Lee Memorial Health System

Board of Directors

Planning Committee of the Whole

Meeting

March 6, 2008, 1:00pm
Lee Memorial Hospital Boardroom
2776 Cleveland Ave, Ft. Myers, FL 33901

Electronic Board Packet

All meetings are open to the public and the public is invited to attend. Any public input pertaining to an agenda item is limited to three minutes and a "Request to Address the Board of Directors" card must be completed and submitted to the Board Assistant prior to the meeting.
LEE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS

PLANNING COMMITTEE OF THE WHOLE MEETING

Thursday, March 6, 2008
1:00 p.m.
Lee Memorial Hospital - Boardroom

AGENDA

1. CALL TO ORDER (Planning Co-Chair Jason Yost)
   The meeting of the Planning Committee of the Whole of the Lee Memorial Health System Board of Directors will be called to order. Matters concerning the business of Lee Memorial Health System consisting of Southwest Regional Medical Center/Gulf Coast Hospital & Lee Memorial Hospital/HealthPark Medical Center and its subsidiaries (HealthPark Care Center, Inc., Lee Memorial Home Health, Inc., Cape Memorial Hospital, Inc. doing business as Cape Coral Hospital, and Lee Memorial Medical Management, Inc.) may be reported, discussed and recommended by the Committee of the Whole, then referred to the full Board of Directors for final action.

2. PUBLIC INPUT: Any public input pertaining to items on the Agenda is limited to three minutes and a “Request to Address the Board of Directors” card must be completed and submitted to the Board Assistant prior to meeting.

3. Consent Agenda (Approval)
   A. February 14, 2008 Planning Committee Minutes
   B. Annual Workforce Competency Report for FY 2007
   C. FY 2008 System Strategic Scorecard Summary

4. Centers for Medicare & Medicaid Services (CMS) Rule (Verbal Update)
   (Jim Humphrey, Board Counsel & Keith Arnold, Legislative Consultant - 10 min)

5. Cape Coral Hospital Emergency Room Expansion (Update)
   (Dave Kistel, Vice President/Facilities and Support Services – 20 min)

6. Gulf Coast Hospital & Southwest Regional Consolidation Project (Update)
   (Doug Luckett, Chief Administrative and Ancillary Services Officer/SWRMC/GCH and Dave Kistel, Vice President/Facilities and Support Services – 30 min)

7. FY 2008 System Strategic Priorities (Verbal Update)
   (Jim Nathan, President/CEO -10 min)

8. Time Sensitive Issues

9. Other Items

10. Date of the next Regular Planning Committee of the Whole:
    Thursday, April 10, 2008, 2:00pm
    Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue, Fort Myers, FL

11. ADJOURNMENT of PLANNING COMMITTEE
PUBLIC INPUT – AGENDA ITEMS:

Any public input pertaining to items on the Agenda is limited to three minutes and a “Request to Address the Board of Directors” card must be completed and submitted to the Board Assistant prior to meeting.

Refer to Board Policy: 10:15D: Public Addressing the Board

Non-Agenda Item:
Individuals wishing to address the Board on an item NOT on the Agenda, the Board office must be notified of subject matter at least seven (7) days prior to the meeting to allow staff time to prepare and to insure the matter is within the jurisdiction of the Board.
Planning Committee of the Whole
March 6, 2008

CONSENT AGENDA ITEMS
(for approval)

A. February 14, 2008 Planning Committee Minutes

B. Annual Workforce Competency Report

C. FY 2008 System Strategic Scorecard Summary
Meeting Called to Order

The Planning Committee of the Whole meeting was CALLED TO ORDER by Planning Chairman Linda Brown, MSN, ARNP at 2:37 p.m.

Public Input

There were NO “Public Input” items to be discussed.

Consent Agenda

Linda Brown asked if any members wished to pull any of the following items from the Consent Agenda for discussion:

A. January 17, 2008 Planning Committee Minutes
B. Rehabilitation Hospital Annual Executive Summary Report (Exhibit 1)

A motion was made by Nancy McGovern to approve the Consent Agenda consisting of:

A. January 17, 2008 Planning Committee Minutes
B. Rehabilitation Hospital Annual Executive Summary Report (Exhibit 1)

The motion was seconded by Marilyn Stout and it carried with no opposition.

Outpatient Services Executive Summary Report

Guert Peet reviewed the Outpatient Services Executive Summary Report (Exhibit 2). Discussion ensued regarding the following topics:

- Issues resulted from combining inpatient and outpatient services with high volumes
- Competition between services
- Services offered at outpatient facilities
- Possible growth and expansion of facilities
- Leasing facilities vs. the use of LMHS capital for outpatient facilities
- Quantifiable tactics and strategies
- Expanding and moving forward without creating heavy competition with physicians
- Bonding and forming partnerships

A motion was made by Jack Eikenberg to accept the Outpatient Services Executive Summary Report (Exhibit 2). The motion was seconded by Nancy McGovern and it carried with no opposition.

System Naming Methodology Project

Anne Rose thanked Linda Brown for her service as the outgoing marketing Board liaison and welcomed Kerry Babb as the incoming. Anne presented the System Naming Methodology Project (Exhibit 3). She said there were no new research studies conducted; all statistical information was obtained through previous surveys and interviews conducted not related to this project. She added the names and logos included in the presentation are for hypothetical purposes. Discussion ensued with regard to the following topics:

- Processes used in the past for choosing facility names
- Attracting patients from outside the community to seek care at LMHS

A motion was made by Jack Eikenberg to accept the System Naming Methodology Project Report (Exhibit 3). The motion was seconded by Nancy McGovern and it carried with no opposition.

NOTE: Documents referred to in these minutes are on file by reference to this meeting date in the Office of the Board of Directors and are available for public inspection.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DISCUSSION</th>
</tr>
</thead>
</table>
| | • Various opinions and suggestions with regard to naming the new facility on Metro Parkway and Daniels  
| | • Future plans to research and survey the community  
| | • Condensing the number of names associated with LMHS  
| | • Creation and development of facility naming and the sense of pride associated with this process  
| | • Significant financial implications associated with changing facility logos and future budgeting for such costs  
| | • Physician, staff, and community involvement in the System naming process  
| | • Prestige and reputation of existing facility names  

Jim Nathan gave historical insight regarding LMHS acquiring facilities and the naming processes involved. He added the naming of these facilities has been a very emotional experience in the past. Further discussion ensued regarding:  
• Timeframe for naming the new facility is "As soon as possible", with a three to six month research process  
• The basics to naming a facility should be: "Who, What, When, Where"  
• Working with limited funds  
• Recapturing the Bonita market  
• Survey the Medical Staff for their suggestions and input and bring back to the Board in thirty days  

Discussion ensued regarding the temporary name for the facility on Metro and Daniels.  
(Fred Pollier left the meeting at 4:07)

A motion was made by John Donaldson to approve the recommended temporary name of Gulf Coast Medical Center for the new facility at Metro and Daniels Parkway. The motion was seconded by Jason Yost. Richard Akin, Marilyn Stout, Jack Eikenberg, and Wayne Daltry voted in opposition however the motion passed.

| FY 2008 SYSTEM STRATEGIC PRIORITIES | Jim Nathan gave a verbal update regarding the five FY 2008 System Strategic Priorities of Long Term Facility Plan, Financial Focus, Physician Leadership & Relationships, Organizational Clarity, Clinical Operational Effectiveness (Exhibit 4). He said we are all aware of our current financial situation. He said there are external factors of which we have no control over and we are working hard to handle these financial issues. Discussion ensued regarding the following topics:  
| | • Use of federal government funding  
| | • Positive and negative effects of Presidential decisions on health care  
| | • Current losses and waste in Home Health |

| TIME SENSITIVE ISSUES | There were NO "Other Items" to be discussed. |

| OTHER ITEMS | There were NO "Other Items" to be discussed. |

| ADJOURNMENT | The Planning Committee of the Whole meeting was ADJOURNED by Planning Chairman Linda Brown MSN, ARNP at 4:25 p.m. |

Minutes were recorded by Beth Finney, Executive Secretary/Board of Directors Office

Lois C. Barrett, MBA  
Board Secretary
DATE: February 29, 2008                  LEGAL SERVICE REVIEW? YES___ NO_X__

SUBJECT: Workforce Competency Report

REQUESTED EFFECTIVE DATE (IF APPLICABLE): N/A

REQUESTOR & TITLE: Jon C. Cecil, Chief Human Resources Officer

PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)
An annual report to the Board, which is recommended by JCAHO and placed on Consent Agenda.

PROPOSED MOTION:
Consent agenda item - Accept report.

PROS TO RECOMMENDATION                           CONS TO RECOMMENDATION
N/A                                               N/A

LIST AND EXPLAIN ALTERNATIVES CONSIDERED
N/A

FINANCIAL IMPLICATIONS     Budgeted _____  Non-Budgeted _____
(including cash flow statement, projected cash flow, balance sheet and income statement)

N/A

OPERATIONAL IMPLICATIONS (including FTEs, facility needs, etc.)
N/A

SUMMARY
The Annual “Workforce Competency Report” provides the LMHS Board of Directors a summary of information regarding the workforce competency levels, intervention programs, and enhancement initiatives in order to assure safe and competent care is provided to our patients. JCAHO typically reviews this report during its surveys.
Workforce Competency Report

for Fiscal Year 2007
Presented to the Board of Directors March 2008
## CONTENTS

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BOARD SUMMARY

Each year the Human Resources Department provides the Board of Directors with a Workforce Competency Report. This report serves two primary purposes:

1. It provides the Board of Directors with information regarding the current workforce competency levels, competency intervention programs, and competency enhancement initiatives.
2. It is a standard Joint Commission report completed annually.

When we refer to the Workforce Competency Report, one question that might come to mind is: “what is a competency?” LMHS defines a “competency” as the minimal level of skills or knowledge a staff person needs to demonstrate to be deemed proficient for a specific task and apply it in a meaningful specific way. Whereas “performance” is what a person actually does, demonstrates, and accomplishes.

During Fiscal Year 2007, the Leadership team performed competency assessments/reviews on 7694 employees. Only 5 employees were found to be unable to perform the required core or population served job competencies.

To ensure that our workforce is able to meet the competency expectations today and in the future, the Education Staff continues to perform needs assessments, data collection & analysis, and program development around competency issues. For example, the competency classes offered for 2007 had a direct correlation to the Learning and Competency needs assessment performed in 2006. Topics showing direct correlation included but were not limited to: restraints, Patient Controlled Analgesia/Epidural Analgesia, pressure ulcer prevention, basic and advanced cardiac rhythms, point of care testing, IV therapy, medication administration/safety, lab labeling, risk for falls, pain management and infection control, hemodynamic monitoring, Code Blue review and central intravenous skills.

The remaining pages in this report provide detailed information regarding competency status, programs, initiatives, trends, etc. If you have any questions about this material, please contact Mel King at 574-0323.
INTRODUCTION

This report provides information on the levels of competence for direct patient care staff, indirect patient care staff, and non-patient care staff at Lee Memorial Health System for the period of October 1, 2006 through September 30, 2007 (Fiscal Year 2007).

PURPOSE: This report is produced to provide a summary of the workforce competency level to the Board of Directors so the Board members will be informed and better able to support future decisions that may indirectly or directly impact workforce competency issues. This report is also provided to comply with the Joint Commission standards. The following excerpts are taken from the Human Resource Management section of the 2007 Comprehensive Accreditation Manual for Hospitals.

Standard HR.3.10
Staff competence to perform job responsibilities is assessed, demonstrated, and maintained.

Rationale for HR.3.10
Competence assessment is systematic and allows for a measurable assessment of the person’s ability to perform required activities. Information used as part of competence assessment may include data from performance evaluations, performance improvement, and aggregate data on competence, as well as the assessment of learning needs.

