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

QUALITY & EDUCATION
COMMITTEE OF THE WHOLE MEETING

Thursday, June 12, 2008
1:00 p.m.
Lee Memorial Hospital - Boardroom

AGENDA

1. CALL TO ORDER (Quality & Education Chairman Kerry Babb)
The meeting of the Quality & Education 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 Florida 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. May 15, 2008 Quality & Education Meeting Minutes
   B. Patient Safety Plan

4. Clinical Improvement Opportunities and Preliminary Retreat Plans (Update) (Brett Hickman, Healthcare Advisory Partner/PricewaterhouseCoopers - 30 min)

5. Physician Services Report (Update) (Jack Eikenberg, Consultant - 15 min)

6. Orthopedic Implant Request for Proposal (RFP) Status Report (Verbal) (Kerry Babb, Quality & Education Committee Chairman and Bill Tousey, RN, MBA, Vice President/Cooperative Services of Florida – 10 min)

7. Hospitalist Report (Verbal Update) (Larry Antonucci, M.D., Chief Administrative Officer/CCH – 15 min)

8. Surgery Operations Report (Verbal Update) (Donna Giannuzzi, RN, Chief Patient Care Officer – 15 min)

9. Clinical Information Technology Strategic Overview (Update) (Mike Smith, Chief Information Officer – 20 min)

10. Time Sensitive Issues

11. Other Items

12. Date of the next regular Quality & Education Committee of the Whole Meeting: Thursday, August 14, 2008 at 2:00 p.m.
Lee Memorial Hospital Boardroom, 2776 Cleveland Avenue, Fort Myers, FL

13. ADJOURNMENT of QUALITY & EDUCATION COMMITTEE

BOD/Agenda/061208 Quality & Education Committee of the Whole Agenda
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.
Quality & Education Committee of the Whole
June 12, 2008

CONSENT AGENDA ITEMS
(For Approval)

A. May 15, 2008 Quality & Education Committee Minutes

B. Patient Safety Plan
The meeting of the Quality & Education Committee of the Whole of the Lee Memorial Health System (LMHS) Board of Directors concerning matters of the business of Lee Memorial Health System (LMHS) consisting of Lee Memorial Medical Center (LMMC), HealthPark Medical Center (HPMC), Cape Coral Hospital (CCH), and Lee Memorial Hospital (LMH) and its subsidiaries (HealthPark Care Center, Inc., Lee Memorial Home Health, Inc., Cape Memorial Hospital, Inc.) may be reported, discussed and recommended by the Committee of the Whole, then referred to the full Board of Directors for final action was CALLED TO ORDER by Quality and Education Chairman Kerry Babb at 2:06 p.m.

### PUBLIC INPUT

There were NO “Public Input” items.

### MEETING MINUTES

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

A. April 10, 2008 Quality & Education Meeting minutes

B. FY 2008, 2nd Quarter Risk Management Report (Exhibit 1)

A motion was made by Marilyn Stout to approve the Consent Agenda consisting of:

A. April 10, 2008 Quality & Education Meeting minutes

B. FY 2008, 2nd Quarter Risk Management Report (Exhibit 1)

The motion was seconded by Denise Heinemann and it carried with no opposition.

### PUBLIC HAND HYGIENE STATIONS

Stephen Streed presented the Public Hand Hygiene Stations Update (Exhibit 3). Discussion ensued with regard to monitoring the use of hand hygiene stations and the actual cost per use. Stephen said the cost for the hand hygiene stations is minimal while the prevention of spreading germs is a great benefit in terms of cost savings in the future.

### “BAKER ACT” UPDATE

Larry Antonucci and Joseph Daley gave a verbal update regarding patients who have been placed under the “Baker Act”. Joseph explained when a patient is Baker Acted they are involuntarily held so they can’t harm themselves or others. Consequently, these patients do not require being detained however they do not necessarily require patient care as provided by a medical physician in an emergency room, rather these patients require the treatment of a psychiatrist. He said in response to the current need for psychiatric care in our community.
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DISCUSSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELIANT HEALTH CARE UPDATE</td>
<td>LMHS has hired three psychiatric nurse practitioners and one psychiatrist at an offsite location. In addition, they are working toward centralizing care for psychiatric patients to one or two locations, which will provide better management and care for these patients. Joe said they have been actively involved with administration to provide the best care effectively and efficiently for these patients. Discussion ensued with regard to providing the appropriate psychiatric care based on the patient’s age and length of care required: short term vs. long term. Jim Nathan gave a brief update on the geriatric center Reliant will be opening in September. He said this center will accept patients with psychiatric needs who would otherwise be admitted to the acute care facilities. Jim said Reliant is currently in negotiation to obtain their Certificate of Need (CON) for a full service psychiatric facility in the community. Discussion ensued with regard to financing for the Reliant facility.</td>
</tr>
<tr>
<td>FAILURE MODE EFFECTS ANALYSIS (FMEA) 2007 PATIENT ELOPEMENT UPDATE ON JOINT COMMISSION</td>
<td>Christine Crawford reviewed the Failure Mode Effects Analysis (FMEA) on 2007 Patient Elopement Report (Exhibit 4). Jim Nathan said the LMHS team is constantly preparing and awaiting the arrival of Joint Commission, any day now. Christine gave a brief overview of the processes involved during a visit from the Joint Commission. She said there are inspections, patient tracers, and interviews during their visit that must be planned on a moments notice.</td>
</tr>
<tr>
<td>MEDICAL STAFF BUSINESS</td>
<td>Mark Greenberg reviewed the following Medical Staff Rules and Regulations: A. Lee Memorial/HealthPark Medical Center i. Rule #8: Medical Records, Rule #8-B. (2) History and Physical Examination (Exhibit 5) B. Cape Coral Hospital i. IV – Records and Charting/Suspension, 4.2 History &amp; Physical (Exhibit 6) Discussion ensued regarding the processes and requirements for preoperative patient examinations by both the surgeon and anesthesiologist. Discussion also included the patient cancellation rate for surgery. John Donaldson suggested revising the Medical Staff Rules and Regulations to require preoperative patient examinations by both the surgeon and anesthesiologist. Mary McGillicuddy recommended approving the current revisions to the Medical Staff Rules and Regulations to maintain compliance however, recommended bringing these back to the Medical Staff for review and modification.</td>
</tr>
<tr>
<td>ORTHOPEDIC IMPLANT REQUEST FOR PROPOSAL (RFP) STATUS REPORT</td>
<td>Bill Tousey gave an update on the Orthopedic Implant Request for Proposal Status. He said LMHS is working with Clinical Benchmarking in processing the data collected from the RFP process and submitting a progress letter (Exhibit 7) to the Orthopedic Physicians. He said this letter explains the current issues with orthopedic implant pricing and proposed next steps. Kerry Babb said it is important for the physicians to know the vendors are not “playing ball” and LMHS will continue to pursue lower prices on orthopedic implants. Kerry said the basic fundamental issue here is we have high volumes but are still paying very high prices. He said we are working toward bringing pricing in line with volumes consequently saving the patient and the System money while maintaining a partnership with both physicians and vendors.</td>
</tr>
<tr>
<td>FY 2008</td>
<td>Chuck Krivenko and Becky Watt reviewed the FY 2008 1st Quarter Organizational Performance</td>
</tr>
<tr>
<td>SUBJECT</td>
<td>DISCUSSION</td>
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<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>1&lt;sup&gt;st&lt;/sup&gt; QUARTER ORGANIZATIONAL PERFORMANCE SCORECARD</td>
<td>Scorecard (Exhibit 8).</td>
</tr>
<tr>
<td>FY 2008 2&lt;sup&gt;nd&lt;/sup&gt; QUARTER COMPLIANCE REPORT</td>
<td>Charles Swain reviewed the FY 2008 2&lt;sup&gt;nd&lt;/sup&gt; Quarter Compliance Report (Exhibit 9).</td>
</tr>
<tr>
<td>FHA ON-SITE PEER REVIEW</td>
<td>Charles Swain reviewed the Florida Hospital Association Compliance Program Effectiveness and On-Site Peer Review (Exhibit 10).</td>
</tr>
<tr>
<td>TIME SENSITIVE ISSUES</td>
<td>There were NO “Time Sensitive Issues”.</td>
</tr>
<tr>
<td>LARRY DANIELS MEMORIAL SERVICE</td>
<td>Cathy Stephens reminded everyone the Memorial service for Larry Daniels will be held in the Lee Memorial Hospital Chapel immediately following this Quality meeting.</td>
</tr>
<tr>
<td>OTHER ITEMS</td>
<td>There were NO “Other Items”.</td>
</tr>
<tr>
<td>ADJOURNMENT</td>
<td>The Quality &amp; Education Committee of the Whole meeting was ADJOURNED by Quality and Education Committee Chairman Kerry Babb at 4:06 p.m.</td>
</tr>
</tbody>
</table>

