubinemia. A "Bili-Baby Clinic" was created in our pediatric primary care clinic, shifting this care from Holtz Children's Hospital (which has a higher cost) to a clinic setting. Also, non-emergent gynecological patients are now being seen in the clinics instead of in our Emergency Departments.

Jackson Mental Health Hospital provides a full continuum of care to children, adolescents, adults and seniors with psychiatric disabilities. The main focus of operations this fiscal year was centered on improving operational efficiency to increase patients' satisfaction while enhancing revenues and program growth. Several key projects included the expansion and restructuring of our Mental Health Outpatient Programs, streamlining the delivery of services to our patients. The opening of an outpatient, adult Partial Hospitalization Program (PHP) is generating opportunities for business growth. Since its inception, the PHP's average daily census has been 13 patients with monthly gross revenue averaging $92,000. For inpatient services, two inpatient units were restructured to match resource consumption to volume and care needs. Additionally, renegotiation of the state-wide Inpatient Psychiatric Program (SIPP) contract for three years resulted in savings of $92,000 and a total contract value of $8 million.

Corporate functions at JHS are those that support all the operating business units. While not directly related to patient care, world-class support functions are essential to world-class clinical operations. During a time of financial stress, it is easy to assume that administrative functions can be eliminated. In fact, an investment in a support service may improve both clinical and financial performance more than an equivalent investment in direct patient care. The indirect value of these functions increases the need to justify each expenditure. As a result, these core corporate functions are herein described individually.

Labor and benefit costs represent approximately 59 percent of JHS' total expenses and is managed by Human Resource Capital Management (HRCM).

The recruitment, development and performance evaluation of the employees is a critically important corporate function. While all direct service positions in the Human Resources division were maintained this fiscal year, there have been numerous other reductions in staff, while at the same time maintaining quality service for all JHS employees. These improvement efforts resulted in a decrease of 13.6 FTEs and $200,000 in purchased services.

Specific cost reduction and efficiency efforts include redesign of workflow for Occupational Health while increasing services to the Jackson workforce as evidenced by increased vaccinations. This department achieved a 29 percent decrease in FTEs. In addition, there was a focus on services provided by vendors to assure that JHS received full value under each contract. Two specific examples were a 38 percent decrease in cost for employee drug screening and an expansion in work-

life resources for employees at no additional cost. The Worker's Compensation Program continues to realize cost reductions year after year. Improved service, reductions in lost work days, and reductions in restricted work days for injured employees have generated a $3.5 million cost reduction since inception. Integration between our Benefits and Leave Management departments has resulted in better control over benefit expenses through awareness of the employment status and leave status of our employees. Those efforts have continued with a new contract for a Third Party Administrator.

The Quality and Patient Safety division is charged with developing a standardized and integrated approach to quality and patient safety. While quality care is the priority of the division, cost reduction is an expected outcome because in health care, high quality, efficient care costs less. A key initiative during this fiscal year was to streamline case management and social work interventions and processes. The most impactful element of this effort is the implementation of an integrated unit-based care management model. This collaborative approach to managing the patient's care at the appropriate level based on acuity is the prerequisite for planned reductions in length of stay and increased capacity in specialty care units. This will drive financial improvement in FY 2010-11. In addition, palliative care services have been expanded to better match resource requirements to care needs during the last days and weeks of a patient's life. As a corporate function, care management has been expanded to include both Jackson North and Jackson South. This will assure consistency across the system.

Utilization Management Services implement cost-avoidance and revenue enhancement initiatives within JHS. Both of these benefits are generated by managing the timeliness and efficacy of the care delivered and assuring that patients are seen in the lowest cost environment. Some of the areas of increased efficiency have been chemotherapy utilization, high-cost therapy, non-formulary pharmacy items, implantable devices and radiation therapy. In order to be sure that JHS services are used appropriately, Utilization Management began reviewing all requests to our Transfer Center for clinical necessity for transfer and potential funding sources. All non-county residents who come to the emergency room for stabilization are also reviewed. As a result, JHS has achieved a cost avoidance of approximately $3 million per month during this fiscal year.

Renal dialysis is one of the most challenging services to manage for safety net hospitals because it is a costly, lifelong service that would otherwise be unavailable to patients with no funding sources. At JHS, the Renal Management Department oversees our outsourced adult dialysis department and the contract with other dialysis centers to fund care for the uninsured. As a result of its efforts, the cost of dialysis for unfunded patients has declined by $1.6 million in FY 2009-10.

The focus of the Revenue Cycle Division is to optimize integration within the system and achieve optimal financial performance. A series of process improvements and tactics are focused on increasing net patient revenue and decreasing bad debt expense. These initiatives are organized in three major areas: patient access and registration, coding and pricing, and billing and collections.

The primary focus for patient access during FY 2009-10 was to enhance the registration and financial clearance process utilizing current resources. By transferring and training underutilized

personnel from other areas of the system, both cash collections and billing accuracy were improved. Specifically, point-of-service cash collections improved by 20 percent or $4 million. Additionally, the improvement in registration accuracy supported the increase in the "clean claim" rate to 67 percent. A total of 44 FTEs were eliminated by more efficient scheduling and improved process flows.

One of the keys to long-term sustainability is the implementation of a system-wide electronic medical record. Our Health Information Management Department is the junction between clinical documentation of care and accurate billing for those services. This department must ensure the accuracy and security of clinical information while optimizing cash flow for the system. In 2010, the total FTEs in the department were reduced by 25. In addition, the accounts receivable inventory of medical records that were on hold for coding after discharge and before billing went from $60 million to $15 million. This significantly improved cash flow for the health system.

The single largest asset of JHS (besides bricks and mortar) is patient accounts receivable. Our Central Business Office (CBO) has responsibility for billing more than 900,000 patient encounters and collections of more than $1.1 billion in cash every year. As the final stage in the revenue cycle process, the CBO partners with all departments to ensure that JHS receives the funding necessary to meet it mission. The CBO eliminated 70 FTEs during FY 2009-10, which was the third year of the creation of the Corporate Business Office, a combination of all three major facilities and clinics into one unit under one leadership team. In addition, a substantial effort in FY 2009-10 has been to collect old accounts that were not processed effectively in prior years. This reduced our accounts receivable by $50.5 million.