SUMMARY: Data contained in this report was compiled from annual employee competency reviews, performance improvement plans, corrective action information, counseling data, learning needs assessments, performance improvement initiatives and risk management issues. The report further summarizes specific patterns, issues and trends relative to levels of competence and identifies priorities for clinical education and continuous performance improvement measures.

Information in this report includes (1) Levels of Competence, (2) Patterns and Trends, and (3) Competence Maintenance Activities.

TIMELINE: The following sequence of events constitutes the timeline for developing the Board Competency Report.

<table>
<thead>
<tr>
<th>Event</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year being reviewed</td>
<td>October 2006 through September 2007</td>
</tr>
<tr>
<td>Annual performance and competency assessments completed</td>
<td>October 2006 through November 2007</td>
</tr>
<tr>
<td>Period for employees who do not meet competency expectations to be retrained &amp; reevaluated</td>
<td>November 2007 through February 2008</td>
</tr>
<tr>
<td>HR &amp; Education departments collect and analyze data and develop Workforce Competency Report</td>
<td>February 2008</td>
</tr>
<tr>
<td>Workforce Competency Report presented to the Board of Directors</td>
<td>March 2008</td>
</tr>
</tbody>
</table>

LEVELS OF COMPETENCE:

LMHS continues to reinforce performance and competency reviews as an ongoing system of planning, coaching, reviewing, rewarding and recognizing employees. Performance and competency reviews are part of a mutually cooperative process focusing on continual performance improvement; linked with LMHS strategic goals; annual self review; a personal development plan which identifies strengths and areas for development and growth; and measuring the attainment of strategic goals.
## Results for the Annual Core Competency Review

<table>
<thead>
<tr>
<th>Evaluation Result Definitions</th>
<th>Number of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong>: Able to perform ALL core competencies INDEPENDENTLY</td>
<td>7597</td>
</tr>
<tr>
<td><strong>Level 2</strong>: NEEDS ASSISTANCE to be able to perform core competencies</td>
<td>94</td>
</tr>
<tr>
<td><strong>Level 3</strong>: UNABLE TO PERFORM one or more core competencies</td>
<td>3</td>
</tr>
</tbody>
</table>

When employees are reviewed as being unable to meet a required competency and/or needs assistance, they are immediately rescheduled for a follow-up evaluation and are given special attention and training to raise their competency levels or transition them to another role.

### Status of Employees Unable to Perform Competencies

- One was retrained and re-evaluated
- Three transferred to another position
- One was terminated

## Results for the Annual Population Served Competency Review

<table>
<thead>
<tr>
<th>Evaluation Result Definitions</th>
<th>Number of Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 1</strong>: Able to perform ALL population served competencies INDEPENDENTLY</td>
<td>5938</td>
</tr>
<tr>
<td><strong>Level 2</strong>: NEEDS ASSISTANCE to be able to perform population served competencies</td>
<td>13</td>
</tr>
<tr>
<td><strong>Level 3</strong>: UNABLE TO PERFORM one or more population served competencies</td>
<td>2</td>
</tr>
<tr>
<td><strong>Level 4</strong>: Population served competencies NOT APPLICABLE</td>
<td>1741</td>
</tr>
</tbody>
</table>

When employees are reviewed as being unable to meet a required competency and/or needs assistance, they are immediately rescheduled for a follow-up evaluation and are given special attention and training to raise their competency levels or transition them to another role.

### Status of Employees Unable to Perform Competencies

- One was retrained and re-evaluated
- Three transferred to another position
- One was terminated
**Our Process:**

LMHS departments are required to develop and implement job competencies specific to their individual department needs. Individual employee competency is assessed initially upon hire within the orientation and probationary process. Competencies are assessed and evaluated on an ongoing basis and during the annual performance evaluation. Competency assessment documentation is maintained in each individual employee’s departmental file.

In addition, Department Directors may also assess any high risk, low volume competencies that may be pertinent to each job description as necessary. Competencies that relate to departmental performance indicators may also be included in the competency assessment process, both initially and on an annual basis.

Population served competencies must be assessed initially within the probationary period and annually for staff that have regular contact with patients.

A required form, the “Population Served Competencies Addendum Form” addresses each patient population served group, method of competency validation, standard criteria, initials of qualified observer, and date of observation. This form is attached to the annual performance evaluation and filed in the employee personnel file.

**New for 2007:**

Early in 2007, Human Resources and Clinical Learning reviewed the literature for evidence relating to Populations Served Competency, as well as the Joint Commission redefinition of the population served competency standard. Joint Commission Resources and other publications were utilized to develop a new template and process in order for LMHS to meet this new standard. Populations Served Competency (The Joint Commission HR.3.10) refers to staff members’ ability to meet the special needs of specific patient populations served characteristics, such as:

- Age specific needs
- Cultural/Spiritual values
- Disease process or diagnosis
- Cognitive/communication impairment
- Functional Status
- War Years – since some traumas related to different military conflicts

Part of the development process involved reviewing LMHS infrastructure and systems to determine populations served. An assessment of LMHS specific documents and processes involved in competence assessment and care of populations was undertaken. The following policies and procedures and Human Resources documents were taken into consideration:

- Mission, Vision, Values, and Philosophy of Nursing Policy (S15 00 862)
- Scope of Care and Service Policy (M15 00 806)
- Standards of Care and Practice Policy (S15 00 836)
- LMHS Scope of Service Document
- System, Unit Based Spider Diagram (Quality Indicators)
- Job Description Documents
- Initial and Annual Competency Assessment Documents
- Initial and Annual Job Description/Performance Evaluation
- Environment of Care Document
- Current Population Served Competency Assessment Tool

A new template was designed to support and augment the above documents and processes in order to incorporate the content into one meaningful process.

For each identified patient population, a set of competencies must be identified for each job position.
Populations served competencies are required for any LMHS staff position that provides care, treatment, and services to a patient, involving independent judgment regarding any aspect of patient care, treatment, and/or safety.

A service line approach to developing and implementing the population served competencies was piloted in August 2006, with individual services areas being customized each month. This process was completed in October 2007. Once developed, implementation on the units started. By end of fiscal year, LMHS divisions completed the process of transitioning to the new Population Served Competency format.

Competency Assessment

In October 2002, LMHS implemented the Performance Based Development System (PBDS) for the purpose of standardizing the method used to validate competency of nursing staff upon hire for acute care and The Rehabilitation Hospital, including GNs, LPNs and RNs, as well as providing a means for the further development of existing nursing staff. This nationally recognized program has been available commercially for the past 25 years and is currently used in over 500 hospital systems across the United States and Canada. PBDS includes the following educational benefits:

- Validates competency, including the skills sets of critical thinking and interpersonal communication, upon hire per JCAHO requirements.
- Provides management with a tool to understand the most effective and efficient means to orient and develop staff at the bedside.
- Saves LMHS resources by individualizing the orientation of each nurse hired.
- Provides unit-based educators with developmental resources to further develop existing nursing staff at the bedside in response to trending identified through processes including, but not limited to, chart audits, patient satisfaction survey results and the annual learning performance self-assessments.

Upon hire, nursing staff hired for the job classes listed above is required to participate in a competency validation assessment offered as part of the PBDS. Unlike a test that seeks to measure knowledge, this assessment is qualitative in nature and seeks to validate a nurse’s ability to critically think through the use of simulated patient events. Assessments are reviewed and results are generated by the parent company of the PBDS product, Performance Management Systems, Inc. (PMSI). Nurses whose responses indicate the ability to provide safe and effective patient care are considered “acceptable”. Conversely, nurses whose responses do not indicate this ability are found to not meet our expectations and need to complete a development plan that is provided as part of the results generated by PMSI. Results of this assessment are delivered to LMHS within five business days to allow a timely implementation of the development plan for the orientees.

Travelers who do not receive “acceptable” results are cancelled. Regular staff orientees who require the completion of a development plan are assigned to nurses who have received specialized training in the implementation of these development plans.
To date, 2931 nurses have participated in this competency assessment. The following is a summarization of the data generated since the installation of this product.

<table>
<thead>
<tr>
<th></th>
<th>National Averages as reported by PMSI</th>
<th>LMHS FY ‘03</th>
<th>LMHS FY ‘04</th>
<th>LMHS FY ‘05</th>
<th>LMHS FY ‘06</th>
<th>LMHS FY ‘07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Travelers</td>
<td>70%</td>
<td>83%</td>
<td>72%</td>
<td>85%</td>
<td>76%</td>
<td>70%</td>
</tr>
<tr>
<td>Staff LPNs</td>
<td>27%</td>
<td>26%</td>
<td>29%</td>
<td>53%</td>
<td>47%</td>
<td>38%</td>
</tr>
<tr>
<td>Staff RNs</td>
<td>64%</td>
<td>69%</td>
<td>60%</td>
<td>77%</td>
<td>66%</td>
<td>64%</td>
</tr>
<tr>
<td>New Grads</td>
<td>33%</td>
<td>36%</td>
<td>44%</td>
<td>44%</td>
<td>34%</td>
<td>33%</td>
</tr>
<tr>
<td>International Agency RNs</td>
<td>1%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>13%</td>
</tr>
</tbody>
</table>

PMSI is able to provide a descriptive statistical analysis of how nurses are performing on this critical thinking assessment. These national averages are reported in the second column in the table above. Interestingly, these national averages have remained relatively unchanged for the past 23 years that the PBDS product has been available. As revealed by the LMHS averages above, the nursing staff hired by LMHS performs in accordance with nursing staff hired in acute care organizations across the US. The only deficient result identified is that of the agency staff hired by LMHS in December 2006. The agency staff was procured through the MedPro agency. These 54 registered nurses were international recruits from India (49 nurses) and the Philippines (5 nurses). It was anticipated that international nurses would need more critical thinking development than domestically prepared nurses due to cultural and practice differences in countries outside of the US. With this understanding, the education department prepared for these 54 nurses prior to their arrival by providing additional development and preparation for those LMHS staff who would be assigned to work side-by-side with these international recruits. Each of these international recruits received individualized development at the bedside to help with the transition to the practice expectations of LMHS. This individual development consisted of trained clinical coaches validating and documenting these recruits’ acquisition of critical thinking skills, interpersonal communication skills, and most importantly, the ability to provide safe competent patient care. Those nurses we retained are currently functioning per LMHS standards for competence.

Regular staff hired for Southwest Regional Medical Center and Gulf Coast Hospital started participation November 1, 2007. Traveler staff hired for these newly acquired hospitals participated in the competency assessment starting February 1, 2007. New graduate staff started participation in this competency assessment starting May 1, 2007. The installation process was completed in increments to allow for the education of leadership and staff as well as allow for refinement of established PBDS processes according to the needs of these two hospitals.

**Clinical Coach Programs**

In support of the PBDS assessment process, the Clinical Learning Division has provided Clinical Coach Programs. These preceptor programs provide training on the PBDS process for nurses who provide coaching support for new nursing employees. These programs prepare the Clinical Coach to assist in facilitating the new nurse to meet their development needs based on the results of the PBDS assessment. These programs are offered on a monthly basis.

New curricula was developed addressing the needs for Advanced Certified Nursing Assistants who coach the Basic Certified Nursing Assistants.

**Patient Care Services Orientation**

The purpose of the Patient Care Services (PCS) Orientation program is to provide newly employed Patient Care Services personnel with information needed to perform their jobs competently and professionally.

Both licensed and unlicensed staff in the acute care areas and The Rehabilitation Hospital attends PCS Orientation. It is a LMHS requirement that full-time, part-time, PRN, seasonal, travel, and Staffing Resource licensed and unlicensed PCS employees must complete PCS Orientation (either Licensed or Unlicensed as they apply) prior to the independent provision of care, treatment, and services. If employees are returning to LMHS within one year of absence, they may receive updated training on their hiring unit and bypass system PCS Orientation.
The content of the PCS Orientation program focuses on patient safety, LMHS standards of professional practice, and State and Federal regulatory agency guidelines. Topics such as medication management, laboratory specimen labeling/handling, and patient safety guidelines are among the many issues covered during PCS orientation.