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

Lois C. Barrett, MBA
Board Secretary
DATE: June 1, 2008

LEGAL SERVICE REVIEW? YES____ NO_X____

SUBJECT: Patient Safety Plan

REQUESTOR & TITLE: Donna Giannuzzi Chief Patient Care Officer

PREVIOUS BOARD ACTION ON THIS ITEM (IF ANY)

(Justification and/or background for recommendations - internal groups which support the recommendation i.e. SLC, Operating Councils, PMTs, etc.)

The Patient Safety Plan is a framework for the planned, systematic and coordinated approach to patient safety. The Patient Safety Plan applies to all settings of care and all persons directly or indirectly in the care of patients. The plan is integrated based on the consolidation of Southwest Regional Medical/Gulf Coast Medical Center and the three legacy facilities. The previous plan did not clearly state the Lee Memorial Board of Directors accountability for oversight and to whom delegated responsibility is given, as stated on page 5 under "Governance".

SPECIFIC PROPOSED MOTION:

The Board of Directors of the Lee Memorial Health System Recommends the adoption of the "Patient Safety Plan".

PROS TO RECOMMENDATION

N/A

CONS TO RECOMMENDATION

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:

Joint Commission Standard LD.4.40 requires leaders to ensure that an integrated patient safety program is implemented throughout the hospitals. The Board of Directors approval of the Patient Safety Plan demonstrates leaders setting patient safety as a performance improvement priority.
PURPOSE:

This Patient Safety Plan is developed to provide a framework for the planned, systematic, coordinated and continuous approach to maintaining and improving patient safety throughout Lee Memorial Health System.
SCOPE:

A. Lee Memorial Health System strives to assure the safety and well being of patients, employees and visitors. This Patient Safety Plan policy applies to all department / departments/units regardless of the setting of care, and would include inpatient, outpatient and includes inpatients, outpatients, emergency services and all other services provided by Lee Memorial Health System. This policy also applies to all patients, employees, physicians, visitors, volunteers, students, and contractors providing services through consultation or contractual arrangement or other agreements; and students.

B. The scope of the Patient Safety Plan includes ongoing assessment using internal and external information, knowledge and experience to prevent errors, reduce adverse events and improve and maintain patient safety.

C. Types of patient safety or medical/health misadventures included in data analysis may include:

1. Sentinel events:
   a. An unanticipated death or major permanent loss of function (physical or psychological), not related to the natural course of the patient’s illness or underlying condition OR
   b. The event is one of the Joint Commission reviewable sentinel events (even if the outcome was not the death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition).

2. Signal Events:
   A signal event is an unexpected occurrence that did not involve death or major permanent loss of function; nor is it one of the reviewable sentinel events, but it is of significant risk of a serious adverse outcome that an intense analysis of the system or process associated with it should be performed, OR is one of the following events:
   a. Any near miss.
   b. Full or expected return of limb or body function to the same level to the adverse event by discharge or within two weeks of the initial loss of said function.
   c. Medication errors that do not result in death or major permanent loss of function.
   d. Suicide other than in an around the clock care setting or following elopement from such a setting.
   e. A death or loss of function following a discharge “against medical advice) (AMA).
f. Unsuccessful suicide attempts.

g. Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical sequelae.

D. The Patient Safety Plan establishes mechanisms that support:

1. A coordinated, collaborative and interdisciplinary approach in establishing plans, processes and mechanisms to enhance patient safety among all members of the health care team.

2. A focus on process and systems.

3. Ongoing, proactive strategies for identifying and reducing unanticipated adverse events and safety risks.

4. The initiation of actions to reduce those risks.

5. Timely and effective response to actual incidents/adverse events.

6. Analysis of incidents/adverse events.

7. The use of information from data analysis to make changes that improve performance and patient safety, and reduce the risk of sentinel events.

8. Timely dissemination of data/information relating to patient safety, to include actions taken.

9. A system-wide non-punitive culture of safety, that is non-punitive.

10. Integration of patient safety priorities into the design and redesign of all relevant organizational processes, functions and services.

Active 11. The active participation of all responsible individuals in ongoing patient safety initiatives.

12 Initial and continual patient safety education for all responsible individuals.

B. Leaders supporting a culture in which patient safety is a priority in all processes, functions and services.

E. As a patient safety strategy, Lee Memorial Health System encourages patients’ active involvement in their own care as a patient safety strategy. Through education, patients will be made more aware of potential adverse events and hazardous conditions and more likely to report their concerns and observations. This occurs through:

1. Communication with patients and families about all aspects of their care, treatment and services.
2. Active participation of patients with patient safety initiatives.

3. Patient-/family education on methods-available methods to report concerns related to care, treatment, services and patient safety issues. Patient-/family educational resources include:

4. LMHS Patient Information Book (Refer to “Speak Up” content.)

5. LMHS Web Site.

6. LMHS Patient Bill of Rights.

F. Lee Memorial Health System’s culture of safety is built upon commitment to improving patient safety, and may involve partnering/collaboration with various external entities for national patient safety issues/initiatives as follows:

JCAHO

JCAHO
2. The Joint Commission Standards and Sentinel Event Alerts.

3. The Agency for Healthcare Research and Quality (AHRQ).


5. The Institute for Healthcare Improvement (IHI).


8. Occupational Safety and Health Administration (OSHA).

D.