During FY 2009-10, JHS technology costs were reduced from FY 2008-09 by eliminating 23 FTEs and an additional $4.4 million in supplies and purchased services. These savings were achieved with a combination of initiatives spanning the breadth of our Information Technology operation, including changing the contractual arrangement with IBM for the mainframe, eliminating contracts that were no longer required and completing the Lawson Enterprise Resource Planning (ERP) implementation.

Corporate integrity is essential in the heavily regulated healthcare industry. Effective compliance and internal controls serve both as defensive and offensive tools for hospitals. The existence of a corporate compliance function that complies with government regulations mitigates the risk of financial penalties should there be an investigation of an error. In addition, leading-edge internal audit and compliance functions serve as a critical monitoring and feedback loop to identify the root causes of errors and assure that the operating changes required to eliminate the causes are made in a timely manner. This serves both the revenue enhancement and cost-reduction objectives of the organization. At JHS, based on the review of the annual Office of Inspector General (OIG) work plan and risk assessments, an annual compliance program audit plan is developed and evaluated monthly based on investigation-triggered audits and special projects. Audits focus on medical necessity, proper documentation, coding, billing and reimbursement. Upon completion of a compliance audit, errors are reviewed with the department administrators to establish corrective

action. The department is re-evaluated periodically to assure effective implementation of the corrective actions.

In addition to traditional internal audit responsibilities for testing and reporting on the effectiveness of internal controls, the Internal Audit Department at JHS has responsibility for compliance with public records requests and performing fraud-related audits should they arise. These additional responsibilities impede the ability of the staff to execute an annual audit plan that would further the cost-reduction and revenue enhancement objectives of the system.

The primary focus in the Supply Chain Management Department this budget year has been to implement a new Enterprise Resource Planning (ERP) system for our division, increase expense reduction initiatives and ensure supply expense reduction throughout the system. We have focused on inventory reductions, cost savings and service level improvements in the patient care units and various support and clinical areas. Inventory in our supply automation units has decreased from June 2009 to June 2010 by approximately 38%, from $10.9 million to $6.8 million. Our service level improvements, as measured by a "stock out" rate, has improved 28%, although we experienced our highest level stock outs in November due to Lawson ERP going live and then financial challenges with vendors that were placing supply accounts on credit hold or prepayment status.

The ERP support team continues to be partially supported with an employee from our Value Analysis Team. We have maintained momentum and focus with an estimated $1.8 million supply chain spend reduction initiative in FY 2010. Our internal financial sustainability (FS) projects continue to deliver benefit in many different functional areas with an estimated benefit in FY 2010 of $4,107,000. Two of our FS projects have been fueled recently with greater partnership and collaboration with the SEIU and AFSCME Efficiency Task Forces throughout the organization. These two projects are inventory management and increased use of reprocessed/remanufactured supplies. The reprocessing initiative is an environmental and financial sustainability project.

Reprocessing has shown an estimated 33% growth annually since its start and is on target for $1.5 million in savings for FY 2010. Physician and clinical support is critical to the success of both programs. The FY 2011 proposed budget includes a reduction in funding for related supplies.

The proposed FY 2011 budget is focused on reducing cost and ensuring the necessary resources are in place so that Procurement Management can serve and deliver the requirements of Jackson's many user departments. The department underwent a restructuring that resulted in the elimination of eight budgeted FTEs (including three vacant positions). The workload was redistributed among the remaining 30 staff members. Currently Procurement Management is in the process of working many priority solicitations focused on the Jackson Centers of Excellence. Among the most significant projects that will be completed during the 2010 fiscal year include:

- Group Purchasing Organization (GPO) Services – new contract
- Food/Nutrition Services – new management contract
- Ambulatory Pharmacy Management Services – new operation

- Multi-Function Device Print Management Services – printing and copying machines
- Budget Analysis and Product Line – replacement system

Additionally, the following large projects were started during the current fiscal year and will be completed in FY 2011:

- Collection Agency Services
- Enterprise Biomedical Services – management contract
- Correctional Healthcare Services – management contract
- Waste Management Services – new contract
- Pharmacy Distribution – new contract

All of these projects are aligned with the transformation of JHS into a sustainable and financially viable organization. Moreover, the projects noted above have been designed to produce cost-saving results in the form of improved processes, reduction in spending and FTE realignment.

Jackson North Medical Center

Key objectives at Jackson North Medical Center during FY 2009-10 were to improve the hospital's financial performance compared to FY 2008-09 by improving efficiencies in operations and reducing expenses, while at the same time continuing to focus on growth, and ensuring high quality and excellence in patient and physician services and satisfaction.

The leadership team at Jackson North reduced FTEs by 100, including reduction of overtime and agency usage, resulting in a reduction in total salary costs as a percentage of operating expenses from 57 percent in 2009 to 55 percent in 2010. In addition, purchased services decreased by 11 percent. The care protocol for mental health and neurosurgical patients was changed to a more efficient model. Today when these patients arrive at Jackson North, they receive the necessary care to stabilize their condition and receive medical clearance for transfer to Jackson Memorial. In addition to improving outcomes for these patients, Jackson North reduced expenses by $3.6 million in FY 2009-10.

While increasing operating efficiency, Jackson North also improved operations to mitigate the volume declines being experienced by community hospitals nationwide. Patient access was improved as evident by a decline in the number of people who leave the emergency room before being seen by a physician from 8% to 3.8%. Net patient revenue was improved on the existing patient volume through increased efforts to qualify uninsured patients for Medicaid and improvements in documenting the services provided. The result of these revenue enhancement efforts was $1,000 in additional net patient revenue per admission. For outpatient services, the increase was $360,000 annually.

Offsetting the industry and market declines in volume, growth at Jackson North during FY 2009-10 was accomplished through the recruitment of 20 new physicians to the medical staff, the launch of a

marketing campaign and implementation of two new programs — certification as an Advanced Primary Stroke Center and state approval for a Percutaneous Cardiac Intervention program.

Jackson North is also affiliated with the Florida International University of Herbert Wertheim College of Medicine and in 2010 welcomed their first class of 43 students.

Jackson South Community Hospital

In 2005, the system received approval from county voters for a General Obligation Bond to fund the expansion of Jackson South Community Hospital. Throughout FY 2009-10, construction has proceeded on 160,000 square feet of new space and 23,000 square feet of renovations. Minimizing Jackson South's financial losses and improving overall efficiencies was the primary objective of FY 2009-10. The hospital faced difficult decisions, which included the consolidation of Obstetric Services into those at Jackson Memorial Hospital. This decision was recently overturned by the Board of County Commissioners, causing additional financial challenges. During FY 2009-10, Jackson South reduced FTEs by 63, including reduction of overtime and agency usage, resulting in a reduction in total salary cost as a percentage of operating expense from 67 percent in FY 2008-09 to 65 percent in FY 2009-10. Total FTEs per adjusted occupied bed ratio is now 4.34, well below the approved benchmark. Average length of stay was also improved, decreasing from 4.13 to 3.99 days.