**Summary of Traveler and Contract Personnel Competency Evaluations**

The contract services or managing entity, of contract personnel verifies that employees have met the necessary health screening, certification, and licensure and/or other credentials, competencies and criminal background checks. Lee Memorial Health System verifies population served competencies and conducts performance reviews. RN Traveler personnel are required to undergo health screening, nursing orientation, and PBDS, as are LMHS registered nurses. Performance reviews are completed at the end of each assignment period by the current supervisor and held on record in the department. A copy is forwarded to the contract service provider. Reasons for no re-hire status can include poor performance, lack of adequate skills, attendance issues, and transportation problems.

The next page illustrates the competency levels of Travelers and Contract staff/external service providers. The RN traveler staff that were terminated was due to PBDS scores and/or not meeting job expectations. Meeting expectations for a PBDS assessment is a requirement of their employment.

**Summary of dependent Allied Health Practitioners Competency Evaluations**

Effective in FY ’07 The Joint Commission implemented HR.1.20 requiring hospitals to review qualifications, assess competency and evaluate performance of dependent Allied Health Practitioners (AHPs). LMHS dependent Allied Health Practitioners are physician employed or sponsored staff who work under the supervision or direction of independent physicians at LMHS facilities. Dependent AHPs job classifications include Surgical Technicians, First Assistants, Research Coordinators, RNs, LPN, Auricular Therapists, Audiologist and a Mental Health Counselor. Each existing dependent AHP received an assessment of competency and an evaluation of performance in conjunction with the LMHS employee review cycle and will continue to receive future assessments and evaluations at the same frequency of employees.
## Summary of Patient Care & Patient Services Traveler personnel competency evaluations

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Number of Incumbents</th>
<th>Number Meeting or Exceeding COMPETENCY Standards</th>
<th>Number Termed or no longer used due to Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse (RN)</td>
<td>607</td>
<td>513</td>
<td>94</td>
</tr>
<tr>
<td>Licensed Practical Nurse</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Surgical Tech</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Respiratory Therapist</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Certified Surgical Tech</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Physical Therapist</td>
<td>12</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Physical Therapist Assistant</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Occupational Therapist Assist.</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Ultrasound Tech</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Radiology Tech</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Polysom Tech</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>649</strong></td>
<td><strong>554</strong></td>
<td><strong>95</strong></td>
</tr>
</tbody>
</table>

## Summary of Patient Care & Patient Services Contract/external service personnel competency evaluations

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Number of Incumbents</th>
<th>Number Meeting or Exceeding COMPETENCY Standards</th>
<th>Number Termed or no longer used due to Competency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auto-Transfusionist</td>
<td>4</td>
<td>4</td>
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Data Collection History

For the last seven years, an annual assessment of educational and staff development needs have been conducted through the annual performance appraisal process. Prior to 2003, the assessment was a summary report completed by the department head, and forwarded to Human Resources with the completed performance appraisal paperwork for the department. Although responses were not received from all departments, the report was adequately representative of the organization to form patterns and trends of educational needs.

Beginning in FY 99, the data were separated into Clinical/Direct Patient Care, and Non-Patient Care educational needs. In FY 01, a third category was added, recognizing the role of Indirect Patient Care. This category includes departments that routinely interact with patients, but are not hands-on with the patient. Examples would include housekeeping, food services, and maintenance, where personnel are in the patient rooms, but attending to issues other than patient care.

From this data, education needs were aggregated for the various target populations. Many of the specific needs relate to patient care, such as medication administration, physical assessment, intravenous tubes and pumps, and interpreting laboratory results and cardiac rhythms. Other topics identified in patient care areas could be other than clinical skills, such as working in teams, communication skills, and use of various computer and information technology systems.

The introduction of the Indirect Patient Care categories recognized the need to develop skills in the clinical setting for non-clinicians. The Indirect Patient Care audience represents a bridge between direct patient care and non-patient care. Topics are clinical in nature, but tailored for a non-clinical audience.

The third category of education requests was Non-Patient Care areas. These would include any department, which does not have patient care contact, such as the Finance, Human Resources, Marketing or Information Systems Departments. Additionally, topics may be of a non-clinical nature, such as communication skills, and are important to either a clinical or non-clinical target population.

In 2003, the method of data collection was further enhanced. For the FY 03 performance evaluation cycle, a first step was taken in an effort to capture educational needs assessment data electronically. A space was provided on the electronic evaluation form to identify up to five topics for development for each individual, based on a menu of 40 frequently requested topics. Although it was not required to make an entry on this section of the form, it did require a conscious step to move beyond the question. In the initial year FY 03, a total of 8060 responses were received. In FY 07 we received 18,707 responses. We feel this gives us an accurate picture of the educational needs of the organization.

While this is still not a scientific assessment methodology, it is much more complete than we have been able to produce in past years. This represents a major step forward in the automation of our data collection capabilities, and also is a step toward Individual Learning Plans for employees.

Additionally, this data is reflective of the focus on our five System Strategic Goals of quality, community, service, people and finance.
FY 07 Highlights

In FY 07 several pilot classes were introduced in response to the education needs assessment. LMHS also partnered with Business and Industry Services of the Lee County School System to present several sessions in Communication, and Teamwork. These sessions were well received.

In FY 07, LMHS changed vendors for our e-learning platform. On August 1, 2007, LMHS launched Nursing Spectrum CE-Direct and offered ‘seats’ for 2,317 acute-care nurses throughout the system. LMHS offered over 400 different on-line courses for nurses to self select needed educational offerings in order to improve their competencies. Many nursing units also used these on-line courses to provide initial and ongoing unit education. Between August 1, and October 31, 2007, there were 3,722 contact hours were completed on-line. This was 2,022 more completed contact hours then the entire previous year. LMHS is anticipating approximately 10,000 nursing contact hours to be completed in FY 08.

FY 07 Organizational Effectiveness coordinated the effort for over 600 LMHS leaders (4 hours each) to complete the FEMA National Incident Management System (NIMS) courses on-line. These courses help develop LMHS leaders competencies in emergency preparedness management.

To fill the need for customer service training, the Customer Service Department presented approximately 2,102 hours of classes to new and current employees.

LMHS continues to meet our regulatory requirements by offering programs such as the following:

- American Heart Association (AHA): Courses provided by Organizational Effectiveness and SWRMC Staff Development
  - Basic Life Support
  - Advanced Cardiac Life Support
  - Pediatric Advanced Life Support
  - Neonatal Resuscitation Program
- Mandatory Education Update
- HIV/AIDS education
- Domestic Violence
- Prevention of Medical Errors
- Health Information Portability and Accountability Act (HIPAA)
Education Needs Assessment for FY 07

Once again with the performance evaluations for FY 07 an option was provided to indicate up to 5 topics for staff development. This list includes approximately 90 choices. Employees and supervisors report the five areas they feel they need further development. Results are summarized in the graph below data gathered from the above assessments will be analyzed and used to develop the system education plan for 2008.

New in 2008

The Annual Mandatory Education module has been adapted to satisfy the continuing education requirements for healthcare workers on HIV & AIDS education. This will eliminate the need for employees to attend specific live classes, which will result in a more effective use of employee’s time, and increase the compliance rate for this education. An administrative enhancement is an on-line tool for the units to record their staff’s completion of the Annual Mandatory Education module electronically. In FY 08 the original LMHS and HCA Annual Mandatory Modules were merged and there will be one LMHS module to be completed each year by each employee. This change is estimated to save resources in labor and as well as eliminate numerous opportunities for hand-off errors.

Registration

The new on-line registration for classes was utilized in FY 07 with great success. We have expanded the on-line registration process, so it can be used to register for multiple courses. This makes the registration process much more efficient, and eliminates numerous opportunities for error, making it a much more reliable and accurate process.
Leadership Development

Lee Memorial’s Leadership Development function delivered a myriad of organizational learning and organizational development (OD) services in FY 07 including facilitating, coaching, consulting, designing, and teaching to help the organization, team and individuals be more successful and effective. LMHS’ leadership development program continues to be competency-based and focuses on learning activities that give participants (leaders and staff alike) real-time experiences to demonstrate and develop essential leadership competencies. In order to provide for as much individualization as possible, the Leadership Development function has adopted multiple learning-level approach and encourages participants to take an active role in their own learning. A fundamental goal of the function is that leaders begin to recognize and address their own learning needs and that the learning experiences provided are engaging, interactive, practical and use methods by which adults learn best.

FY 07 saw a continuation of several leadership programs that continue to help drive employee satisfaction in a positive direction—especially in the “My Supervisor/My Director” section of the annual employee satisfaction survey tool.

In FY 07, a total of 115 leaders completed the 40-hour Emerging Leaders Foundations of Leadership curriculum. The Emerging Leaders program targets employees new to supervision or management, managers who have recently joined LMHS, staff preparing to move into formal leadership positions as well as mid-level leaders desiring to update their skills with new management approaches and knowledge. The program draws participants and “guest-speakers” from across the entire health system and is based on the following assumptions:

- Adults learn best through experiences.
- Adults learn best through problem solving.
- Adults learn best when the learning is of practical and immediate value.

Emerging Leaders curriculum outlines the skill needed to become strong and competent leaders while providing opportunities for the practical application of the skills and techniques being described. Course work focuses on the significant and challenging leadership skills of communicating, delegating, coaching, motivating, and hiring. The program culminates in a special commencement program with health system president and CEO, Jim Nathan, conducting a personal Q&A session disclosing some of his “leadership learnings” while the participants discuss their personal/professional growth and development during the program.

LMHS’ leadership core competencies include “Understanding Our Business and Services”. In order to build leadership competence in all divisions, the 2005 Emerging Nurse-Leader curriculum was retooled to include operational-level leaders from across the system. A total of 24 mid-level leaders completed the curriculum which focused on the “business-side” of healthcare including modules designed to build acumen in healthcare finance, staffing models, clinical quality, process improvement and productivity.

Behavioral Interviewing and Selection Success continues to be a well-attended leadership development course. The goals of the interactive course include reducing new-hire turnover, improving the “on-boarding” experience for orientees and to improve selection decisions based on identifying essential competencies and using specific job-related criteria. A total of 54 front-line hiring managers completed the four-hour training program in FY 07.

Leadership Development and Clinical Learning departments teamed up in FY 07 to design and deliver a much needed (and requested) learning event: Charge Nurse Development. A total of 118 “charge-nurses” from across the system attended the 8-hour training program focused on maximizing employee performance and patient satisfaction through effective unit-based leadership.

Leadership Update continues to present timely, essential topics for the entire management team from front-line supervisors through executive-level leaders. The monthly Leadership Update meeting has been adapted to include critical information for leaders on productivity and quality improvement efforts and uses a rotating senior-leader speaker to highlight the system’s areas of strategic focus. It is a critical part of every leader’s on-going development.
COMPETENCE MAINTENANCE ACTIVITIES

Learning Needs Assessment Data and Developmental Planning

The Clinical Learning, SWRMC Staff Development, Leadership Development and Organizational Effectiveness Departments’ aggregates the organizational learning needs data received from the annual and 90-day performance evaluations. Additional employee learning needs are identified through employee surveys, employee satisfaction data, performance improvement initiatives, and program evaluation feedback. This aggregate data is used to develop and present education and training programs to meet the stated learning needs.

Leadership continuously assesses employee learning needs and documents during the annual employee performance evaluation conference. The employee and their immediate supervisor then build an employee development plan which includes:

- Areas to be developed
- Annual employee goals, and
- Plans detailing how development will be implemented.