8. Voluntary Hospitals of America (VHA).

G. Lee Memorial Health System will continually strive for performance improvement/best practices with the following strategic patient safety goals:

1. Improve medication safety.

2. Implement information systems to improve safety.

3. Institute clinical safety processes.

4. Educate on safety.

5. Develop methods to monitor and assure safety.
6. Provide a safe environment for employees.

RESPONSIBILITIES:

Every employee, member of the medical staff, student, volunteer, and contractor, and volunteer is responsible to:

A. Promote patient safety and prevent harm to patients.
B. Promptly report patient safety events and issues according to policies and procedures.
C. Participate in the investigation and resolution of patient safety issues when requested.
D. Participate in performance improvement activities relating to patient safety.
E. Promote a culture of non-punitive error reporting and organizational learning to improve patient safety.

GOVERNANCE:

Oversight and direction of the Patient Safety Plan is provided by the LMHS Board of Directors. Administrative.

The Lee Memorial Board of Directors is accountable for providing System-wide oversight and direction for the Patient Safety Plan. The Board has delegated responsibility for administrative direction and prioritizing are provided by prioritization of activities to the following LMHS Councils / Committees as follows:

A. Quality and Safety Redesign:

Quality Management Council:

Integrates, analyzes and reviews quality and safety information for the System for the purposes of organization decision-making and performance improvement. Advises the Board, Medical Staff and Senior Leadership Council on opportunities for improvement, consistent with the business needs and priorities of the organization. Recommends chartering of system-wide performance improvement teams and is responsible for oversight of those teams. This Council is responsible for an annual evaluation of the Safety Plan’s effectiveness and for providing a System-wide Safety report to the Board on an annual basis.

B. Clinical Performance Improvement Committee:

Review and assess system-wide clinical performance initiatives in the area of safety.

Identify and eliminate barriers to performance improvement.

C. System Standards and Compliance Committee:
Manages

Conducts continuous review of regulations in a self-assessment perspective to determine the organization-wide patient safety program initiatives.

Ensures current level of compliance with the goal of identifying opportunities to improve regulatory compliance and accrediting agencies’ requirements and standards (i.e. JCAHO and OSHA) patient care processes.

C. System Policy and Procedure Committee:
Guides an efficient process for the development and updating of all Patient Care Policies and Procedures: Major functions of the committee include:

1. Determining the need for a new or revised Policy.
2. Assigning the author and providing guidance (if needed).
3. Establishing the timeline and expectations.
4. Determining the next “step” for review.

D. Hospital Standards and Compliance Committees:

1. Provide facility -specific continuous review of regulations in a self-assessment perspective to determine the current level of compliance with the goal of identifying opportunities to improve regulatory compliance and patient care processes.

2. These committees are responsible for evaluating Joint Commission, CMS and other regulations validating compliance through existing monitors or initiation of monitors where current compliance is unknown or not recently documented.

E. Patient Safety Measurement Committee:

1. To collate, trend and review occurrences of real and potential patient harm, including, but not limited to: adverse drug events, operative failures, infections, falls, and decubiti.

2. If urgent, these trends to be acted upon to improve overall patient safety.

E. ADE Risk Reduction Committee:

F. Pharmacy and Therapeutics Committee:

1. Maintains oversight of system-wide management of the safety of the medication process.

2. Reviews and measures medication safety.
FG. Environment of Care Safety Committee:

1. Assures consistency in the Safety Management Program throughout LMHS.
2. Routinely reviews all system-wide safety-related policies and procedures.
3. Ensures patient safety relating to the environment of care.

RESPONSES:

A. Immediate Response

All staff should remain vigilant to the occurrence, or potential occurrence of patient safety events. Whenever such an event occurs, staff should act immediately to minimize any potential harm to the patient. Such actions might include:

1. Removing the patient from a dangerous situation (fire, etc.).
2. Protecting other patients from the risk.
3. Notifying the supervisor and/or patient’s physician of the situation.
4. Facilitating any diagnostic or interventional actions that might be needed.
5. Preserving of factual information or evidence for use in subsequent analysis.

B. Reporting Response

Refer to S24 00 777 Reporting Safety Related Incidents for a detailed description on the reporting of incidents and adverse events. Refer to S0702 403 Identification, Reporting, and Management of Sentinel Events and Signal Events.

C. Organizational Response

Refer to S24 00 772 Reporting Incidents and Adverse Events for a detailed description on the identification, reporting and management of sentinel and signal events.

D. Proactive Organizational Response

LMHS regularly performs Failure Mode Effect Analysis (FMEA) as a process improvement methodology to anticipate potential process failures, and to implement preventive measures before they occur. For a detailed description of FMEA, refer to the Lee Memorial Health System Performance Improvement Guide (found in Public Folders under Performance Improvement) Refer to policy S06 00 361 Healthcare Failure Mode Effects Analysis.

E. Critical Incident Stress Response
LMHS provides a confidential and caring procedure for response to staff, employees and volunteers who have encountered a distressing event with sufficient impact to influence their effective coping skills. Refer to S06 00 134 Critical Incident Stress Response (CISR) and Activation Plan for a detailed description of this process.

RELATED POLICIES:
S06 00 134 Critical Incident Stress Response (CISR) and Activation Plan
S06 00 361 Healthcare Failure Mode Effects Analysis
S06 00 717 Performance Improvement Plan
S07 02 403 Identification, Reporting, and Management of Sentinel and Signal Events
S24 00 772 Reporting Incidents and Adverse Events
S24 00 777 Reporting Safety Related Incidents

REFERENCES:
Agency for Healthcare Research and Quality (AHRQ)
Centers for Disease Control and Prevention (CDC)
Institute for Healthcare Improvement (IHI)
Institute for Safe Medication Practices (ISMP)
The Joint Commission National Patient Safety Goals (Goal #13)
The Joint Commission Standards and Sentinel Event Alerts
National Forum for Healthcare Quality Measurement and Reporting (NQF)
Occupational Safety and Health Administration (OSHA)
Section 395.1055(g) Florida Statutes (2006)

This Patient Safety Plan is developed to provide a framework for the systematic, coordinated and continuous approach to maintaining and improving patient safety throughout Lee Memorial Health System.
# Agenda

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Section 1

Introduction
Section 1 - Introduction

Introduction

- Brett Hickman, Partner
  - National leader of the physician integration and strategic planning practice

Today’s Presentation will focus on:
- The future of quality and its impact on a sustainable healthcare system
- Significant changes in future reimbursement methodologies
- Impact of pay for performance on the healthcare delivery system
- LMHS originally engaged PwC to review a selection of 14 physician practices where LMHS is currently making a substantial investment in the practice. A high level review of PwC’s findings from this engagement, as well as setting the stage for the collaborative design session at the August Board Retreat, will be discussed
- For the engagement described above, PwC was charged with reviewing all aspects of these physician practices, including:
  - Physician Compensation
  - Practice Operations
  - Billing & Coding
Section 2

Major Trends Driving Quality Agenda for Integrated Delivery Systems
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

Increases in Health Care Expenses are Unsustainable

The Medicare Trust Fund will be insolvent by 2020
The U.S. pays more for healthcare than other developing nations.