JMH Health Plan *[Managed Care]*

The primary focus in FY 2010 has been establishing a foundation upon which the health plan is in position to grow and increase its margins in FY 2011 and beyond. The considerable developments established in FY 2010 included systems conversions, staff reductions, a new Medicare Risk Product, strategies to bring additional PHT and county members into the JMH Health Plan, audit and recovery services to manage expenses, and contract renegotiations to align expenses with products and to obtain more favorable pricing for pharmacy services.

For FY 2011, there are three initiatives designed to build upon the foundations and grow the product. The Public Health Trust membership initiative will utilize the JMH Health Plan (JHP) as the sole source provider of medical benefits to the employees of the Public Health Trust. The second initiative is to create and develop the Exclusive Provider Organization (EPO) network. This will establish a network market niche around the Jackson Health System hospitals utilizing community providers who have admitting privileges at JHS. It will offer a competitively priced product to small employers and individuals who are geographically located around the JHS facilities. The third initiative is to develop and implement Management Service Organization (MSO) arrangements. MSOs are designed to grow the Medicare and Medicaid membership while also providing a better mechanism for managing the medical expense for this high-cost population.

These initiatives will help the JHP membership to increase by 20,000 members in FY 2011 while at the same time contributing an additional $7.9M to the plan's operating profits. In doing the financial modeling, we assumed the commercial medical loss ratios would be about 1% higher than our existing commercial business, which we believe is reasonable given the other claim cost initiatives

implemented in FY 2010. On the additions to the Medicare and Medicaid membership we assumed a three-point improvement in medical loss ratios due to the more aggressive medical expense management of the MSOs.

Corrections Health Services

JHS provides healthcare services to the Miami-Dade County incarcerated population at five unique facilities. A comprehensive set of services are available consistent with community healthcare standards. While Miami-Dade County has had a decline in the number of prisoners, the patient encounters for Corrections Health Services (CHS) have grown because the population is older and sicker, requiring chronic and acute care medical and mental health treatment.

Operational efficiencies during FY 2008-09 and FY 2009-10 were gained through several initiatives, including a large reduction in pharmacy costs due to improved drug controls and utilization management. Offsetting these savings, CHS converted a number of licensed practical nurse positions to registered nurse positions in order to enhance the staffing mix and meet government guidelines in the delivery of care to an incarcerated population.

Moving Forward – What's in Store for FY 2010-11?

Jackson Health System

Fiscal Years 2009 and 2010 - Budget to Actual Comparison Plus FY 2011 Proposed Budget

(Excludes GOB & Special County Capital Contributions)

	FY 2009 Budget	FY 2009 Actual	FY 2010 Approved Budget	FY 2010 Projection	FY 2011 PHT Approved Budget
Net Patient Revenue	$ 1,312.6	$ 1,063.2	$ 1,270.5	$ 1,152.3	$ 1,190.5
Other Operating Revenue	278.2	249.6	320.1	256.5	385.4
Total Operating Expense	1,968.6	1,944.9	1,944.7	1,836.1	1,905.2
Net Operating Results	(377.8)	(632.1)	(354.0)	(427.3)	(329.3)
Total Non Operating Items	388.4	372.9	347.5	349.7	318.0
Total Net Income (Loss)	$ 10.6	$ (259.2)	$ (6.5)	$ (77.6)	$ (11.3)

Dollars in Millions

The FY 2010-11 proposed budget represents a survival plan for Jackson but maintaining safety net services does not assure financial sustainability. Sustainability will only result from recapturing market share through working with our physician partners, rationalizing the services we can realistically provide, effectively growing the health plan to capture the coming market for the newly

covered patients under healthcare reform, and investing in outpatient modalities that will allow us to compete for patients in non-acute settings. Competition for JHS' traditional patients is already here and growing as competitors position themselves to participate in this expanding funding source. This only increases the pressure on JHS to renew itself so it can be financially viable to continue to carry out its mission. This budget is a first step in achieving long-term sustainability.

Jackson Memorial Main Campus

At Jackson Memorial main campus, caring for patients is the JHS core process. To be truly sustainable we must continually strive to be the best healthcare value for both cost and quality. Programs initiated in FY 2010 will continue in FY 2011 as we refine and improve care delivery. Clinical documentation improvement and unit-based care management programs will also be expanded to Jackson North and Jackson South. Emergency Department care management services will be expanded to provide 24/7 coverage. These improvements should increase the JHS operating margin by $14.8 million in FY 2010-11.

Improvements in utilization management will continue cost avoidance and generate incremental revenues in 2011. Additional emphasis will be placed on enhancing the controls on specialty referrals for the uninsured through the Access Plus program. Strategies are in place to develop and implement evidence-based order sets and a full palliative care admission service. These efforts will have a $3.6 million benefit to the system. The primary initiative for improved utilization in outpatient renal dialysis is to convert all unfunded/undocumented patients currently in the outpatient dialysis program to Emergency Medicaid and to reduce the number of patients in outpatient dialysis. As a result, dialysis expenses will be reduced by $550,000 for the fiscal year.

Planned improvements in the laboratory focus on utilizing technology to eliminate labor-intensive manual processes. A robotic system for sample preparation is planned for the core laboratory. By automating manual processes, lab capacity is increased. This allows Jackson Memorial to bring in additional volume, reducing the costs per test and increasing revenue. The campus-wide pneumatic tube system will eliminate the need for hand-delivery of samples to the laboratory. Patient care will be enhanced by this system because samples will be received in the lab sooner, improving the timeliness of lab results.

Continued efficiencies in surgical services will be achieved through consolidation of all pediatric surgical cases into the new pediatric operating rooms. The focus in surgical intensive care will be to decrease length of stay by making sure that patients are in the best care level to meet their clinical needs. Patient and physician satisfaction will be improved by planned improvements in the staffing and operation of the pre-operative unit. Reduced length of stay in these high-acuity areas opens capacity for those patients waiting in the emergency departments. Also, a new focus for the staff will be to improve controls concerning recording all charges for each surgical case. This will result in improved net patient revenue. The cost management in the department will be further refined through monitoring and reporting on cost per case and cost comparisons by surgeon.