Direct Patient Care Learning Needs:

Leadership identified the following categories as direct patient caregiver’s learning needs. These learning needs were documented in written assessments:

- Basic and Advanced Clinical Skills
- Critical Care Nursing Skills
- Critical Thinking
- Delegation
- Legal Aspects of Charting
- Surviving Depositions
- Certification Review Programs
- Pain Management
- Assessment and Management of Pressure Ulcers
- Documentation Updates
- Basic Work and Time Management Skills
- Relationship and Interpersonal Skills
- Leadership and Management Skills
- Mentoring
- Trauma
- Charge Nurse Development
- Toxicology

Indirect Patient Care Learning Needs:

Leadership identified the following categories as indirect patient care provider’s learning needs. These learning needs were documented in written assessments:

- Basic Work Skills and Time Management
- Relationship and Interpersonal Skills
- Computer Skills
- Team Building and Development
- Leadership and Management Skills
Non-patient Care Learning Needs:

Leadership identified the following categories as non-patient care provider’s learning needs. These learning needs were documented in written assessments:

- Computer Skills
- Human Resources Skills
- Relationship and Interpersonal Skills
- Customer Relations Skills
- Finance and Budget Skills
- Leadership and Management Skills

Leadership Learning Needs:

Leadership learning needs were documented from a variety of sources including self-assessment; interview with senior leaders; 360-degree multi-rater feedback and annual leadership accountability evaluations. These learning needs include:

- Role of leadership
- Building successful teams
- Time management skills
- Process improvement
- Effective coaching
- Effective communication
- Healthcare finance for the non-financial manager
- Performance management
- Continuous learning
- Behavioral interviewing and hiring practices
- Goal setting
- Public speaking
- Decision making skills
- Managing conflict
- Employee retention and engagement
- Mentoring
- Project Management

Status of education initiatives in the clinical disciplines:

Human Resources, Staff Development, Organizational Effectiveness, and Clinical Learning are committed to meeting the orientation, training, remediation and educational needs of LMHS employees and management. The orientation process, OnBoarding, was designed to meet not only the safety and regulatory training requirements but also the socialization needs of the new employee.

The first 90 days of employment are carefully structured. The new employee is paired with a seasoned and competent employee, meetings with their supervisor are regularly scheduled and their interactions with other employees and departments are monitored. Clinical Learning and Organizational Effectiveness offers an extensive list of training and educational programs for all levels of employees during this period.

In addition to the ongoing nursing student the residency and internships for RN’s, continuing education seminars are provided, Clinical Learning provides residency and internships for RN’s, and continuing education seminars. Primedia-Trinity Learning for e-learning was discontinued in September 2006. In its place, a contract was initiated with Nursing Spectrum CE-Direct. In FY 07, LMHS was able to offer thousands of e-learning courses to nurses for contact hours.

Educational Programs Offered in Response to Needs Assessment (Direct Patient Care)
<table>
<thead>
<tr>
<th>Course Category</th>
<th>Programs Offered</th>
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</table>
| Internship Programs                 | Internship programs are provided throughout the year for new graduates, nurses returning to the bedside, and nurses desiring to change careers. The curriculums for these programs are based on Benner’s model of novice to expert and support a critical thinking model based on the PBDS assessment process. The rationale for using this model as the curriculum template is to enhance the critical thinking of nurses in order to provide the safest and competent care to our patients. Internship programs include:  
Medical Surgical Core Program  
Progressive Care Program  
Intensive Care Program  
Neonatal Intensive Care Program  
Open Heart Intensive Care Program  
Pediatric Internship Program  
Pediatric Intensive Care Program  
High Risk Perinatal Program  
Maternal Child Internship Program  
Emergency Nursing Program  
Emergency Nursing “Bridge” Program  
AACN Critical Care Web Based Program |
| Orientation Improvements and        | On-Boarding Program  
Navigator Program  
System Nursing Orientation:  
Nursing Orientation provides a review of Patient Care Services and key elements processes to promote safe and competent care to our patients. The program supports the ANCC Forces of Magnetism. Student and traveler nurses also attend the nursing orientation program.  
Performance Based Development System (PBDS) is integrated into the Nursing Orientation process |
| Professional Practice               | Evidence Based Practice Monthly Program – Live and On Line  
“Where is the Evidence” Literature Review Programs  
First Annual Nursing Research and EBP Conference  
Monthly Journal Clubs each Campus |
| Intravenous/Phlebotomy Training     | Monthly phlebotomy programs  
Venous Access Device Programs  
PICC Line Programs  
IV Training for Radiology Department  
Central Line Therapy On Line Program  
Affiliation with High Tech Central for LPN IV Therapy Course  
IV Medication Administration Update |
| Regulatory Education/Other          | Self Study Module on Age Specific Care, Cultural Competence, HIV/AIDS, Domestic Violence, Prevention of Medication Errors  
Live presentations on HIV/AIDS, Domestic Violence, Prevention of Medication Errors  
Care of the Patient with Restraints  
Code Blue Review Program  
HIPAA Training/Self Study  
Monthly Ethics Programs  
Transcultural Nursing and Self Study Module  
On Line Cultural Competency Programs “80 Weeks Around Lee County” |
<table>
<thead>
<tr>
<th>Course Category</th>
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| Patient/Employee Safety Education | Prevention of Medical Errors  
Lab Labeling In-services  
Radiation Safety  
Workplace Violence and Safety  
Ergonomics in the Workplace  
Hazmat Awareness  
Patient Safety Updates – Policy and Procedure Self Study Modules  
Suicide Awareness Program Self Study  
Fall Assessment Prevention Program  
Diligent Lifting Program  
Medication Reconciliation  
Hand-Off Communication Module  
Pressure Ulcers  
Pain Management  
Toxicology  
Included in System and Nursing Orientation Programs  
Annual Competency Learning Fair Programs  
Radiology and Infection Control  
Immunizations Update  
Integrated into Internship Programs  
Wound Vac Protocol  
Ventilator Infections  
Sepsis for Oncology RNs  
Neutropenia Precautions  
Central Line Blood Stream Infections |
| Infection Control                | Basic Life Support (BLS)  
Advanced Cardiac Life Support (ACLS)  
Pediatric Advanced Life Support (PALS)  
BLS Instructor Program  
BLS Instructor Update Programs  
Neonatal Resuscitation Programs |
| American Heart Association Programs | Cardiac Rhythms Programs  
12-Lead EKG Programs  
Progressive Care Programs  
Open Heart Intensive Care Program  
Basic Concepts of PA Catheter  
Intra-Aortic Balloon Pump Program  
Progressive Care Certification Review Program  
Critical Care Certification Review Program  
Cardiovascular Disease Prevention |
| Cardiology Programs              | Trauma Nursing Care Certification Program (TNCC)  
Organ/Tissue Donation  
Making Triage work for you  
Trauma Challenges |
| Trauma Education                 | Oncology/Hematology Internship Program  
Biology of Breast Cancer  
Elderly Cancer Patient Corner  
Bleeding Precautions  
Neutropenia for Oncology RNs  
Oncology Case Studies  
Sepsis for Oncology RNs  
Radiation Safety  
Elderly Cancer Patient Corner  
Biology of Breast Cancer  
Palliative Care  
Thrombocytopenia for Oncology RNs  
Managing Cancer Pain  
Alternate Dosing – Ovarian Cancer |
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<th>Course Category</th>
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| Respiratory Care Education   | Chest Tube Module  
|                              | Arterial Blood Gas In-services  
|                              | Pulse Oximetry/Respiratory Assessment  
|                              | Prevention of Ventilator Associated Infections                                   |
| Pediatric Education          | Radiation Therapy for Children  
|                              | Pediatric Oncology  
|                              | Pediatric Oncology Certification Review  
|                              | Pediatric Pain Management  
|                              | Pediatric Haematopiesis Transplant  
|                              | Pediatric Ventilation  
|                              | Growth & Nutrition/Cystic Fibrosis  
|                              | Cleft Lip & Palate In-service                                                   |
| Geriatrics Education         | Alzheimer, Dementia Review  
|                              | Elderly Cancer Patient Corner  
|                              | Secure Project – Aging Sensitivity Program  
|                              | Annual Geriatrics Seminar through Clinical Learning  
|                              | Prevention of Falls  
|                              | Medical/Surgical Certification Review                                             |
| Unit Specific Programs       | Recognizing DVTs  
|                              | Oncology Education  
|                              | PACU Class  
|                              | Diabetes Education  
|                              | Parish Nurse Preparation Course  
|                              | Neonatal Abstinence Program  
|                              | Fetal Scalp Electrode Placement  
|                              | Vascular Seals                                                                   |
| Annual Learning Fair Program for Patient Services Staff | Restraints  
|                              | Patient Controlled Analgesia/Epidural Analgesics  
|                              | Pressure Ulcer Prevention  
|                              | Basic and Advanced Cardiac Rhythms  
|                              | Point of Care Testing  
|                              | IV Therapy General  
|                              | IV Therapy Central Lines  
|                              | Medication Administration/Safety  
|                              | Lab Labeling  
|                              | Risk for Falls  
|                              | Documentation  
|                              | Pain Management  
|                              | Infection Control                                                                |
| Leadership Development       | Foundations of Leadership, aka, Emerging Leaders  
|                              | Strategic Leaders (aka Emerging Nurse-Leaders)  
|                              | Mentoring for Professional Development  
|                              | Behavioral Interviewing and Selections Success  
|                              | Human Resources Fundamentals  
|                              | Customer Service Excellence  
|                              | Enhancing Productivity in Healthcare  
|                              | Project Management  
|                              | Unlocking Unit Excellence-Advisory Board  
|                              | Finance for Non-Financial Managers  
|                              | Understanding Yourself and Others (DiSC)  
|                              | Effective Meeting Leadership  
|                              | Conflict Management  
|                              | Team Building  
|                              | Physician Leadership Development  
|                              | Train the Trainer: Concepts of Adult Learning  
|                              | Charge Nurse Development  
|                              | Lunch and Learn for Leadership:  
<p>|                              | - Passionate Leadership: Rekindling the Spark                                    |</p>
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<thead>
<tr>
<th>Course Category</th>
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<td>• Standardizing Meeting Minutes</td>
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<td>360 degree Multi-rater Feedback</td>
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<td>Customized leadership performance coaching</td>
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<td>National Incident Management System (NIMS)</td>
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<td>Love’em or Lose ‘em – Getting Good People to Stay</td>
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<td>Clinical Coach Programs</td>
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<td>PCCN/ICU Review Course</td>
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<td>Charge Nurse Development</td>
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<td>Clinical Educator Development (Program Evaluation, Team Building)</td>
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<td>Fetal Monitoring Basic and Advanced</td>
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### Educational Programs Offered in Response to Needs Assessment
#### (Indirect Patient Care)

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<td>Customer Service Unit Specific Programs</td>
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<td>Corporate Compliance Training</td>
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<td>HIPAA Training</td>
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<td>Coaching and Mentoring Programs</td>
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<td>Timekeeper Training</td>
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<td>Hazmat Decon Team</td>
<td>Hiring the Best – Behavioral Interview</td>
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### Educational Programs Offered in Response to Needs Assessment
#### (Non-Patient Care)

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Clinical Learning Updates
Professional Nurse Advancement Program (PNAP)

Background

In July of 2002, the Professional Nursing Advancement Program (PNAP) was developed to recognize registered nurses who demonstrate excellence in nursing practice. The driving forces behind the development of this program were a desire to recognize clinical expertise and excellence, to raise the standards of nursing practice at LMHS, to recognize the contribution of nursing practice to patient outcomes, and to aid with recruitment and retention efforts for expert nurses.