Source: OECD Health Data 2005
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

Current Healthcare Challenges

The U.S. pays more for health care than other developing nations

Life Expectancy At Birth

Source: OECD Health Data 2005
OECD countries are converging in spending trends. Global health spending will triple to $10 trillion in 2020.

Drivers:
- Aging Population
- Rising standard of living
- Consumerism
- China

2003 US per capita spending on healthcare → $5,670
Rest of OECD → $2,352
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

Current Healthcare Challenges

*Annual amount of health spending that has been calculated to be wasteful:*

$1.2 \text{ Trillion}$

Source: PricewaterhouseCoopers Health Research Institute
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

Current Healthcare Challenges

“We should be working together for the best interests of the patient in a system of care. Without clear direction, you can begin focusing on multiple initiatives and lose sight of your goal.”

We should be working Together...
### Annual cost of treating chronic diseases:

<table>
<thead>
<tr>
<th>Disease</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiovascular Disease</td>
<td>$393 B</td>
</tr>
<tr>
<td>Cancer</td>
<td>$210 B</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$132 B</td>
</tr>
<tr>
<td>Arthritis</td>
<td>$127 B</td>
</tr>
<tr>
<td>Alzheimer’s</td>
<td>$100 B</td>
</tr>
</tbody>
</table>

Source: AHA, CDC, National Diabetes Information Clearinghouse, Alzheimer’s Foundation of America
75%, or $1.4T, of all healthcare costs are related to Chronic Disease.
“Medicine will move from treating disease to how do you maintain wellness.”

Source: Lee Hood
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

Current Healthcare Challenges

“Lack of coordination is the biggest waste.”

Source: Scott Wallace, Medical Alliance for Health Information Technology
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

Current Healthcare Challenges

Where the US ranks in preventable deaths among 19 industrialized countries:

LAST
Section 2 - Major Trends Driving Quality Agenda for Integrated Delivery Systems

The Transitioning of the U.S. Healthcare Delivery Model

<table>
<thead>
<tr>
<th>Payment</th>
<th>Volume based</th>
<th>Performance based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Venue</td>
<td>Hospital based</td>
<td>Integrated, outpatient</td>
</tr>
<tr>
<td>Records</td>
<td>Paper</td>
<td>Electronic</td>
</tr>
<tr>
<td>Treatment</td>
<td>One size fits all</td>
<td>Personalized</td>
</tr>
<tr>
<td>1990</td>
<td>2000</td>
<td>2010</td>
</tr>
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Section 3
Pay For Performance
The Truth About Quality, Outcomes and Evidence Based Medicine
Section 3 – Pay For Performance

Align Incentives Through Integration

**Foster high performance through payment incentives (as reflected in the IOM recommendations):**

- Select performance measures for all providers
- Ensure coordination of care among providers
- Collect and report performance information publicly
- Ensure participation by all providers as soon as possible
- Use existing sources of revenue for rewards
- Phase in implementation within a learning system
- Reform payment systems over time

Institute of Medicine of the National Academies, September 2006

Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series)

http://books.nap.edu/catalog/11723.html
HealthSpring's Pay for Quality pilot structures reimbursements for physicians to encourage more extensive preventive care, rewarding physicians for performing key preventive screenings and check-ups. “The focus is on preventing complications and catching problems before they become serious.”

Results: Healthcare utilization by Members:

- ER visits per 1,000 – 7% reductions
- Hospital admissions per 1,000 – 11% reduction
- Health plan’s medical cost ratio – 8% reduction
Section 3 – Pay For Performance

Value-Based Purchasing as an Economic Policy – The Relationship to Other Policy Initiatives

VALUE-BASED PURCHASING

- Consumerism
- Transparency
- Quality
- Efficiency

P4P
Section 4

Value Based Pricing
Section 4 – Value Based Pricing

CMS: March of the 900 lb. Gorilla Towards Value-Based Purchasing

- **October 2003**
  - **Medicare Modernization Act**
  - Reporting on 10 core measures for 0.4% payment update, up to 21 measures, 2% in ’07. Patient satisfaction to be added on ’08.
  - [hospitalcompare.hhs.gov](http://hospitalcompare.hhs.gov)

- **April 2004**
  - **ONCHIT Formation**
  - Executive Order establishing the goal of interoperable electronic health records within 10 years

- **August 2006**
  - **“Better Care, Lower Cost”**
  - Executive Order directing federal agencies to provide health care quality and price information
  - [hhs.gov/transparency](http://hhs.gov/transparency)

- **July 2007**
  - **Physician Reporting**
  - Voluntary program launched with 16 core measures. 1.5% payment bonus

- **2009**
  - **Outpatient Quality**
  - CMS plans to develop measures specifically for hospital outpatient care

- **2009**
  - **Deficit Reduction Act (2005 Sec. 5001b)**
  - Bill proposing value-based payments starting 2009
Section 4 – Value Based Pricing

Value-Based Purchasing

- The current Medicare payment system is broken. It provides few disincentives for overuse, under-use or misuse of care, and does not reward efficiency. Fundamental change requires a commitment by all Medicare providers.

National Business Coalition on Health’s publicly stated goals:

- To embarrass the delivery system into improvement
- Patient volume migration to high performers
- In other words it is a “value based” healthcare system that focuses on price and quality

\[
\text{Value} = \frac{\text{Quality}}{\text{Price}}
\]
Deficit Reduction Act (2005) Section 5001(b)

Secretary of Health and Human Services to develop a plan to implement value-based purchasing (VBP) commencing Fiscal Year (FY) 2009 for Medicare hospital services.

By statute, the plan must include consideration of:

1. the development and selection of measures of quality and efficiency in inpatient settings;
2. reporting, collection, and validation of quality data;
3. the structure, size, and source of value-based payment adjustments; and
4. disclosure of information on hospital performance.

Change Philosophy of CMS – Per HHS Secretary Levitt Spring 2008

- To this point the CMS has been a “passive payer” of healthcare services
- Under Value Based Pricing the CMS will be an “active purchaser” of healthcare services. They will be purchasing (paying) based on the value they receive
- Must develop “systems of care
- CMS will stop paying for “events or episodes” of care and start paying for true “Disease Management” – goal 2010
Nonlinear Exchange for Translating Total Performance Score into Percent of VBP Incentive Payment Earned

At Least Full Incentive Earned.

Dollars Not Earned Is Area Above Curve.

Adapted from HHS Report to Congress:: Plan to Implement Medicare Hospital Value-Based Purchasing Program, November 21, 2007
Section 5

Global Reimbursement
Global Reimbursement

MS-DRG REIMBURSEMENT

- CMS has been quite open in its intention that "specialty hospitals" would bear the brunt of the reduced payments under MS-DRG. However, the payment reductions are not limited to specialty hospitals. In fact, any hospital that doesn’t serve a general cross section of the Medicare population is likely to suffer. And the majority of these hospitals are not “specialty” at all.