A substantial improvement in outpatient pharmacy services will be achieved through contract management of retail pharmacy operations. The annual benefit is projected to be more than $3.4 million due to cost avoidance, enhanced revenue opportunities, and cost savings from improved efficiencies. Also, with the continuation of a FY 2009-10 initiative, JMH will achieve projected inventory savings of $1 million by optimizing purchases, reducing inventory levels, improving personnel efficiencies through expanded utilization of Omnicell pharmacy carousel and an additional $1.5 million in FY 2011.

The improvement initiatives in clinical services will continue in FY 2010-11 with scheduling automation for the Pulmonary Lab. Integrated patient care rounds in the cardiovascular units will be utilized to reduce length of stay, and improve allocation of services and patient satisfaction. Patient care areas will be reconfigured to increase private ICU rooms and decompress the emergency area. The approval criteria for device insertion will be further refined to improve patient care and reduce cost of implants. A new Catheterization Lab Suite is planned to improve physician satisfaction and increase the lab's capacity.

Support Services will continue its cost-reduction efforts with specific improvements across all departments, including Nutrition Services, Environmental, Biomed, Laundry and Linen, and Waste Management Service. We are renegotiating with current vendors and consolidating contracts in Laundry and Linen and Waste Management Service. Outsourcing through an RFP process is projected to produce savings in Clinical Engineering Services and Nutrition Services. Savings will be realized through standardization, improved productivity and contract consolidation in Environmental Services. The cost reduction efforts are expected to yield $9.4 million.

Improvements in the Revenue Cycle division must be continuous. Specific initiatives for FY 2010-11 have been developed for each major area. In patient access, centralized registration will be fully in force for the first time, along with comprehensive eligibility assistance for patients presenting in any setting, inpatient and outpatient. This will result in additional improvements in accuracy of billing information and increased funding for previously uninsured patients. Improvements to patient access are expected to increase patient net revenues by $31.3 million.

The other areas of Revenue Cycle will continue on the path to improvement. Also, there will be incremental efficiencies through improved coding quality and outpatient coding resulting in $2.8 million in new net patient revenues. The Managed Care Department will continue its improvements, estimated to be $2.7 million for FY 2011. In the Central Business Office, reorganization of workflow and improved vendor management for necessary collection agencies will result in $38.4 million of additional net patient revenue for JHS. The pricing charge capture initiative combined with the anticipated cost report recoupment is expected to generate an additional $14 million.

Technology is an essential element of the transformation plan for JHS. Many of the strategies of the operating units are only achievable with an effective, contemporary IT infrastructure and operations. The Information Technology Division is responsible for the execution and management of tactics that support the entire operating strategy. It is equally as important to manage the investment in

technology as its functionality. During FY 2010-11, a number of initiatives are planned to deliver the balance of resource management and technology that supports the enterprise strategy.

In FY 2010-11, the IT division is planning for two initiatives to directly generate revenue. The first is to achieve meaningful user status at JHS, which can increase net revenue by $5.6 million. The American Recovery and Reinvestment Act (ARRA) of 2009 established criteria for incentives that will be paid out to healthcare providers who demonstrate meaningful use (MU) of health information technology (HIT). To qualify for these incentive payments, healthcare providers are required to implement and demonstrate extended use (90 consecutive days) of HIT. JHS is well positioned to qualify for these incentives in 2011 with some final technology investments. The second opportunity is an expansion of the JHS commitment to serve the healthcare needs of the Caribbean. In partnership with Philips, JHS will leverage existing technology capabilities to provide PACS data warehouse and infrastructure services to other hospitals in the Caribbean. In short, we are "selling" our excess storage capacity to smaller hospitals. The initial pilot consists of 50,000 studies at a mark-up price of $3/study. Projected revenue is $150,000. This revenue stream has the potential to grow as the initial Caribbean customer performs 250,000 studies a year, and there are other customers interested in the service. As a part of the overall effort to reduce spending at JHS, the IT division will reduce expense by in-sourcing technical support. Current outsourcing agreement expense will be reduced by $150,000 as the positions are transitioned to internal positions. An additional $900,000 in savings will be achieved by migrating legacy revenue cycle systems to a less costly platform. This strategy will retain access to historic data in read-only format. Finally, by co-locating the JHS network and servers with Miami-Dade County, $600,000 of lease costs can be eliminated.

Technology is a capital intensive area and therefore a significant amount of the total capital expenditures at JHS are for new equipment and applications. The IT management team has identified two strategies to reduce the capital requirements in FY 2010-11. By building a virtual server infrastructure, JHS will avoid $500,000 in capital replacement of the old servers. Also, by converting the old, fragile e-mail services to "cloud computing," $1.5 million of replacement costs will be eliminated. Essentially, rather than making substantial capital investments to messaging-related servers and storage infrastructure, JHS will outsource e-mail services. By doing so, ongoing support costs will decrease, as well as those costs related to capacity and obsolescence planning.

During FY 2010-11, Women's Hospital Center and Holtz Children's Hospital will focus on several growth and expense reduction initiatives. Physician recruitment is central to the service line priorities in orthopaedics, gastroenterology, cardiology, ambulatory day surgeries and obstetric deliveries. Planned reductions in expenses include a thorough analysis of staffing ratios and consolidation of an additional nursing unit.

Pediatric orthopaedics is a revenue-generating service line with favorable margins. This is a high-volume program that has operated beyond capacity for many years. By recruiting an additional pediatric orthopaedic surgeon and a nurse practitioner, JMH could serve an incremental 155 inpatient cases and 345 incremental outpatient cases. This increase in volume will result in the

generation of $2 million in operating income. With increased capacity, the volume growth will come from retaining the patients who are currently referred to Holtz by community physicians and through transfer agreements with other hospitals. Because of capacity constraints, patients are currently referred to Miami Children's Hospital. These patients could be retained in the system.

Like orthopaedics, gastroenterology (GI) growth requires the recruitment of two new physicians. One of the strongest child health services at Holtz, pediatric GI is currently at capacity. A modest impact of 114 incremental inpatient cases and 196 incremental outpatient cases will be achieved in FY 2010-11. The demand for pediatric GI services exists currently, but JMH does not have physician capacity or supporting staffing to serve them. In this case, aggressive recruitment is essential to achieving this growth. This increased volume will result in $200,000 in operating income.