Levels of Advancement and Domains of Practice

There are two levels of advancement in the PNAP program, referred to as Level II, and Level III. Each PNAP level reflects 5 domains of nursing practice. These domains include:

1. Patient advocacy & caring practices
2. Clinical judgment
3. Collaboration
4. Competence development/growth
5. Evidence-based practice and nursing

Eligibility

The PNAP is open to all full-time and part-time staff RNs who provide direct patient care and are employed within the acute care facilities and the Rehabilitation Hospital. Participation in the program is totally voluntary.

Applicants for advancement must meet the following requirements:

- Must have worked a minimum of 1040 hours in the past 12 months.
- Must have no disciplinary action at the written level or above within the last 12 months.
- Have received a successful performance evaluation.
- Employees can advance after 6 months in a RN position with a completed performance evaluation from their manager/director

Application process

The Application process for the PNAP is simple. Applicants first must read the PNAP policy and procedure, and then obtain a PNAP application online from the PNAP webpage on the nursing website. Next, they should contact the PNAP chairperson to be assigned a coach at least 4 weeks before the submission deadline. And finally, they submit their completed portfolio to the PNAP chairperson by the designated submission date. After the PNAP chairperson verifies that the portfolio submission is complete, an acceptance letter is sent out to the staff member along with their designated review date. This review is a peer-centered process which allows the applicant the opportunity to describe their experiences and/or qualifications, and allows the PNAP committee the opportunity to clarify any of the elements of the PNAP portfolio submission.

Portfolio content

All Level II and Level III applications must contain the following:

- Application form completed and signed by the applicant and their manager/director.
- Current professional resume.
- A minimum of three (3) clinical exemplars with references and bibliography.
- Documents that support or demonstrate your actions.

Additionally, all Level III applicants must include:

- Copy of degree with date received, or copy of grades for 6 credit hours within the last year.
- Copy of approved professional nursing certification.
**Recognition**

The rewards for participating in the Professional Nurse Advancement Program are many. In addition to the personal reward that comes with such a professional accomplishment, each applicant who successfully advances through the PNAP will receive a beautiful pin signifying their achievement and a certificate of advancement. In addition, announcement of successful PNAP candidates is made through organizational and nursing newsletters. Finally, successful PNAP candidates receive a monetary award:

- Level II $2,500.00
- Level III $5,000.00

In order to maintain the advancement achieved, nurses must reapply to the PNAP each year. If a candidate is unsuccessful in their attempts at promotion through the PNAP, they will be assigned a coach/mentor to help facilitate their application and/or interview process.

In FY07, there were a total of 112 nurses promoted through the PNAP (both Level II and Level III). Until January 2008, the PNAP program had been limited to those nurses practicing at CCH, LMH, and HPMC. Currently, nurses in the LMHS are invited to participate in this program, and educational sessions and coaching are being offered for nurses at SWRMC and GCH.

**Patient & Employee Safety Programs**

The majority of educational programs for clinical staff and employees are designed with a focus on patient and employee safety. In addition, programs are also centered on educating staff concerning the National Patient Safety Goals of the Joint Commission. Some of the programs held in 2007 are as follows:

- Patient Care Services Update Module focusing on Patient Safety Goals & LMHS policies
- Frequent “J Mails” written communication to reinforce patient safety issues and policies
- Unit Specific Environment of Care Programs
- Prevention of Medical Errors
- Promoting a Culture of Safety
- Proper Blood Banding Procedure
- Lab Labeling Programs
- Falls Prevention Program
- Hand Off Communication
- Medication Reconciliation
Programs Planned for 2008

✓ Nursing Supervisor Development Program called Emerging Nurse Leaders
✓ Mentoring Program
✓ Personal Best
✓ Clinical Coach Programs
✓ DISC
✓ Team Building
✓ Communication
✓ Conflict Management
✓ Meeting Minutes
✓ Running Effective Meetings
✓ School at Work
✓ Certified Nursing Assistant Competency Assessment Program
✓ Skills Validation Fairs for Patient Services Staff
✓ Professional Development Seminars
✓ Medical-Surgical Certification Review Course
✓ Progressive Care Certification Review Program
✓ Critical Care Nursing Certification Review Program
✓ Evidenced Based Nursing Practice Monthly Program and Seminar
✓ Older Adult Sensitivity Program
✓ Maternal Child Certification Review Program
✓ Cultural Diversity Programs
✓ Pediatric Certification Review Program
✓ Trauma Education Programs
✓ Development Programs for Clinical Educators
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<th>Favorable Direction</th>
<th>Period Reported</th>
<th>FY 2007 Actual</th>
<th>FY 2008 Target</th>
<th>Fiscal YTD Actual</th>
<th>Current Period</th>
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<tr>
<td><strong>PEOPLE</strong></td>
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<td></td>
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<td>Employee Satisfaction (Likelihood to Recommend)</td>
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<td>Jan-08</td>
<td>74.7</td>
<td>74.7</td>
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<td>Vacancy Rate</td>
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<td>7.02%</td>
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<td>13.10%</td>
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<td>Mortality Rate - Acute</td>
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<td>Dec-07</td>
<td>1.71%</td>
<td>1.99%</td>
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<td>Medication Errors(Level II)</td>
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<td>0.33</td>
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<td>ALOS - Acute</td>
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<td>↓</td>
<td>Dec-07</td>
<td>4.29</td>
<td>4.60</td>
<td>4.38</td>
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<td>Complication Rate - Acute</td>
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<td>5.45%</td>
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<td>Surgical Infection Rate - Acute</td>
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<td>Qtr 1</td>
<td>0.96%</td>
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<td><strong>SERVICE</strong></td>
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<td>Patient Satisfaction</td>
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<td>HCAHPS (% Top Box) - Likelihood to Recommend</td>
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<td>61.8%</td>
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<td>Gross IP Revenue per CMI Admission</td>
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<td>Dec-07</td>
<td>$18,181</td>
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<td>Free Standing O/IP Registrations</td>
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<td>Net Fixed Assets per CMI Adjusted Admission (FYTD)</td>
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<td><strong>FINANCE</strong></td>
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<td>Operating Margin</td>
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<td>Dec-07</td>
<td>2.8%</td>
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<td>Cash/Debt Ratio</td>
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<td>74.2%</td>
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<td>Days in Accounts Receivable</td>
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<td>60.0</td>
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<td>Wages % of Net Revenue</td>
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<td>Dec-07</td>
<td>51.0%</td>
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<td>53.8%</td>
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<td>Net Revenue per CMI Adjusted Admission</td>
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<td>Dec-07</td>
<td>$6,658</td>
<td>FY $7,404</td>
<td>FYTD $6,998</td>
<td>CM $6,881</td>
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<td>Cost per CMI Adjusted Admission</td>
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<td>Dec-07</td>
<td>$6,475</td>
<td>FY $7,081</td>
<td>FYTD $6,998</td>
<td>CM $6,901</td>
</tr>
</tbody>
</table>

*Notes:
1. Quality Index: 3/5 Meets; 4/5 Exceeds

Prepared by Planning and Strategy
4. Centers for Medicare & Medicaid Services (CMS) Rule (Verbal Update)

(Jim Humphrey, Board Counsel & Keith Arnold, Legislative Consultant – 10 min)

There is no documentation for this item.
**HOUSE OF REPRESENTATIVES STAFF ANALYSIS**

**BILL #:** HB 351  
**SPONSOR(S):** Reagan and others  
**TIED BILLS:**  
**IDENT./SIM. BILLS:** SB 816

**REFERENCE**  | **ACTION**  | **ANALYST**  | **STAFF DIRECTOR**
---|---|---|---
1) Committee on Infrastructure | 8 Y, 0 N | Brown | Miller
2) Economic Expansion & Infrastructure Council | | | |
3) Policy & Budget Council | | | |
4) | | | |
5) | | | |

**SUMMARY ANALYSIS**

HB 351 creates the “Mark Wandall Traffic Safety Act.” The bill authorizes counties and municipalities to enact ordinances permitting the use of traffic infraction detectors and specifies the required content of the ordinance. The penalty for failing to stop at a steady red light, as determined through the use of a traffic infraction detector, is a fine of $125. The bill describes requirements that must be met when issuing a ticket through documentation by the traffic infraction detector and the challenge procedure to be followed if someone other than the vehicle owner was driving the vehicle at the time of the alleged violation.

The bill provides a complaint process for complaints that a county or municipality is employing traffic infraction detectors for purposes other than the promotion of public health, welfare, and safety or in a manner inconsistent with the law. Each county or municipality that operates a traffic infraction detector must submit an annual report to the Department of Highway Safety and Motor Vehicles (Department) which details the results of the detectors and the procedures for enforcement. The Department must submit a summary report to the Governor and Legislature on or before December 1, 2009, which includes a review of the information submitted by the counties and municipalities and any recommendations or necessary legislation.

The bill revises the definition of “habitual traffic offender” to include three convictions for a violation of a traffic control red light within a three-year period. Violations detected by use of a traffic infraction detector are not considered convictions for habitual traffic offender purposes. A severability clause is also provided.

To the extent local governments choose to enact ordinances to permit the use of traffic infraction detectors there will be a fiscal impact to the local governments for the cost of the installation and maintenance of the devices, the amount of which will vary depending on the negotiated agreement between the local government and any private vendor providing the equipment. There may be an increase in fine revenue for the local governments that choose to enact ordinances permitting the use of traffic infraction detectors, the amount of which is indeterminate and reliant on driver awareness and future behavior.

The bill is effective upon becoming law.
FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government- The bill authorizes a local government to enact an ordinance to permit the use of traffic infraction devices to photograph motor vehicles that run red lights. The local government is also authorized to impose a fine of $125 on vehicle owners whose vehicle ran a red light, as determined by a traffic infraction device.

Promote Personal Responsibility- The use of traffic infraction devices by local governments may promote personal responsibility by increasing the likelihood of a sanction for failure to obey a traffic control device.

B. EFFECT OF PROPOSED CHANGES:

Present Situation

According to the Department, in 2007 there were 106 fatalities and 10,720 injuries related to motor vehicle drivers who disregarded a traffic signal in Florida.¹

Traffic infraction detectors, or “red light cameras,” are used to enforce traffic laws by automatically photographing vehicles whose drivers run red lights. A red light camera is connected to the traffic signal and to sensors that monitor traffic flow at the crosswalk or stop line. The system continuously monitors the traffic signal, and the camera is triggered by any vehicle entering the intersection above a pre-set minimum speed and following a specified time after the signal has turned red. A second photograph typically shows the red light violator in the intersection. In some cases video cameras are used. Cameras record the license plate number, the date and time of day, the time elapsed since the beginning of the red signal, and the vehicle speed. Over 110 cities and towns in 20 states across the country currently participate in a red light camera program². Red light cameras have been used in at least 33 foreign countries since the 1970s.³

An Insurance Institute for Highway Safety (IIHS) review of international red light camera studies concluded that cameras reduce red light violations by 40-50 percent and reduce injury crashes by 25-30 percent.⁴ A 2005 study of red light camera programs in seven metropolitan communities by the Federal Highway Administration concluded that there was a 25 percent reduction in right-angle collisions, but a 15 percent increase in rear-end collisions.⁵ It is possible that the volume of rear-end collisions will decline as drivers get used to the idea that the vehicle in front of them will stop at a red light.⁶

Other studies, including a 7-jurisdiction study conducted by the Virginia Department of Transportation⁷ and a USDOT-funded study by the Urban Transit Institute at North Carolina A&T University,⁸ have reached conflicting results regarding crash reduction. The results of these studies are best summarized by this excerpt from the North Carolina study:

¹ Email from Office of Legislative Affairs, Department of Highway Safety and Motor Vehicles, February 12, 2008.
⁶ Id.
⁷ Available online here: http://www.thenewspaper.com/rlc/docs/05-vdot.pdf
⁸ Available online here: http://www.thenewspaper.com/rlc/docs/burkeyobeng.pdf
The results do not support the conventional wisdom expressed in recent literature and popular press that red light cameras reduce accidents.... Our findings are more pessimistic, finding no change in angle accidents and large increases in rear-end crashes and many other types of crashes relative to other intersections. We did find a decrease in accidents involving a vehicle turning left and a vehicle on the same roadway, which may have been included as an angle accident in some other studies. However, given that these left turn accidents occur only one third as often as angle accidents, and the fact that we find no benefit from decreasing severity of accidents suggests that there has been no demonstrable benefit from the RLC [red light camera] program in terms of safety. In many ways, the evidence points toward the installation of RLCs as a detriment to safety.