- In the correction to the 2008 final rule for IPPS, CMS lists the estimated impact of all the changes for 2008, primarily driven by the severity-adjusted DRGs and their cost-based weights. All hospitals were estimated to gain 3.7 percent over average 2007 payments, with urban hospitals gaining 3.3 percent to 4.3 percent. *Specialty hospital gains were on average 1.2 percent (far less than rate of inflation)*

- Medicare will no longer pay for conditions that are potentially preventable or complications that result from processes of care and treatment, rather than the natural progression of an underlying illness
  - POA indicators include: fall-related injuries, decubitus ulcers, accidental laceration during a procedure, improper administration of medications, hospital-acquired pneumonia, air emboli, pneumothorax during a central line insertion, urinary tract infections, and so forth.
  - This list closely mirrors the eight complications that Medicare will no longer pay for – see next slide
The Centers for Medicare & Medicaid Services (CMS) announced a new demonstration for hospitals to test the use of a bundled payment for both hospital and physician services for a select set of episodes of care to improve the quality of care delivered through Medicare fee-for-service.

The goal of the Acute Care Episode (ACE) demonstration is to use a global payment to better align the incentives.

CMS plans to competitively award only one ACE demonstration site per market area during the first year of the demonstration and is open to applicants from Texas, Oklahoma, New Mexico, and Colorado.

Each demonstration site, or "Value-Based Care Center", will be selected and actively marketed by CMS to both beneficiaries and referring physicians.

For purposes of this demonstration, a bundled payment is a single payment for both Part A and Part B Medicare services furnished during an inpatient stay. The select sets of procedures included in the bundled payment demonstration are 28 cardiac and 9 orthopedic inpatient surgical services.

This demonstration provides an opportunity for Value-Based Care Centers to develop efficiencies in the care they provide to beneficiaries through increasing market share, quality improvement in clinical pathways, improved coordination of care among specialists, and "gainsharing."

This demonstration also provides an opportunity for Medicare to share savings achieved through the demonstration with beneficiaries who, based on quality and cost, choose to receive care from participating demonstration providers.
Section 6

High level observations from the physician contract review
Section 6 – High level observations from the physician contract review

High level observations from the physician contract review

- LMHS has positioned itself well by diversifying from a primary care based to a multi-specialty based organization
- LMHS has built a solid foundation for a successful future infrastructure
- The health system is organized in a manner that creates a distinct competitive advantage relative to sovereign immunity and access to care

Global opportunities for future success and growth:

- Ability to position physician organization and structure that will maximize all reimbursement but protect patient from unnecessary duplication of cost
- Opportunity exists to improve the basic operational performance
- Opportunity to redesign incentives to meet the LMHS future state goals of around quality operating efficiencies and cost
Section 7

LMHS Collaborative Design Session (CDS)
Goals & Objectives for the Board Retreat
Section 7 – LMHS Collaborative Design Session

LMHS Collaborative Design Session Overview

- The collaborative design process brings together key stakeholders to drive to decisions regarding major organizational issues in an accelerated focused environment. PwC uses structured techniques to facilitate the participants in the development of a high-level vision and corresponding operational details.

- PwC brings together the right balance of subject matter expertise to work with LMHS representatives to build the vision of their new environment.

- The collaborative design session is a facilitated process of intensive group exploration, co-design, and decision making to address the strategic and operational needs of the organization.

- The Collaborative Design Session follows a five-step model:
  - Orient – Create common understanding or starting point for decision making
  - Discover – Investigate and observe influences affecting the issue
  - Define – Determine the requirements for the issue being approached
  - Design – Draft the concept of the model or solution
Our Services were performed and this Report was developed in accordance with our engagement letter and are subject to the terms and conditions included therein.

Our Services were performed in accordance with Standards for Consulting Services established by the American Institute of Certified Public Accountants ("AICPA"). The procedures we performed did not constitute an examination or a review in accordance with generally accepted auditing standards or attestation standards. Accordingly, we provide no opinion, attestation or other form of assurance with respect to our work or the information upon which our work was based. We did not audit or otherwise verify the information supplied to us in connection with this engagement, from whatever source, except as may be specified in this Report or in our engagement letter.

Our work was limited to the specific procedures and analysis described herein and was based only on the information made available through June 6, 2008. Accordingly, changes in circumstances after this date could affect the findings outlined in this Report.

This Report and all PricewaterhouseCoopers deliverables are intended solely for the management and board of directors of Lee Memorial Health System for their internal use and benefit and are not intended to nor may they be relied upon by any other party ("Third Party"). Neither this deliverable nor its contents may be distributed to, discussed with, or otherwise disclosed to any Third Party without the prior written consent of PricewaterhouseCoopers. PricewaterhouseCoopers accepts no liability or responsibility to any Third Party who gains access to this deliverable.

This Report is intended for the use and benefit of Lee Memorial Health System only and is not intended for reliance by any other Party.
In the past few months, I've held casual and in depth conversations with more than 50 executives, administrators and doctors involved in both inpatient and outpatient LMHS work.

The collective skill sets and dedications seem superior to nearly all the public and private firms previously served. That is fortunate, because the problems and challenges appear equally more complex than most of the commercial and industrial situations. It is also unusual, because greater Ft. Myers is really a small town with limited access to trade talents. As management increasingly presents deteriorating financial pictures, both in operating and portfolio revenues, and at the same time feverishly and with great urgency seek cost reductions, containments and new revenue sources, all the abilities available will be needed to survive.

50% of the 2,400 acute care hospitals are in red ink and at least 500 have zero capital reinvestment funds to fix and replace basics. Reimbursement schedules will not improve. Costs will rise, entitlements should increase and the non insured will continue to require subsidy. At the same time, few doctors have indicated much interest in working for less and fewer patients have suggested higher charges.

Such data clearly describes a time for bold, deliberate, positive actions and stabilizations, perhaps more urgent than what naturally evolves. How can you do more with less? How do you run a technology oriented, highly skilled labor intensive business without cash and capital? Answer; with great difficulty!

The perplexing situation is much about money and people. Not to just achieve operating surpluses, but first to survive and then to continue and sustain a superior medical mission. No margin, no mission.

Management and board/community together, should look for every revenue improving opportunity; capturing a greater share of the total health care
spending, ancillary and ambulatory gains, tighter appropriate protocol practices, better pricing, philanthropic aid, and, even tax support, since imposed Medicare and Medicaid reimbursement fail to cover costs. Cost containment is most internally accessible and best understood. Revenue increases may require structural change to a more external, market oriented posture. "Build it and they will come", no longer works. Ask developers. If you don't go get it, it won't come to you.

At one time, not too long ago, enough money floated around systemically to permit all contestants to prosper. Not so today. Everyone is squeezed; hospitals, docs, patients and, the public, who end up paying for much of everything. We may be entering an era where quality will be critical, but value will control. Value means quality at a better than fair cost. Think Wal-Mart and Costco and consider relating that model to value oriented, cost contained, high quality medical treatments and processes.