Upgrading and consolidating pediatric ambulatory facilities will provide for comprehensive, family-centered care. This facility will include ambulatory surgery, diagnostic imaging and clinic space. It will support the growth of existing and development of new, innovative programs. Finally, it will position us in a partnership with Children's Medical Services (CMS), which could stabilize programs and funding for decades. Currently, substantial volumes of patients are lost to other providers in the market because existing facilities provide poor access for patients and are both inefficient and unsuitable for pediatric care. The growth in ambulatory services will build on the strength of the current medical staff.

The business plan for the incremental growth of the pediatric cardiology service includes recruitment of a second pediatric interventionist/intensivist, a general cardiologist (preferably with fetal training), a nurse practitioner and a pediatric psychologist. Conservatively, these additional providers will serve 670 incremental patients in FY 2011 and generate $600,000 in additional net income for JMH.

Growth in obstetrics drives revenue in its service line but also results in downstream revenue in other areas of the system. With the recruitment of an additional obstetrician and a nurse practitioner — and development of concierge services and upgrades to services and facilities for obstetrical patients — an additional 300 deliveries could take place at Jackson. Increases in deliveries are expected to result in downstream revenue, including a potential 15 Level III and 45 Level II neonatal intensive care admissions, as well as 10 pediatric surgeries.

The consolidation of an additional nursing unit into Holtz Children's Hospital will result in the reduction of 18.5 FTEs, totalling $1 million in savings.

To further sustain the financial viability of Jackson Mental Health Hospital, the focus for FY 2010-11 is on growth and expansion of services, including the criminal justice initiative, and enhancing the adult Partial Hospitalization Program to include a Spanish track. The Spanish track is expected to generate $240,000 in net revenue and requires two additional certified therapists at a cost of $160,000. The Mental Health Hospital also secured its first Agency for Healthcare Research and Quality (AHRQ) research grant from the U.S. Department of Health and Human Services for

$300,000. Finally, the 10-bed Medicine-Psychiatry Inpatient Unit planned to open in April 2011 is estimated to increase annual operating margins by $1 million.

Physician Services

Physician Services across the Jackson campuses are designed to meet the medical needs of the public and the educational needs of our partners, the University of Miami and Florida International University. The number and types of physicians needed vary and are determined by the number of patients we must treat and that are needed to provide an appropriate patient load for teaching. This volume of patients and their payer mix determines the revenue needed to sustain and maintain services in the Jackson Health System.

Medical services at Jackson Memorial Hospital are provided primarily by residents and fellows in training programs supervised by attending physicians (academic faculty). The resident work rules limit resident service so their services must be supplemented by a variety of providers – advanced practice nurse practitioners (APRNs), physician assistants (PAs), hospitalists, and employed and community-affiliated physicians.

The current volume of clinical activity and the associated revenue does not completely support our mission. Additional patient volume and revenue is required to make JHS self-sustaining. One strategy to support revenue is to affiliate with physicians in the community to bring funded patients to Jackson. This funding stream allows us to partially subsidize the care of unfunded patients and the cost of training residents.

To support the growth strategies at Jackson North Medical Center, Physician Services will expand the medical staff through our partnership with FIU for primary care, surgery and OB/GYN. Community physician strategies are underway for both cardiology and general medicine.

An important component of any hospital's strategy is to engage the community and build physician referral networks. To ensure the sustainability and vitality of Jackson South Community Hospital, it is paramount to encourage physicians to refer their patients. It is the expectation of JSCH that a multispecialty group will be formed in FY 2011 to increase referrals for the hospital and specialists. There are well over 1,000 primary care and family practice physicians in Miami-Dade who are not credentialed with the health system. A multispecialty group is needed to refer patients to service lines such as the Comprehensive Breast Center. Physicians for this group are being researched and identified.

Surgeons to be recruited include six colorectal and bariatric surgeons to develop a surgical digestive disease management program, and three orthopaedic surgeons to develop orthopedics and sports medicine. A separate focus is to enhance obstetric revenue through increased referrals from community physicians and clinics.

To further stabilize patient volumes, JSCH has the potential to recruit an additional 38 physicians in a variety of specialties: general surgery, gastroenterology, vascular surgery, urology, primary care, gynecology/oncology, interventional cardiology, psychiatry, and oncology.

Primary Care Centers

As with many other patient care divisions, the initiatives planned for Ambulatory Care are focused on increasing revenue through restructuring, improved charge capture and growth, and on decreasing costs through increased efficiency. Plans are underway to convert primary care locations to Federally Qualified Health Centers resulting in $6 million in revenue enhancement. By resuming pregnancy testing, primary care is expected to increase deliveries by approximately 500 cases per year. This downstream revenue will mitigate some of the volume losses expected in FY 2010-11. Improvements in staffing to meet best practice guidelines are planned to eliminate 34 FTES and $4.1 million in personnel costs. Also, the restructuring of the dental clinic will generate a $1.6 million cost savings. An additional reduction of 23 FTEs will generate a salary reduction of $1.8 million, and improved billing practices will enhance revenue by $2 million.

Jackson North Medical Center

The focus for FY 2010-11 at Jackson North Medical Center includes intensified emphasis on growth in volume and revenue generation, excellence in quality and patient/physician satisfaction, and control of expenses consistent with budgeted targets. Jackson North expanded its partnership with Florida International University's College of Medicine to attract outstanding physicians, firmly establishing Jackson North as a community academic medical center. The Jackson North strategy revolves around continued investment in physician recruitment, capital equipment and facility improvements. Jackson North currently operates at or below its peers in most operating benchmarks for community hospitals. Therefore, the FY 2010-11 budget is based on maintaining high efficiency and reducing FTEs by 33.

Jackson South Community Hospital

As Jackson South Community Hospital's new building nears completion, the hospital is poised to grow with the community. The strategic plan is to focus on adult surgical services. To fulfill this plan, Jackson South has begun offering specialized services such as the Urology Center of Excellence, Gastric Sleeve Center for Weight Loss, Comprehensive Breast Center, and the Digestive Center of Health, which encompasses outpatient GI, heartburn and colorectal surgery. Proposed service lines detailed in this budget proposal include orthopaedic and sports medicine, a hospice unit, cardiology and vascular services, advanced women's surgical services, an expanded GI/endoscopy unit, and a sleep lab. Included in these plans are goals for the expanded ER and obstetrics service.