Critics on each side of the debate raise concerns about the scientific methodology of opposing studies and potential bias of researchers. Criticisms have focused on issues such as sample size, control of variables (weather, similarity of intersections, etc), and other possible control methods (e.g., failure to analyze intersections before/after detectors are placed).

Currently there are no recognized independent standards or certifications for the red light camera industry. The Federal Highway Administration (FHWA) and the National Highway Traffic Safety Administration (NHTSA) have developed guidelines for the use of state and local agencies on the implementation and operation of red light camera systems. These guidelines were updated in January 2005.\(^9\) Although not a regulatory requirement, the guidance is intended to provide critical information for state and local agencies on relevant aspects of red light camera systems in order to promote consistency and proper implementation and operation. The guidelines present research that suggests engineering improvements, safety education and increased enforcement by law enforcement officers can significantly reduce red light violations.

Examples of engineering improvements include:

- **Improving signal head visibility.** Signal head visibility can be improved by increasing the size of the traffic signal lamps from 8 to 12 inches. The addition of backplates can also make signals more visible.
- **All-red interval.** An all-red clearance interval, where the traffic signals on all sides are red for a period of time, provides additional time for motorists already in the intersection to proceed through the intersection on the red indication while holding cross traffic on the cross street approaches. The red clearance interval is not intended to reduce the incidence of red light running; rather it is a safety measure.
- **Appropriate yellow times.** The likelihood of a motorist running a red light increases as the yellow interval is shortened. Lengthening the yellow interval, within appropriate guidelines, has been shown to significantly reduce the number of inadvertent red light violations.
- **Traffic signal coordination.** A coordinated traffic signal operation where motorists are able to move smoothly in platoons from intersection to intersection reduces the risk of red light violations and collisions.

Cameras are permitted by current Florida law to enforce violations of payment of tolls.\(^10\) For example, toll facility operators use a digital camera to capture an image of the vehicle’s license plate as the vehicle travels through the tolling zone. If the system receives payment from a SunPass, the image is deleted. If no payment is received, the image is processed for video tolling or is considered a toll violation and a Uniform Traffic Citation is issued.

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\(^10\) s. 316.1001(2)(d), F.S.
In response to the city of Pembroke Pines’ inquiry regarding the use of unmanned cameras to enforce violations of traffic signals, the Attorney General issued an advisory legal opinion on July 12, 2005. The opinion concluded that it was within the local government’s scope of authority “to enact an ordinance authorizing the city:

- to monitor violations of traffic signals within the city and to use unmanned cameras to monitor intersections and record traffic violations;
- to monitor violations of traffic signals within the city and to use unmanned cameras to record the license tag numbers of cars involved in such violations; and
- to advise a car owner that his or her license tag number has been recorded in a violation of the traffic laws.”

The problem identified by a 1997 Attorney General Opinion was whether unmanned electronic traffic infraction detectors may independently be used as the basis for issuing citations for violations of traffic laws. Current statute requires that citations be issued when an officer “observes the commission of a traffic infraction.” The 1997 Attorney General Opinion concluded that nothing precludes the use of unmanned cameras to record violations of s. 316.075, F.S., but “a photographic record of a vehicle violating traffic control laws may not be used as the basis for issuing a citation for such violations.” The 2005 Attorney General Opinion reached the same conclusion, stating, “legislative changes are necessary before local governments may issue traffic citations and penalize drivers who fail to obey red light indications on traffic signal devices” as collected from a photographic record from unmanned cameras monitoring intersections.

Several local governments in Florida have participated in the use of red light cameras enforcement of red light violations. Due to the Attorney General’s Advisory Opinions, the majority of local governments have used the cameras in pilot projects solely for data collection purposes or as a warning system to motorists, by sending a letter and attaching no penalty. Sarasota County, Manatee County, Palm Beach County, Polk County, and the cities of Orlando and Melbourne are examples of local governments that have at one time participated in a red light camera pilot project. The Palm Beach County Commission reported that their two-month pilot project using traffic cameras at a test intersection in Palm Beach County showed alarming results. One fifth of those who ran a red light did so two seconds after the light had changed. On average, fifty cars a day ran the light at the test site during the first month of the pilot project. During the second month of the project, following publicity about the program, that number dropped to less than twenty.

The city of Gulf Breeze passed a local ordinance in 2005 allowing use of red light cameras. A violation by any motor vehicle running a red light that is recorded by a traffic enforcement photographic system is deemed a civil, noncriminal violation and a $100 civil fee is assessed against the motor vehicle owner. The city has installed one red light camera at Daniel Drive and U.S. 98 in front of Gulf Breeze Middle School. The Gulf Breeze City Council adopted the ordinance despite the opinion issued by the Attorney General. The Gulf Breeze Police Chief said that after the signs went up, violations dropped from 150 a month to 95 in a little over a year. The camera was installed by “Traffipax.” According to the police chief, the vendor paid for the initial cost of setting up the program. In return, the vendor is paid a percentage of the $100 fine. “Peek Traffic”, the vendor who donated the equipment and monitoring for Sarasota County’s pilot project, states that a camera typically costs approximately $50,000 and is $10,000 to install.

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11 Attorney General Opinion 05-41.
12 Attorney General Opinion 97-06.
13 s. 316.640(5)(a), F.S.
14 Palm Beach County Board of County Commissioners, “FY 2007 State Legislative Program”, available online here: http://www.pbcgov.com/legislativeaffairs/pdf/LegProg.pdf
Proposed Changes

Local Ordinance Authorization

HB 351 creates the “Mark Wandall Traffic Safety Act.” The bill creates s. 316.0083, F.S., authorizing counties and municipalities to enact ordinances permitting the use of traffic infraction detectors and specifies the required content of the ordinance. Pursuant to the new statute, each local ordinance must:

- provide for the use of a traffic infraction detector to enforce s. 316.075(1)(c), F.S., which requires the driver of a motor vehicle to stop when facing a traffic signal steady red light on the streets and highways under the jurisdiction of the county or municipality;
- authorize a traffic infraction enforcement officer to issue a ticket for violation of s. 316.075(1)(c), F.S., and to enforce the payment of tickets for such violation;
- require signs to be posted at locations designated by the county or municipality providing notification that a traffic infraction detector may be in use;
- require the county or municipality to make a public announcement and conduct a public awareness campaign of the proposed use of traffic infraction detectors at least 30 days before commencing the enforcement program;
- establish a fine of $125 to be assessed against the owner of a motor vehicle whose vehicle fails to stop when facing a red light, as determined through use of a traffic infraction detector; and

Fines

The fine imposed by the local ordinance is done so in the same manner and is subject to the same limitations as provided for parking violations under s. 316.1967, F.S. The Department’s authority to suspend or revoke a license (contained in Chapter 318 and s. 322.27, F.S.) is not applicable to a violation of an ordinance enacted under s. 316.0083, F.S. A violation is not a conviction of the operator, may not be made a part of the operator’s driving record, may not be used for purposes of setting motor vehicle insurance rates, and may not result in points assessed against the operator’s driver’s license. Fines assessed under the ordinance are retained by the county or municipality.

Procedure for Issuance and Contestation of Tickets

HB 351 cites current statutory procedures addressing liability for payment of parking ticket violations and other parking violations16 and applies those procedures to violations of ordinances created under s. 316.0083, F.S., with the following additional requirements:

- the name and address of the person alleged to be liable as the registered owner or operator of the vehicle involved in the violation;
- the registration number of the vehicle;
- the violation charged;
- a copy of the recorded image;
- the location where the violation occurred;
- the date and time of the violation;
- information that identifies the device that recorded the violation;
- a signed statement by a specifically trained technician employed by the agency or its contractor that, based on inspection of recorded images, the motor vehicle was being operated in violation of s. 316.075(1)(c), F.S.;
- the amount of the fine;
- the date by which the fine must be paid;
- the procedure for contesting the violation alleged in the ticket; and
- a warning that failure to contest the violation in the manner and time provided is deemed an admission of the liability and that a default may be entered thereon.

---

16 Section 316.1967(2)-(5), F.S.
The violation is processed by the county or municipality that has jurisdiction over the street or highway where the violation occurred or by any entity authorized by the county or municipality to prepare and mail the ticket. The ticket is sent by first-class mail to the owner of the vehicle involved in the violation no less than 14 days after the date of the violation and the owner is responsible for payment of the fine unless the owner can establish that the vehicle:

- Passed through the intersection to yield the right-of-way to an emergency vehicle or as part of a funeral procession;
- Passed through the intersection at the direction of a law enforcement officer;
- Was, at the time of the violation, reported as stolen; or
- A Uniform Traffic Citation (UTC) was issued for the alleged violation.

The owner of the vehicle must furnish an affidavit to the county or municipality that provides detailed information supporting an exemption as provided above, including relevant documents such as a police report (if the car had been reported stolen) or a copy of the UTC, if issued.

A person may elect to contest the determination that they failed to stop at a red light as evidenced by the traffic infraction detector by electing to appear before a judge authorized to adjudicate traffic infractions. If the person elects to appear before the court, they are deemed to have waived the limitation of civil penalties imposed for the violation and the court may impose a civil penalty not to exceed $125 plus court costs. The court may take appropriate measures to enforce collection of any penalty not paid within the time permitted by the court.

A certificate sworn to or affirmed by a person authorized under s. 316.008, F.S., who is employed by or under contract with the county or municipality where the infraction occurred, or a fax of such a certificate, that is based upon inspection of photographs or other recorded images produced by the traffic infraction detector, is considered evidence of the facts contained in the certificate. A photograph or other recorded image evidencing a violation must be available for inspection in any proceeding to adjudicate liability for violation of an ordinance enacted under s. 316.0083, F.S.

The bill authorizes counties and municipalities to provide the names of those who have one or more outstanding violations, as recorded by traffic infraction detectors, to the Department. Pursuant to s. 320.03(8), F.S., if a person’s name appears on the Department’s list, a license plate or revalidation sticker may not be issued until the fine has been paid.

Accountability

The bill provides for a complaint process for complaints that a county or municipality is employing traffic infraction detectors for purposes other than the promotion of public health, welfare, and safety or in a manner inconsistent with the law. A complaint may be submitted to the governing board of the county or municipality.

Each county or municipality that operates a traffic infraction detector is required to submit an annual report to the Department, which must contain:

- the complaints received, along with any investigation and corrective action taken by the governing body;
- the results of using the traffic infraction detector; and
- the procedures for enforcement.

The Department must submit an annual summary report to the Governor and Legislature which must contain:

- a review of the information received from the counties and municipalities;
- a description of the enhancement of the traffic safety and enforcement programs; and
- recommendations, including any necessary legislation.
The first report must be submitted on or before December 1, 2009. After reviewing the report, the Legislature may exclude a county or municipality from further participation in the program. Any traffic infraction detector installed on the state’s streets or highways must meet requirements established by the Department of Transportation (DOT) and must be tested at regular intervals according to procedures prescribed by DOT.

**Definition of Habitual Traffic Offender**

The bill revises the definition of “habitual traffic offender,” as contained in s. 322.264, F.S. The current definition includes a person whose record, as maintained by the Department, shows that such person has accumulated the specified number of convictions for specified offenses within a five year period. The offenses currently include three or more convictions of any one or more of the following offenses:

- voluntary or involuntary manslaughter resulting from the operation of a motor vehicle;
- driving under the influence;
- any felony in the commission of which a motor vehicle is used;
- driving a motor vehicle with a suspended or revoked license;
- failing to stop and render aide in the event of a motor vehicle crash resulting in the death or personal injury of another; or
- driving a commercial vehicle while his or her privilege is disqualified.