LMHS and this Board has a unique opportunity and a powerful obligation to seize the day and institute whatever business model changes are required to survive. Immunity, dominance, a farsighted Board and a strong management team provides those elements of potential success.

Respectfully,

J. M. Eikenberg
6. ORTHOPEDIC IMPLANT REQUEST FOR PROPOSAL STATUS REPORT
(Kerry Babb, Quality & Education Committee Chairman and Bill Tousey, RN, MBA, Vice President/Cooperative Services of Florida– 10 min)

(Verbal Update)

There is no documentation for this item.
7. Hospitalist Report
   (Larry Antonucci, M.D., Chief Administrative Officer/CCH – 15 min)

(Verbal Update)

There is no documentation for this item.
8. SURGERY OPERATIONS REPORT
(Donna Giannuzzi, RN, Chief Patient Care Officer – 15 min)

(Verbal Update)

There is no documentation for this item.
DATE: June 9, 2008

NAME OF SERVICE LINE/ENTITY UPDATE: Clinical Information Technology - Strategic Overview

PERSON RESPONSIBLE & TITLE: Mike Smith, Chief Information Officer

KEY ACCOMPLISHMENTS

Successful LPG Epic Rollout to date
Successful Gulf Coast Expansion Readiness to date
Strategic Clinical Information Technology direction established with Epic

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FINANCIAL STATUS (including cash flow statement, projected cash flow, balance sheet and income statement)

N/A

PROBLEMS/ISSUES

N/A

ANTICIPATED NEEDS

Determination of timing for migration to Epic in the LMHS Acute Care settings

SUMMARY/COMMENTS

This is a Strategic Overview of the current state and direction of LMHS Clinical Information Technology
See the attached presentation.
Clinical Information Technology (IT) Strategic Overview
LMHS Future IT Vision

LMHS Information Technology

OPERATIONAL SYSTEMS
- ADT/Patient Mgmt
- Orders/Results
- Materials Management
- HR/Time and Attendance
- General Accounting

PHYSICIAN SUPPORT
- Remote Access to data
- Clinical Documentation
- Telemedicine
- Diagnostic Imaging

MANAGED CARE
- Referral Processing
- Contract Mgmt
- Patient Eligibility
- Provider Profiling

ANCILLARY SYSTEMS
- Lab
- Radiology
- Pharmacy

MODALITY INTEGRATION
- Images
- Diagnostics

OUTCOMES MGMT
- Quality Measures
- Outcomes
- Utilization Mgmt.

INFORMATION MGMT
- Decision Support
- Data Standards
- Cost Accounting
- Strategic Information
- Marketing Information

TECHNOLOGY SERVICES
- Interconnectivity
- Transaction Interfaces
- Security
- Transaction Backups
- Business Continuation

ENTERPRISE SCHEDULING

COMMUNITY/REGIONAL/STATE

Computerized Patient Record

Clinical Case Management

Master Member Index

Financial Repository

Clinical Repository

Community Health Record

IN HOME SERVICES
- Appointments
- Medical Reference
- Educational Video
- Chronic Disease Monitoring/Management
- Home tele-medicine
- Interactive electronic medical record
- E-consults

PUBLIC/COMMUNITY HEALTH SERVICES ORGANIZATIONS
- Immunization History
- EMT Training Records
- Service Directories
- 911/Public Safety
- County Health Department

EMPLOYERS, GOVERNMENT, PAYORS (including FINANCIAL INSTITUTIONS)
MANAGED CARE COMPANIES

- Payment Advice
- Payment Notice
- On-Line Enrollment
- Patient Status
- Contract Mgmt.
- Pre-Certification
- Benefits Management
- Utilization Management
- PQIP
Strengths of Current CIS Environment

There are many strengths LMHS has been able to take advantage of in the current clinical IT environment:

- **Robust Clinical Systems.** LMHS currently has in place some of the best departmental systems in the industry (i.e. lab, radiology, cardiology, clinical documentation, medical records, nurse staffing, etc.)

- **Robust Community Patient Index/Clinical Data Repository.** Provides current and historical integrated clinical data access across LMHS hospitals and most outpatient diagnostic settings.

- **Web-based Clinical Portal (NetAccess) front ending clinical applications for physicians and nurses.** Supports easy to access clinical views of realtime information within and outside the hospitals, across the continuum of care. Emergency departments no longer pull charts. Also provides single sign-on capabilities.

- **Integration of diagnostic imaging and other clinical modalities into the clinical patient record and IT environment.** Examples are Heartlab, Wireless Telemetry, Tele-Radiology, Fetal Monitoring, etc..

- **Highly reliable, high integrity computing environment internally and across all LMHS locations throughout the community.**
  - A requirement for a robust clinical computing environment
  - Demonstrated during the recent natural disasters
  - But not to be taken for granted
Patient: John Test Patient

Results viewable across locations, back to 1999

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Sex: M  BD: 02/26/1931  MR#: 853042  PT#: 6585086
Rm/Bed: R515 B

**CARDIOLOGY** (Up to latest results)

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**Patient:** John Test Patient

**User:** KLMisd

**Allergies:** NKDA

### VITALS PLOT

#### Vitals

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Physician Testimonials

- This is a terrific system. Net Access makes it a pleasure to log on.  
  *Pediatric Physician*

- The system... is easy to use and definitely helps to improve physician satisfaction.  
  *Internal Medicine Physician*

- I have been enjoying the web page and electronic access to Lee very much!! Have a good week.  
  *Podiatric Surgeon*

- Net Access is a giant leap forward... I use Net Access twice a day...  
  *Pediatric Physician*

- We have been using Net Access in the ER... It is much easier to access old records with a couple of mouse clicks. We rarely request paper charts now.  
  *ER Physician*

- I was able to review a patient’s previous clinical history on-line, learned of a previously treated malignancy and was able to render an accurate interpretation that would have otherwise been incomplete  
  *Pathologist*

- ... it (Net Access) has changed the way I practice medicine. ... I was able to provide better medical care in a more efficient manner...  
  *Pulmonologist*

- (Net Access)... provides improved access to patient data, decreased medical errors, decreased medical costs due to duplication of services, improved patient satisfaction, improved physician satisfaction...  
  *GI Physician*

- Because Net Access allowed me quick access to lab results remotely, I understood an abnormal situation and proceeded with an important surgery that same day... it (Net Access) is saving me time and allowing me to deliver better care  
  *Thoracic Surgeon*
An example of the value of technology (recent e-mail from a specialist)

“I’m on call tonight and just received a call from Dr. Greene in the Cape ER about a “frequent flyer” with a new HA (headache). Radiology (tele-rad) has read the CT brain and feels there is an acute CVA (aneurism). The neuro exam is normal but the patient c/o (complains of) severe HA.

At home, I’ve reviewed the ER records, past exams and reports in netaccess and viewed the images from 2 hrs ago and 10 minutes later I called back Dr Greene.

The lesion is chronic for at least 6 mos! The pt does not need to be admitted and can be symptomatically treated for HA.

The hospital saves money/resources on this probably uninsured pt. and I can go back to sleep!