When the new building is complete, there will be seven new surgical operating room suites and outpatient procedure rooms, 48 additional private rooms, 12 new critical care beds and enhanced imaging services. The new facility and the recruitment of new physicians to the medical staff are

critical to respond to the volume declines attributable to the opening of two Baptist Urgent Care and Outpatient Centers within the a five-mile radius and the opening of Homestead Hospital in 2007.

As the new building is opened to patient care, the financial performance of Jackson South is expected to improve dramatically with a "Year 1" net benefit for FY 2010-11 of $1.8 million and a profit margin of 13.42 percent. This performance is based on more than 2,000 admissions and approximately 800 outpatient visits.

Jackson South's labor reductions will also have an ongoing benefit in 2011. A further reduction of 37 FTEs, along with continued limited use of overtime and agency personnel, will result in a reduction in total salary cost as a percentage of operating expense from 65 percent in FY 2009-10 to 63 percent in FY 2010-11. As part of this reduction, JSCH will realize $3,356,100 in reduced salaries.

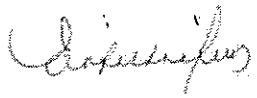
Corrections Health Services

Another key initiative is to outsource the operation of Corrections Health Services to a private company with extensive experience and a proven track record serving this population. This outsourcing is expected to generate $8 million of incremental benefit for Jackson, freeing up public funding to serve other populations. In addition to the outsourcing effort, $1.1 million in cost reductions will be achieved through a reduction of 15 FTEs across the division.

My team and I look forward to working with the county through this budget process to find the right balance for our community of providing necessary medical services while also aligning our organization within our fiscal capabilities. It is never easy making these types of decisions, especially when they involve medical services. We believe we have found the right balance between continuing to provide these critical services while streamlining the health system to work more efficiently and reduce costs. As we move forward in creating our long-term sustainability, we hope to increase our efforts of attracting more paying patients and becoming the provider of choice for care in Miami-Dade, which will, in turn, fund our mission.

I would like to thank the county – the manager, mayor, commissioners and the county staff assigned to help us during this time – for their continued support and guidance. The extra assistance during this challenging time has been greatly appreciated. I would also like to thank the members of our Public Health Trust Board of Trustees for the countless hours they have volunteered and dedicated to this institution. Despite the challenges, they remain committed to guiding Jackson to a healthier future. There is no other institution like Jackson in Miami-Dade, and the commitment and devotion of so many clearly show its important role in our community.

Sincerely,



Eneida O. Roldan, M.D., M.P.H., M.B.A.
President and CEO
Jackson Health System

Attachment A

Year	Elements of Health Reform	Impact on Jackson Health System
2010	Insurance reforms begin: Coverage for children with pre-existing conditions; children can stay on parent's coverage until age 26; a prohibition on annual or lifetime limits	This may positively impact the current self-paid market at the system level.
	Reductions in hospital market: Updates begin and continue through 2019	This will have a negative impact on our long-term inpatient rehabilitation and inpatient psychiatric facilities by producing a 0.25% reduction in 2010 and 2011.
	Multiple initiatives focused on primary care launch	We need to position ourselves in the primary market by hiring primary care physicians and converting our clinics into Federally Qualified Health Centers. We need additional resources to engage and recruit these physicians.
	$400 million for FY2011 and FY2012 becomes available to address geographic variation	Florida will be faced with a tremendous negative impact due to the high cost of care. I am currently participating on the advisory council to combat these reductions to Florida.
	Patient-Centered Outcomes Research Institute is created to study comparative effectiveness	We need to position Jackson to be part of the pilot and demonstration projects at the national level. Advocacy and lobbying efforts are needed.
	National Healthcare Workforce Commission is established to assess staffing needs	We have initiated talks with our nurses union, Service Employees International Union Local 1991. We are involved at the state level with the Florida Hospital Association workforce initiative.
2011	States are required to establish health insurance exchanges	It will impact the JMH Health Plan.
	Center for Medicare and Medicaid Innovation established	We are waiting for more details from CMS.
	Medicaid Quality Measurement Program established	Re-engineering has begun.
	Unused residency slots allocated to primary care and general surgery	Requires additional advocacy at the federal level.

2012	Value-based purchasing program starts: Hospital payments for FY2013 based on FY2012 performance	Not ready. It will impact reimbursement significantly.
	Value-based purchasing demo for critical access hospitals established	Not ready. This will significantly impact reimbursement.
	Hospitals and physicians meeting certain criteria can form Accountable Care Organizations.	We need to engage our academic partners. Conversations are underway with the University of Miami, and discussions with Florida International University are planned.

Year	Elements of Health Reform	Impact on Jackson Health System
2013	Beginning in FY2013, hospitals will be penalized for "excess" readmissions	We implemented a readmission program that currently tracks Diagnosis Related Groups (DRG) with readmission rates. We are being monitored at the state level. We participate in a program with the Florida Hospital Association.
	National, voluntary, five-year bundled payment pilot launches	We continue to address efficiencies as this will impact reimbursement.
	States required to enhance Medicaid payments to primary care providers	We need to establish a primary care network. This requires additional resources for recruitment.
2014	Individual insurance mandate takes hold	We need to aggressively retain our current patients and employ competitive measures in the market. This may have a positive impact as more individuals are covered.
	Medicaid expansion begins	This could have a positive impact on our paying patient load. We may retain more patients or lose patients due to increased options.
	Cuts to Disproportionate Share Hospital payments begin	The cut will amount to a total of $10 billion to states. This will significantly impact our funding sources.
	Independent Payment Advisory Board begins counselling Congress on	We must continue our focus on expense reduction and economy of scales at all

reductions in health spending	levels.
Penalties started in FY 2005 for hospital-acquired conditions continue for 10 years	We participate in medical and surgical quality programs at the state level and are working toward a reproducible quality program with consistent high-performing measures. More resources are needed.