The term also applies to drivers receiving 15 convictions for moving traffic offenses for which points may be assessed as set forth in s. 322.27, F.S., within five years.

The bill applies the “habitual traffic offender” label to drivers who receive three or more convictions for a violation of a traffic control signal steady red light indication. In computing the number of convictions, all convictions during the last three years previous to July 1, 2008, will be used, provided at least one conviction occurs after that date.

Ordinance violations issued pursuant to this bill are not considered convictions, and therefore would not count towards the “habitual traffic offender” statute. Only someone who is issued a uniform traffic citation by a law enforcement officer and subsequently convicted of the violation is subject to the proposed provisions in the definition of “habitual traffic offender”.

The bill provides a severability clause and is effective upon becoming law.

**C. SECTION DIRECTORY:**

**Section 1.** Citing the act as the “Mark Wandall Traffic Safety Act.”

**Section 2.** Amending s. 316.003, F.S.; defining the term “traffic infraction detector.”

**Section 3.** Creating s. 316.0083, F.S.; creating the “Mark Wandall Traffic Safety Program” to be administered by the Department; authorizing counties and municipalities to enact ordinances permitting the use of traffic infraction detectors and specifying the topics of the required ordinances; exempting emergency vehicles from an ordinance enacted under this section; providing penalties for traffic control signal violations detected by traffic infraction detectors; providing for the issuance, challenge, and disposition of tickets; providing for disposition of fine revenue; providing a process for complaints that a county or municipality is employing detectors in a manner inconsistent with this section; and requiring the Department to submit a report to the Governor and Legislature.

**Section 4.** Amending s. 316.0745(6), F.S.; requiring traffic infraction detectors to meet requirements established by the Department of Transportation and be tested at regular intervals.
Section 5.  Reenacting s. 316.1967, F.S.

Section 6.  Reenacting s. 320.03, F.S.

Section 7.  Amending s. 322.264, F.S.; revising the definition of “habitual traffic offender” to include 3 convictions for violation of a traffic control red light within a 3-year period.

Section 8.  Reenacting s. 322.27, F.S.

Section 9.  Reenacting s. 322.34, F.S.

Section 10. Providing a severability clause.

Section 11. Providing that the bill is effective upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   See Fiscal Comments.

2. Expenditures:

   See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   To the extent local governments choose to enact ordinances to permit the use of traffic infraction detectors there may be a fiscal impact to the private sector. Traffic infraction detectors will increase the scope of a local government’s enforcement of red light violations; therefore increasing the possibility of a motor vehicle owner receiving a ticket for a red light violation. The fine for the ordinance violation, as determined by a traffic infraction detector, is $125. If a person chooses to contest the ticket, they may appear before a judge, but they are deemed to have waived the limitation of civil penalties imposed for the violation and, if the ticket is upheld by the judge, may be charged the $125 fee plus court costs.

D. FISCAL COMMENTS:

   Two state agencies will incur minor expenses as a result of this legislation. The bill requires the Department of Highway Safety and Motor Vehicles to collect reports from municipalities and to prepare an annual report for the Legislature. The bill also requires the Department of Transportation to prepare standards for traffic infraction detectors. The Department of Highway Safety and Motor Vehicles may also require programming changes to address the additional “habitual traffic offender” requirements.
To the extent local governments choose to enact ordinances to permit the use of traffic infraction detectors there may be a fiscal impact to the local governments for the cost of the acquisition, installation and maintenance of the devices, the amount of which will vary depending on the negotiated agreement between the local government and any private vendor providing the equipment and service. The price of a traffic infraction detector ranges from $50,000 to $100,000 each. There may also be installation, maintenance and monitoring fees, based on the negotiated agreement. The number of local governments that will choose to enact local ordinances as authorized by this bill is unknown; therefore the fiscal impact to local governments is unknown.

Local court systems may see a caseload increase, in the event that vehicle operators choose to contest tickets as permitted under the bill. Although the bill permits the court to impose a penalty “not to exceed $125 plus court costs,” there may be an indeterminate cost to the local court system.

There may be an increase in fine revenue for any local governments that choose to enact ordinances permitting the use of traffic infraction detectors. The amount of revenue is indeterminate, as the number of ordinance violations to be issued is unknown, and reliant on driver awareness and future behavior.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because the bill does not appear to: require counties or cities to spend funds or take action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

   None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

On line 62, the bill uses the term “citation” to refer to a ticket issued for an ordinance violation. This usage is inconsistent with the term “ticket” as otherwise used in the bill’s red light camera provisions.

D. STATEMENT OF THE SPONSOR

   No statement submitted.

IV. AMENDMENTS/COUNCIL SUBSTITUTE CHANGES

On Thursday, February 21, 2008, the Committee on Infrastructure reported the bill favorably with three amendments. The first amendment removes the provision allowing a uniform traffic citation (UTC) issued by law enforcement to be set aside if a camera ticket has been issued. (Another provision of the Act allows the camera ticket to be set aside instead, and the UTC enforced against the violator.) The second and third amendments are technical amendments to remove an unnecessary statutory citation.
Cape Coral Hospital

EMERGENCY ROOM EXPANSION UPDATE – March 6, 2008

By Dave Kistel, Vice President Facilities & Support Services
CCH Emergency Room Expansion

Summary

Expand the Cape Coral Hospital Emergency Room from a 24 bay treatment center to a 42 bay treatment center.

The project will be constructed over multiple phases to minimize disruption to ongoing operations.
ER Expansion & Renovation
Relocation Projects

Scope of Work
Phase 1 – Completed
• Medical Records Relocation 6,334 sf
• ER Physician Billers Relocation 771 sf
• ER Temporary Holding 303 sf

Total: 7,408 sf
ER Expansion & Renovation
Square Footage Summary
Existing ER 15,702 S.F.

<table>
<thead>
<tr>
<th>Phase</th>
<th>New S.F.</th>
<th>Renovated S.F.</th>
<th>Total Per Phase</th>
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<td>5,295</td>
<td>4,732</td>
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<tr>
<td>Phase 6</td>
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<tr>
<td>Total Renovated Construction</td>
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<td>Total Completed Construction</td>
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<tr>
<td>Phase</td>
<td>Treatment Bays Available During Construction</td>
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<tr>
<td>--------------------------------</td>
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<tr>
<td>Current ER w/Temp Holding</td>
<td>24 20 + 4 Temp Holding</td>
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<td>Phase 2 during Construction</td>
<td>24 20 + 4 Temp Holding</td>
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<tr>
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<td>29 17 + 7 Fast-track Treat + 1 Fast-track GYN + 1 Pod-B ENT + Pod-B Exam + 2 FH (minus 3 old &amp; 4 temp hold)</td>
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<tr>
<td>Phase 3 Complete</td>
<td>36 17 + 7 Fast-track Treat + 1 Fast-track GYN + 2 Pod-B ENT + 1 Pod-B ISO + 1 Pod-B GYN + 5 Pod-B Exam + 2 FH</td>
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<td>Phase 4 during Construction</td>
<td>34 15 + 7 Fast-track Treat + 1 Fast-track GYN + 2 Pod-B ENT + 1 Pod-B ISO + 1 Pod-B GYN + 5 Pod-B Exam + 2 FH (minus 2 old Pod-B)</td>
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<td></td>
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<tr>
<td>Phase 4 Complete</td>
<td>41 15 + 7 Fast-track Treat + 1 Fast-track GYN + 2 Pod-B ENT + 1 Pod-B ISO + 1 Pod-B GYN + 12 Pod-B Exam + 2 FH</td>
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<td>Phase 5 during Construction</td>
<td>32 7 + 7 Fast-track Treat + 1 Fast-track GYN + 2 Pod-B ENT + 1 Pod-B ISO + 1 Pod-B GYN + 12 Pod-B Exam + 2 FH (minus 8 old Pod-A)</td>
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<td>Phase 5 Complete</td>
<td>42 7 + 7 Fast-track Treat + 1 Fast-track GYN + 2 Pod-B ENT + 1 Pod-B ISO + 1 Pod-B GYN + 12 Pod-B Exam + 2 Pod-A ISO + 1 Pod-A GYN + 6 Pod-A Exam + 2 FH</td>
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<tr>
<td>Phase 6 Complete</td>
<td>42 7 Fast-track Treat + 1 Fast-track GYN + 2 Pod-B ENT + 1 Pod-B ISO + 1 Pod-B GYN + 12 Pod-B Exam + 2 Pod-A ISO + 1 Pod-A GYN + 11 Pod-A Exam + 2 Pod-A Trauma + 2 FH</td>
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ER Expansion & Renovation
Budget Allocation 2006 K6-071CC

- Design 633,728
- Construction/Renovation 7,876,600
- Equipment/Furniture 2,431,072
- Information Technology 439,023
- Internal Labor 13,500

FY 2007 Total Capital Costs 11,393,923
## ER Expansion & Renovation
### Budget Dollars Remaining – February 2008

**K6-071CC**

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<tr>
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<th>Budget Summary</th>
<th>Dollars Spent</th>
<th>Dollars Remaining</th>
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<td>633,728</td>
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<td>Total</td>
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## CCH Emergency Room Construction Schedule

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<thead>
<tr>
<th>Phase</th>
<th>Activity</th>
<th>Duration</th>
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<tr>
<td>Phase 1</td>
<td>Completed</td>
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<tr>
<td>Phase 2</td>
<td>Start, Complete Inspect, Move-in</td>
<td>(9) July 2008 – April 2009</td>
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<tr>
<td>Phase 4</td>
<td>Start, Complete Inspect, Move-in</td>
<td>(5) Oct. 2009 – March 2010</td>
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<td>Phase 5</td>
<td>Start, Complete Inspect, Move-in</td>
<td>(5) March 2010 – Aug. 2010</td>
</tr>
<tr>
<td>Phase 6</td>
<td>Start, Complete Inspect, Move-in</td>
<td>(3) Aug. 2010 – Nov. 2010</td>
</tr>
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Gulf Coast Hospital
Southwest Florida Regional Medical Center
Consolidation Project

Activation and Occupancy Planning

March 6, 2008
Construction Update

• The Gulf Coast Hospital project is moving forward at a rapid pace. Through the end of February we are about 65% complete and are still anticipating a first quarter of 2009 opening. Over the next few months we will be working out the sequences for completing final inspections and certifications, moving all equipment, stocking the building, performing all in-service training of equipment, and the logistics of the department and patient moves which will define the target move in date.

• The final slab for the building was poured last week in the atrium on the 1st floor. We have completed the majority of in-wall rough-ins for the mechanical, electrical, and plumbing services. Drywall installation has begun in Admitting, Pre-Op and the Clinical Lab. With the exception of the egress pathways that were put in place for the egress from the existing building, all walls have been framed. The major diagnostic equipment vendors were on site the week of February 18th to review their spaces for the equipment deliveries, rough-in requirements, and verify the layouts based on their final design drawings. We expect delivery of this equipment in the fall of 2008.

• The second floor is the most complete floor in the building. Finishes are well under way. Nearly all casework has been installed with the exception of a few countertops at the nurse stations. Doors have been hung and much of the painting is complete. Ceiling tiles are being installed and flooring is scheduled to begin within the next few weeks.
• The third floor is just behind the second floor in percentage complete. Much of the casework has been installed. Final painting and handrail installations have begun. All drywall installation is complete and ready to receive paint.

• Drywall installation was completed last week on the fourth floor. Painting has begun and casework installation is scheduled to begin next week. Installation of ceiling grid began last week.