Currently at SWR (Southwest Regional), I would not be able to access the ER records because their handwritten, past reports would require the electronic passcode device which is at the office so I can access records while at work when necessary and CT images can not be reviewed!!!

I know you know this information, and I don’t mean to be repetitive, but I thought a “real” example might be helpful to illustrate a common occurrence in our world.”
But, there are significant limitations and barriers to our current clinical IT environment that cannot be overcome with the systems that we have in place:

- **Seamless access to key clinical information within the acute setting is a continuous struggle.** One of the most common complaints is that the two systems (CliniComp and Net Access).

- **Separate Clinical Order/Result Management Systems (Net Access), Pharmacy (Siemens) and Clinical Documentation (CliniComp) systems cause inefficiencies in clinical workflow.**

- **Barriers to sharing information across care settings** (Particularly with Lee/HP/CCH, Gulf Coast, Home Health, HP Care Center)

- **Barriers to future technology opportunities**
  - Electronic MAR with bar-coding, Computerized Physician Order Entry (CPOE), clinical decision support engines
  - Data Mining (reporting)

- **Long-term viability of current solutions are at risk:**
  - Siemens Invision is legacy product, being replaced with Soarian. Soarian has not reached level of maturity for consideration at LMHS.
  - CliniComp is a small vendor with ongoing concerns about company stability and viability in long term

- **New Hospital (GulfCoast) is on HCA/Meditech System - not integrated, and doesn’t make sense to use Siemens/CliniComp in that facility**
Clinical IT Work Underway

1. Epic implementation approved for Lee Physician Group
   - Rollout under way – Approximate 25 providers are live on system
   - Will continue through 2009

   Epic live in Lee, HP and CCH Emergency Rooms
   **Epic selected as LMHS Future Clinical IT Strategy**

2. Extending existing HCA Meditech to new Gulfcoast facility
   - temporary solution

3. Extending LMHS Clinical Systems into East Cancer and Diagnostic Campus

4. Implementation/integration of large amount of major diagnostic equipment
   - Selection/implementation of new Radiology PACS
   - Installation of Heartlab, Telemetry, at Gulf Coast
   - Imaging systems at Gulf Coast and East Outpatient Campuses

   - 64, 40 and 16 slice CTs
   - Rad Imaging Rooms
   - R&F Rooms
   - Nuclear Cameras
   - MR
   - PetCT
   - C-Arm Imaging Devices
   - Ultrasounds
   - Mobile X-Ray
   - Cath Labs
   - Echo lab
   - EKGs

   Total: 64, 40 and 16 slice CTs: 4
   Total: Rad Imaging Rooms: 3
   Total: R&F Rooms: 2
   Total: Nuclear Cameras: 2
   Total: MR: 1
   Total: PetCT: 1
   Total: C-Arm Imaging Devices: 4
   Total: Ultrasounds: 4
   Total: Mobile X-Ray: 4
   Total: Cath Labs: 3
   Total: Echo lab: 2
   Total: EKGs: 14
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<td>Shriner's Hospitals for Children Corp.</td>
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<td>ETMC Regional Healthcare System</td>
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<td>Dartmouth Hitchcock Medical Center</td>
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<td>Memorial Hermann Healthcare System</td>
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<td>Medical Univ. of South Carolina</td>
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<td>Lifespan</td>
<td>167 Point Street, Providence, RI 02903</td>
<td>Intermountain Health Care</td>
<td>4646 West Lake Park Blvd, SLC, UT 84120</td>
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<td>The Ohio State University Med. Center</td>
<td>200 Meiling, 370 W. 9th Ave, Columbus, OH 43210</td>
<td>Johns Hopkins Medicine</td>
<td>1101 E. 33rd Street, Suite 008, Baltimore, MD 21218</td>
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<td>BJC HealthCare</td>
<td>4444 Forrest Park Avenue Suite 500, MD 6066-500, St. Louis, MO 63108-2259</td>
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<td>The Ohio State University Med. Center</td>
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<td>Saint Barnabas Health Care System</td>
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<td>Johns Hopkins Medicine</td>
<td>1101 E. 33rd Street, Suite 008, Baltimore, MD 21218</td>
<td>University of Chicago Hospitals &amp; H.S.</td>
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<td>1151 Azalea Garden Road, Norfolk, VA 23502</td>
<td>Orlando Regional Healthcare</td>
<td>1414 Kuhl Avenue MP5, Orlando, FL 32806-2093</td>
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National Challenges

- Aging population – worse in Lee County
- Increasing reliance on government funding
- Health costs rising much faster than cost of living
- Decline in employer-sponsored health insurance
- Increase in uninsured & underinsured
National Challenges

- Provider reimbursement relatively flat; expenses rising much faster
  - Reimbursement regulated, expenses not

- Shortage of trained healthcare professionals

- Increasing regulatory/patient safety demand
  - Data collection and transparency

- Increasing consumer demand for accountability

- Lack of political will to pursue systemic reform
Local Challenges 2008

- Patient Volumes are down
  - Fuel Prices
  - Stock Market
  - The Economy
  - Housing Inventory
  - Out Migration
  - Tax base implications

- Non and Under-insured are increasing faster than national average
State/Local Challenges 2008

- Physician shortages –
  - Reimbursement Issues
  - Call coverage
  - Florida

- Capital Needs
  - Facilities (Gulf Coast, Aging Plants)
  - IT
  - Etc.

- Our Market
  - Aged population (demographics 5 years ahead of nation, payor mix)
The National Healthcare IT Agenda is little help

- No sustainable financial model for Regional Health Information Exchanges (RHIOs)
- No appetite for a national patient identifier number
- Concerns about competition/data sharing
- Security/confidentiality concerns
- Patient information custodial concerns
- Inadequate focus on clinical intuitiveness/usability
Our Community Opportunity
Our opportunity – the good news

- Addressing these issues requires a systemically different, far more advanced level of integrated IT systems, supporting:
  - elimination of unnecessary, duplicate diagnostic tests
  - support for improved caregiver efficiency
  - support reduction in length of stay
  - support elimination of unnecessary encounters
  - support movement of necessary encounters to the most effective care setting (seamless, continuum-based care)
  - improved efficiency of care givers
    - Documentation as a by product of care
    - Point of care automation
      - Bar coding
      - Automated data collection – feeds from “smart beds, etc.”
      - Statistics/operational monitors created as a by-product of activity

- There is no other sustainable way to enable the significant improvements that are needed
Lee County – Good News

- County patient identifier numbering system
  - MPI exists – 1 million + citizens, very high integrity
- Managed, secure, reliable IT environment
- Successful track record with physicians –
  - Net Access, Heartlab
- Spectacular install to date – Epic
- Significant interest from non-employed physicians to utilize LMHS’ IT solutions
  - Epic integrated with other LMHS IT Systems
- We have largely overcome RHIO challenges
Lee County Situation (cont)

In addition...