Attachment B

HISTORICAL CONTEXT

Over the last five years, JHS has implemented several initiatives to varying degrees of success. Those initiatives included, but were not limited to:
Revenue Cycle

- Denial Management – Automated identification of retrospective denials and reduction of prospective denials
- Patient Access – Implemented inpatient financial clearance center to screen patients for insurance eligibility
- Case Management – Streamlined the processes to support timely authorization of Medicaid authorization

Operations

- Labor – Created staffing grids for all Variable staffed patient care departments, based off Solucient Benchmarking data and best practices
- Labor – Developed process to track and manage positions within the organization
- ED – Implemented officer of the day to provide structure and one view over all ED activities
- Org Structure – Developed org structure charts, that better align the organization to industry standards for span of control

BOARD OF COUNTY COMMISSIONERS
OFFICE OF THE COMMISSION AUDITOR

MEMORANDUM

TO: Honorable Dennis C. Moss, Chairman
and Members, Board of County Commissioners

FROM: Charles Anderson
Commission Auditor

DATE: September 15, 2010

SUBJECT: FY 10-11 BCC/Non-Mayoral Budget Recommendations

In accordance with Ordinance No. 10-36, the Office of the Commission Auditor (OCA) has prepared budget recommendations for all departments and divisions that report to the Board of County Commissioners (BCC). Additionally, budget recommendations have also been prepared for the non-mayoral departments: the Commission on Ethics and the Public Trust (COE), the County Attorney's Office (CAO), and the Office of the Inspector General (OIG).

The Mayor's FY 2010-11 Proposed Budget, Volume 1, Page 19, states:

> *Policy Formulation and other functions outside of Mayoral purview have been slightly adjusted in the Proposed Budget. A five percent reduction from a flat subsidy has been proposed for the Office of Inspector General, the Commission on Ethics, the County Attorney's Office, the County Executive Office and the offices that report to the Chairman of the Board, including the Commission Auditor, Protocol and Employee Recognition, Media, Office of the Chair and the Office of Intergovernmental Affairs (OIA). Individual district office budgets have been held flat.*

During the past two months, we met and/or discussed the Proposed Budget with the aforementioned offices, including most individual BCC district offices. The primary focus was to review any budgetary concerns they may have had with the proposed budgets for their offices. The following information represents our proposed recommendations to the offices (at the time of our meetings):

- The Office of the Chair and its direct offices are recommended to be restored to a flat budget (Attachment 1). The Offices will receive Non-Departmental reserves **($305,000)** to reach the recommended budget for FY 10-11.

- The individual district offices agreed (when we met) to employ the flat budget method with the same allocated amounts used for the FY 09-10 Adopted Budget. They will utilize various alternatives such as: frozen vacancies and carryover to remain flat and within budget for FY 10-11.

- The OCA is recommended to be restored to a flat budget (Attachment 2). The OCA will freeze two legislative analyst positions, utilize carryover, and receive Non-Departmental reserves **($135,000)** to reach the recommended budget for FY 10-11.

- The OIA is recommended to remain at five percent below subsidy (Attachment 3). The OIA will utilize carryover and lower the starting salary of the replacement for one vacant staff position in order to meet the FY 10-11 budget allocation.

- The COE is recommended to be restored at 3.47% above the FY 09-10 projected year end budget (Attachment 4). The increase takes into account that the original FY 09-10 Adopted Budget did not include the carryover and is now shown in the FY 09-10 year-end projections. Originally, the COE requested a budget increase of 8.38% for FY 10-11 ($2.391 million, 4.71% more than the FY 10-11 request). In order to achieve the 3.47% increase, the COE will freeze positions, reduce operating expenses, apply payroll adjustments, and receive Non-Departmental reserves **($94,000)** to reach the recommended budget for FY 10-11.

- The CAO is recommended to be restored to a flat budget (Attachment 5). The CAO will seek legal work reimbursement from various proprietary departments not currently in the system. At this time, the CAO currently receives reimbursement from GSA, Finance, Seaport, and PHT for legal work but not from the other proprietary departments accessing their office attorneys. We propose that $900,000 be charged to those other proprietary departments to reach the recommended budget for FY 10-11.

- The OIG is recommended to receive Non-Departmental reserves **($10,000)** to provide for background checks on advisory board appointees as requested by the Board of County Commissioners (Attachment 6).

The recommended requests from Non-Departmental reserves total **$544,000.**

Should you require additional information, feel free to contact me at (305) 375-2524.

Attachments

c: Honorable Carlos Alvarez, Mayor
George M. Burgess, County Manager
R.A. Cuevas, County Attorney
Jennifer Glazer-Moon, Special Assistant/OSBM Director
Diane Collins, Acting Division Chief, Clerk of the Board
Christopher Mazzella, Inspector General
Robert Meyers, Executive Director, Commission on Ethics and the Public Trust
Joe Rasco, Director, Intergovernmental Affairs

Office of the BCC Chair

($000s)		FY 2009-10 Budget	FY 2009-10 Projection	Mayor's Proposed Budget FY 2010-11	OCA Proposed Budget FY 2010-11	Variance b/w Mayor vs. OCA
REVENUE						
CW	General Fund Countywide	$1,702	$1,357	$1,675	$1,903	$228
UMSA	General Fund UMSA	$835	$694	$557	$634	$77
INTERTRNF	Interagency Transfers	$581	$617	$581	$581	$0
TOTAL REVENUE		**$3,118**	**$2,668**	**$2,813**	**$3,118**	**$305**
EXPENDITURES						
	Salary	$1,859	$1,494	$1,758	$1,859	$101
	Overtime Salary	$212	$200	$175	$212	$37
	Fringe	$627	$518	$577	$627	$50
	Overtime Fringe	0	0	0	0	$0
	Other Operating	$388	$388	$281	$388	$107
	Capital	$32	$32	$22	$32	$10
TOTAL EXPENDITURES		**$3,118**	**$2,632**	**$2,813**	**$3,118**	**$305**
REVENUE MINUS EXPENDITURES		**$0**	**$36**	**$0**	**$0**	**$0**

Mayor's Proposed Reductions
5% reduction from a flat susidy

OCA Proposed Reductions

Non-Departmental Reserves	$305

Office of the Commission Auditor

($000s)		FY 2009-10 Budget	FY 2009-10 Projection	Mayor's Proposed Budget FY 2010-11	OCA Proposed Budget FY 2010-11	Variance b/w Mayor vs. OCA
REVENUE						
CW	General Fund Countywide	$2,550	$2,359	$2,367	$2,492	$125
UMSA	General Fund UMSA	$1,041	$963	$789	$830	$41
TOTAL REVENUE		**$3,591**	**$3,322**	**$3,156**	**$3,322**	**$166**
EXPENDITURES						
	Salary	$2,698	$2,496	$2,398	$2,496	$98
	Overtime Salary	0	0	0	0	$0
	Fringe	$736	$669	$611	$669	$58
	Overtime Fringe	0	0	0	0	$0
	Other Operating	$154	$154	$145	$154	$9
	Capital	$3	$3	$2	$3	$1
TOTAL EXPENDITURES		**$3,591**	**$3,322**	**$3,156**	**$3,322**	**$166**