• Much has changed over the last few weeks on the exterior of the building. All light poles have been installed and the atrium storefront glass installation has begun. All glass & glazing is complete for the windows on the patient tower and is 80% complete at the stairwells. In the next month, final landscaping will begin.
Existing Kitchen & Cafeteria Demolition

Services For Patient Room Headwall
ACTIVATION AND OCCUPANCY PLANNING

An orderly process to define & facilitate all the tasks required to efficiently occupy the construction project in a logical, timely approach.
- Analysis & integration of practices & standards
- Newly configured department policies and procedures
- Combined operation staffing plans
- Training & Education
- Communication

- Facility Readiness
- Installation of New Equipment Furniture
- Facility Relocation
- Information Systems, Telephone Moves

Activation Planning Process
Occupation and Activation Planning Steering Committee

MISSION STATEMENT

It is the mission of the Occupation and Activation Planning Steering Committee to:

• Establish the working policies of the other Task Forces
• Appoint other Task Force Members and designated Chairpersons
• Assign tasks to appropriate Task Forces.
• Maintain the Activation/Occupancy issues log.
• Resolve questions of policy and procedure presented by other Task Forces or by hospital staff.
• Promote open communication and continuity of message during the planning cycle.
• Directly supervise the work of the Activation Planning Project Champion.
Steering Committee and Task Force Organizational Chart

Occupation & Activation Planning Steering Committee
Chair: Alex Greenwood

- Facility Readiness Task Force
  Chair: Alex Greenwood

- Human Resources Task Force
  Chair: Michael Polito

- PR/Communications
  Chair: Lynn Melvin

- Patient Care Task Force
  Chair: Cindy Boily

- Education/Orientation Task Force
  Chair: Nancy Kaplan

- Data Process/Telecomm Task Force
  Chair: Peggy Gayle
Public Relations/Communications Task Force Mission Statement and Tasks:

1. The mission of the Public Relations Task Force is to coordinate and direct the interface between the new Gulf Coast Hospital and outside public.

2. The first tasks to be addressed by the Public Relations and Communications Task Force would include:
   - Develop and schedule Grand Opening ceremonies
     - Coordinate the support needs of all major ceremonies with the appropriate departments (Administration, LMHS Corporate Offices, Dietary, Housekeeping, Security, etc.)
   - Develop and schedule public and private tours of the new facility.
   - Assist departments, as necessary, for special clientele tours (EMT’s and ED).
   - Design and develop a logo, symbol, or motto to be used as the unifying graphic symbol of the move effort.
   - Develop marketing materials capitalizing on the community interest the new facility will bring.
   - Review and revise the facility visitation policy, as required.
   - Develop policies for press coverage response in general, and for the patient move in particular; including patient privacy and consent policies.
   - Develop a standard communication vehicle regarding the new facility progress.
   - Review and revise all Gulf Coast Hospital pre-printed materials, as required.
   - Prepare a new Visitor Information Guide, including way finding maps for the new facility.
   - Coordinate all new facility change of address requirements with local post office, vendors, subscriptions, referring Physicians, and other interested parties.
Human Resources Task Force Mission Statement

1. The Mission of the Human Resources Task Force Team is to identify staff perceived issues, concerns, and barriers that would prohibit a smooth transition to consolidate SWFRMC and GCH departments into one campus, and to develop a plan to create a team that provides a culture where staff are excited and motivated.

2. The membership of this task force will include Brad Pollins, System Director of Organizational Effectiveness, and Michael Polito, HR Business Partner for SW/GCH, as well as a Focus Group of staff from multiple disciplines from both facilities that are informal leaders and spokespersons for their departments. Each team will consist of 14 to 16 members and will meet separately at first to establish a list of opportunities toward meeting our mission. The initial Focus Groups will meet in December 2007.

3. In January 2008, the participants from both Focus Groups on this Task Force will then meet as a single group to review the combined results of the initial meetings. Brad will conduct a Team Building program followed by a planning session to develop recommended solutions for the gaps identified by the teams.

4. Sub-teams will be created and a Senior Leadership Member of SW/GCH invited to participate. The categories of issues identified will include:
   - Attitude/Culture & Communication
   - Equipment & Technology
   - Patient Flow and Standardization
   - Staffing & Training

5. Many of the categories will then feed into existing other Task Forces, only employee input will have been procured to assist in the transition and to remove the gaps.

6. Human Resources (Mike Polito) will participate in all needed activities identified by the Focus Groups as appropriate. Organization Effectiveness (Brad Pollins), and Leadership Development (Carol Simonds) will participate with any facilitation needed, or training recommended, such as Change Management, Team Building, Leadership Development, etc. Clinical Learning will participate in all training and orientation identified by the Task Force from the clinical side.
Information Systems Task Force Mission Statement

1. The mission of the Information Systems Task Force is to coordinate the IT hardware, software, and technical infrastructure needs of the new facility.

2. The membership of this Task Force includes a sub-group of representatives of the departments that will be moving into the new facility for equipment and application reviews, and the IS Task Force Core Team that handles application, hardware, and infrastructure coordination.

3. The Task Force responsibilities include:
   • Finalize equipment specifications for IS equipment
   • Finalize equipment placements, coordinating with furniture and casework.
   • Coordinate installation and testing of data cabling and wireless technology
   • Coordinate installation and testing of all user hardware
   • Combine and expand Meditech modules currently used at SWRFMC and GCH to be used when the new facility opens
   • Coordinate installation and testing of all clinical applications and interfaces
   • Ensure all patient management, patient accounting, human resource, supply chain, and medical records needs are in place and tested
   • Provide and configure all server hardware, server application, and other technology needed
   • Ensure instrument and equipment maintenance is in place
   • Coordinate removal of any IS equipment remaining at SWRFMC, CHCC, or areas within existing GCH that will not be activated in new facility
   • Work with other Task Force teams to create detailed activation & occupancy plans
   • Communicate & track issues & resolutions and escalate to IS Leadership and/or Activation & Occupancy Steering Committee as needed
   • Support the user community by having an IT presence on-site as each unit opens/moves
Major Diagnostic Imaging and Medical Equipment Being Installed

- PC/Workstations (many in-room) 1136
- Printers 185
- Radiology PACS Workstations 30
- Cardiology Imaging Workstation 14
- Employee Time-clocks 16
- Telephones (new phone system) 1250
- Data network connections 2500 +
- Data communication rooms 14
Major New Diagnostic Imaging Equipment Being Installed - Digital

- 64 slice CT 1
- 40 slice CT 2
- Rad Imaging Rooms 3
- R&F Rooms 2
- Nuclear Cameras 2
- MR 1
- Ultrasounds 4
- C-Arm Imaging Devices 4
- Mobile X-Ray 4
- Cath Labs 3
- Echo lab 2
- ICU Monitoring Equipment (2 new, 1 replacement) 3
- Wireless Telemetry (transitioning new system from SW)
Hospital Computer Transition (Pre Construction)

Computer 1
Southwest Regional

- ER
- Radiology
- Pharmacy
- Lab
- ICU
- Nurse Station
- Oper Room
- Billing

Computer 2
Gulf Coast Hospital

- ER
- Radiology
- Pharmacy
- Lab
- ICU
- Nurse Station
- Oper Room
- Billing
Hospital Computer Transition
Today

Computer 1
Southwest Regional

Computer 2
Gulf Coast Hospital

Expansion Under Construction

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Hospital Computer Transition
@ 2 weeks prior to Expansion Opening

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New Room
Numbering for all of
Gulf Coast
Hospital Computer Transition
Post Expansion Opening

COMPUTER
Gulf Coast Medical Center

- ER
- Radiology
- Pharmacy
- Lab
- ICU
- Nurse Station
- Oper Room
- Billing

New Room Numbering for all of Gulf Coast
Education and Training Task Force Mission Statement

1. Identify, organize, schedule, and document the Gulf Coast Hospital staff requirement for training.

2. The membership of this Task Force should include those persons familiar with organizing the on-going educational needs of Gulf Coast Hospital. Since a significant amount of training will involve new building systems and new equipment and furniture, Liaison to these functions as a Task Force member is important.

Finally, identifying new operating methods implied by moving to a new facility will be crucial. Once new methods are discovered, operations simulations should be devised and tested to confirm affected department’s requirements.

3. The first tasks of the Education and Training Task Force would include:
   - Identify new building systems training requirements, including staff affected and schedule
   - Identify new equipment & furniture training requirements, including staff affected and schedule
   - Roster all vendor provided in-service training regimens already purchased, or needed to be purchased with staff schedule coordination.
   - Facilitate scheduling of required training activities
   - Summarize the change elements of operational issues and develop staff simulations to achieve expected results
   - Develop methods for documenting staff competency levels on new systems and items
4. Specific education / orientation programs should address:
   - Safety training and fire evacuation
   - New facility orientation
   - New patient and material transport required
   - New phone system
   - New Nurse Call System
   - Decentralized nurses stations
   - New patient chart handling procedures
   - Patient medication drawers
   - Case cart method of resupply
   - Centralized patient monitoring Techs
   - ED monitors
   - Equipment service booms in the OR and ED
   - IT training initiatives
Facility Readiness

1. The mission of the Facility Readiness Task Force is to ensure those items that must exist, occur, or be in place in order to effect a successful occupancy.

2. The membership of this Task Force should include those persons directly responsible for converting the construction site to health care facility. This may include:
   - Facilities Management
   - Materials Management
   - Housekeeping
   - Security
   - Liaison with construction team

3. The first tasks of the Facility Readiness Task Force would include:
   - Develop a schedule for turnover of space from the building contractor
   - Plan for local, state, and national inspections
   - Define the building systems that will require owner interaction principally training. Specifically note:
     - Fire Control
     - Nurse Call
     - Paging
     - Code Blue
     - Timekeeping
     - Security Systems
• Coordinate aspects of the completed signage system for information and inspection compliance purposes.

• Organize and schedule staff support for the contractor’s building turnover scheme

• Organize a security program for protection of the new facility during contractor / Owner turnover; including a key program and key distribution procedure

• Organize and schedule a method for outfitting the building with new equipment and furniture

• Develop plans for pre-stocking the new building with disposable supplies and small equipment items

• Develop a policy for recovery of supplies left behind in the old facility.
Patient Care and Move

1. The mission of the Patient Care and Move Task Force is to ensure the highest level of patient care up to, during, and after the patient relocations.

2. Membership of the Task Force would include inpatient Nursing leaders, representative(s) of the Lab, Pharmacy, Respiratory Therapy, Emergency, Surgery, and Patient Registration departments, and representative(s) of the Medical Staff.

3. The first tasks of the Patient Care and Move Task Force would include:
   - Finalize the most appropriate day for patient relocation
   - Develop a “from-to” move matrix
   - Define roles and assign tasks for patient issuing teams at the existing facility and patient receiving teams at the new facility.
   - Finalize policy for suppression of patient census and outpatient activity prior to the move
   - Develop pre-move checklists to ensure continuity for care
   - Identify equipment, service, and human resources necessary to accomplish the consensus patient move plan
   - Determine resource requirements and protocol for emergency situations during the move
   - Coordinate ancillary department support requirements before, during, and immediately after the move
   - Develop policy for when new admissions and emergency patients will be routed to the new facility
   - Develop a short-term communication plan to be used during the patient move.
## Activation Responsibility Checklist

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FY 2008 Key Strategic Focus

Financial Focus

Clinical & Operational Effectiveness

Organizational Clarity

Physician Leadership & Relationships

Long-Term Facility Plan

LMHS 2008 Priorities
TIME SENSITIVE ISSUES
OTHER ITEMS
DATE OF THE NEXT
REGULARLY SCHEDULED
MEETING

PLANNING
Committee of the Whole
MEETING

THURSDAY,
April 10, 2008
2:00pm

Lee Memorial Hospital Boardroom
2776 Cleveland Ave, Ft Myers, FL 33901