Mayor's Proposed Reductions

5% reduction from a flat subsidy	$435	

OCA Proposed Reductions

Freeze 2 legislative analysts	$175	
Utilize carryover	$94	
		269
Reimbursements	$31	
Non-departmental reserves	$135	
		166
TOTAL		435

Intergovernmental Affairs

($000s)		FY 2009-10 Budget	FY 2009-10 Projection	Mayor's Proposed Budget FY 2010-11	OCA Proposed Budget FY 2010-11	Variance b/w Mayor vs. OCA
REVENUE						
CW	General Fund Countywide	$821	$783	$786	$786	$0
UMSA	General Fund UMSA	$335	$320	$262	$262	$0
PROP	Carryover	$0	$0	$0	$0	$0
TOTAL REVENUE		**$1,156**	**$1,103**	**$1,048**	**$1,048**	**$0**
EXPENDITURES						
	Salary	$691	$651	$672	$672	$0
	Overtime Salary	0	0	0	0	$0
	Fringe	$184	$171	$188	$188	$0
	Overtime Fringe	0	0	0	0	$0
	Other Operating	$277	$277	$184	$184	$0
	Capital	$4	$4	$4	$4	$0
TOTAL EXPENDITURES		**$1,156**	**$1,103**	**$1,048**	**$1,048**	**$0**

Note: Agree with Mayor's Proposed Budget

Commission on Ethics and Public Trust

($000s)		FY 2009-10 Budget	FY 2009-10 Projection	Mayor's Proposed Budget FY 2010-11	OCA Proposed Budget FY 2010-11	Variance b/w Mayor vs. OCA
REVENUE						
CW	General Fund Countywide	$1,867	$1,806	$2,074	$2,168	$94
PROP	Carryover	$0	$301	$0	$0	$0
PROP	Lobbyist Trutst Fund	$25	$25	$38	$38	$0
TOTAL REVENUE		**$1,892**	**$2,132**	**$2,112**	**$2,206**	**$94**
EXPENDITURES						
	Salary	$1,354	$1,563	$1,489	$1,583	$94
	Overtime Salary	0	0	0	0	$0
	Fringe	$354	$394	$438	$438	$0
	Overtime Fringe	0	0	0	0	$0
	Other Operating	$174	$171	$178	$178	$0
	Capital	$10	$4	$7	$7	$0
TOTAL EXPENDITURES		**$1,892**	**$2,132**	**$2,112**	**$2,206**	**$94**
REVENUE MINUS EXPENDITURES		**$0**	**$0**	**$0**	**$0**	**$0**

Mayor's Proposed Reductions

Elimination of an Investigator	$95
Reduced operating expenses	$9
Elimination of a part-time Intern	$14
Various payroll adjustments	$161
	$279 **(1)**

OCA Proposed Reductions/Additions

Freeze Investigator position	$95
Reduced operating expenses	$9
Freeze second Investigator for 3 months	$60
Various payroll adjustments	$21
	$185
(2) Non-Departmental reserves	$94
	$279

Notes:

(1) Mayor's reduction is from Ethics FY 10-11 proposed budget submission ($2.391 million)

(2) Mayor's reductions revised with Ethics input and reserve added

County Attorney

($000s)		FY 2009-10 Budget	FY 2009-10 Projection	Mayor's Proposed Budget FY 2010-11	OCA Proposed Budget FY 2010-11	Variance b/w Mayor vs. OCA
REVENUE						
CW	General Fund Countywide	$12,716	$12,716	$12,760	$12,760	$0
UMSA	General Fund UMSA	$5,194	$5,194	$4,254	$4,254	$0
PROP	Reimbursements from Outside Agencies	$280	$280	$280	$280	$0
PROP	Reimbursements from Departments	$5,198	$5,198	$5,300	$6,200	$900
TOTAL REVENUE		**$23,388**	**$23,388**	**$22,594**	**$23,494**	**$900**
EXPENDITURES						
	Salary	$18,432	$18,432	$17,930	$18,538	$608
	Overtime Salary	0	0	0	0	$0
	Fringe	$4,004	$4,004	$3,796	$4,004	$208
	Overtime Fringe	0	0	0	0	$0
	Other Operating	$857	$857	$836	$857	$21
	Capital	$95	$95	$32	$95	$63
TOTAL EXPENDITURES		**$23,388**	**$23,388**	**$22,594**	**$23,494**	**$900**

Note: Recommend legal work reimbursement from the following departments including but not limited to: CITT, Consumer Services, DERM, Fire Rescue, Library, Office of the Clerk, Planning and Zoning, Procurement Management, Public Works, Solid Waste Management

Mayor's Proposed Reductions

5% reduction from a flat susidy

OCA Proposed Addition

Additional legal work reimb from various departments	$900

Inspector General

($000s)		FY 2009-10 Budget	FY 2009-10 Projection	Mayor's Proposed Budget FY 2010-11	OCA Proposed Budget FY 2010-11	Variance b/w Mayor vs. OCA
REVENUE						
CW	General Fund Countywide	$1,047	$400	$922	$932	$10
PROP	Carryover	$887	$1,531	$674	$674	$0
PROP	Departmental Oversight (MOUs)	$1,100	$1,050	$1,150	$1,150	$0
PROP	Interest Earnings	$10	$10	$15	$15	$0
PROP	Miscellaneous Revenues	$10	$10	$10	$10	$0
PROP	Proprietary Fees	$2,275	$2,860	$2,850	$2,850	$0
TOTAL REVENUE		**$5,329**	**$5,861**	**$5,621**	**$5,631**	**$10**
EXPENDITURES						
	Salary	$3,833	$3,792	$4,043	$4,043	$0
	Overtime Salary	0	0	0	0	$0
	Fringe	$942	$988	$1,024	$1,024	$0
	Overtime Fringe	0	0	0	0	$0
	Other Operating	$531	$407	$531	$541	$10
	Capital	$23	$0	$23	$23	$0
TOTAL EXPENDITURES		**$5,329**	**$5,187**	**$5,621**	**$5,631**	**$10**
REVENUE MINUS EXPENDITURES		**$0**	**$674**	**$0**	**$0**	**$0**

Mayor's Proposed Reductions
None

OCA Proposed Addition

Background checks-Advisory Board Appointees from Non-Departmental Reserves	$10