- County EMS is engaged
- County Health Department is engaged
- Demographics – age of population ahead of nation
- Community Readiness
- Our market share
Effective Application of IT – The future

We are positioned to make a difference …

- First phase of implementation with new generation World Class EMR - Epic
- Strategic vendor relationships - Epic, Philips, Siemens, GE, Cisco
- Strategic relationship for community connectivity - Embarq
- Essentially all Lee County citizens in the existing Siemens Electronic Record
- Essentially all providers are users of existing Siemens Electronic Record –
  - strong physician credibility with IT
- Ubiquitous information possibility for all Lee County caregivers –
  - Through implementation of Epic throughout county ERs, Emergent Care Centers, other clinical settings
- Provide Epic access for school children
- Feedback loops hardwired into care delivery process – reminders, alerts
- Applied clinical intelligence at point of care, trigger alerts
  - Monitoring/interventions
  - Pharmaco-vigilance
  - Chronic disease management
  - Data Mining

- Future Remote Monitoring/Telemedicine integration with Epic
Consumer Care – At Home

- Technology solutions are allowing elderly people to live at home ("aging in place") while providing a level of monitoring to make sure they are safe and following a routine.

A recent NY Times article cited several studies underway and profiled some of the leading sensor and IT solutions:

- Motion sensors and remote monitoring systems to make sure people get out of bed and take prescription medicines. Alerts are sent to family members when there are deviations.
- Comprehensive monitoring packages with a monthly fee that include the above plus checks for blood pressure, weight, and respiration.
- Wireless sensors and appliances that regulate temperature, light, and appliances,
- A memory bracelet being developed by Intel that vibrates at a specified time to remind the wearer of a doctor’s appointment or to take medications.
- Sensor-infused carpets (aka magic carpets) which measure changes in gait to help avoid falls.
- Projects testing these and many other technology solutions are underway across the country. Dr. Jeremy Nobel, a professor at the Harvard School of Public Health, predicts “a significant increase in the adoption of such systems in two to five years, and widespread adoption in ten years.” One perceived roadblock for wider adoption of in-home monitoring has been the resistance of older people to use the Internet. However, a recent survey by AARP found that older people are willing to use high-tech devices at home, and to pay about $50 a month for the service. (High-Tech Devices Keep Elderly Safe from Afar, NY Times on the Web, May 25, 2008).
Systemically enabling a different care delivery model cannot happen without new Information Technology tools…
- that provide complete accurate information/automation
  . at the point of care
  . with patient interaction
  . at office, home, remote for family monitoring (PHR)
  . Integrated, across the continuum.

Our community is one of a few if not the only one in the country that is positioned for this:
- community readiness
- physician readiness (including non-employed)
- health system readiness
- IT environment readiness

Integrated, seamless IT solution will enable improvements in care delivery and care effectiveness for Lee County – far beyond what can be accomplished otherwise – improving quality, reducing waste and costs
Impact of waiting...

- Long term project – 5 years
- Emerging Clinical IT needs that cannot be effectively met in the interim:
  - Meds automation/bar coding
  - Barcoding patient identification
  - Automation data collection/documentation as by-product of care
  - OR automation
  - Gulf Coast Expansion – “an island” –
    - One-off solutions
    - Continuing use of HCA IT, revenue cycle
- Delay in non-employed physician relationship partnering with LMHS/Epic
- Existing IT solutions (Siemens/CliniComp) – continued risks, issues, minimal clinical development, continued investments are “sunk costs”
- P4P/Transparency reporting is increasing
  - More data
  - Across continuum
  - More manpower/staffing to collect
  - Quality
- Position for chronic care delivery in the community
- Spending money on current systems is a long-term waste of precious dollars, and clinical and IT manpower
Strategic Implementation Phasing

- **Implement Epic in Acute Care Settings**
  - PHASE I
    - a) Standardize Clinical Documentation, Scheduling/Registration, Revenue Cycle, Pharmacy, EMAR, OR, etc. for all hospitals
    - b) Gulf Coast Medical Center first
    - c) Cape Coral
    - d) LMH/HP
  - PHASE II Implement advanced functionality –
    - CPOE, Physician Documentation, clinical alerts, etc.

- **Extend Epic to additional Outpatient Settings**
  - Complete employed primary care rollout (approved/underway)
  - MSO (employed specialists) rollout
  - Community physicians – separate business structure
  - Make available to schools, county health department, EMS

- **Implement Epic for Direct to Consumer**
  - Deployment of Personal Health Record integrated with LMHS EMR (MyChart) – scheduling, access to clinical information
  - Automated in-home clinical alerting

- **Implement Epic in Home Health, Long Term Care**

- **Other non-clinical system replacements (HR, General Financials)**
It’s ALL about Patient Care

- Lee Physician Group
- Health Park Care Center
- Lee Outpatient Centers
- Regional Network Partners
- Lee Home Health
- HealthPark

Technology
- Physician Support
  - Remote Access to data
  - Clinical Documentation
  - Telemedicine
  - Diagnostic Imaging

PHS

lnformation Technology
- Computerized Patient Record
- Enterprise Scheduling
- Community Health Record
- Master Member Index

Advanced Care Management
- Clinical Case Management
- Financial Repository
- Clinical Repository

Decision Support
- Information Management
- Data Standards
- Cost Accounting
- Strategic Information
- Marketing Information

Business Continuation
- Interconnectivity
- Transaction Interfaces
- Security
- Transaction Backups

Physician Support
- Remote Access to data
- Clinical Documentation
- Telemedicine
- Diagnostic Imaging

Managed Care
- Referral Processing
- Contract Management
- Patient Eligibility
- Provider Profiling

Outcomes Management
- Quality Measures
- Outcomes
- Utilization Management

Physician Support
- Remote Access to data
- Clinical Documentation
- Telemedicine
- Diagnostic Imaging

In Home Services
- Appointments
- Medical Reference
- Educational Video
- Chronic Disease Monitoring/Mgt
- Home Tele-medicine
- Interactive Electronic Med Record
- E-consults

Public/Community Health Services
- Immunization History
- EMT Training Records
- Service Directories
- E911/Public Safety
- County Health Department

Employers, Government, Payors
- Including Financial Institutions
- Managed Care Companies

Technology Services
- Interconnectivity
- Transaction Interfaces
- Security
- Transaction Backups
- Business Continuation

Aligned Physicians
- P4P

lnformation Management
- Payment Advice
- Payment Notice
- On-Line Enrollment
- Patient Status
- Contract Management
- Pre-Certification
- Benefits Management
- Utilization Management

Public/Community Health Services
- Immunization History
- EMT Training Records
- Service Directories
- E911/Public Safety
- County Health Department

Lee Convenient Care
- Lee Outpatient Centers
- Lee Home Health
- Regional Network Partners

Southwest Regional
- Lee Memorial Coral (Cleveland)
- Lee Memorial Gulf Coast

Children’s/HealthPark
- Lee Convenient Care
- Lee Outpatient Centers
- Lee Home Health
- Regional Network Partners

Gulf Coast
- Lee Convenient Care
- Lee Outpatient Centers
- Lee Home Health
- Regional Network Partners

Cape Coral
- Lee Convenient Care
- Lee Outpatient Centers
- Lee Home Health
- Regional Network Partners

EMS

It’s ALL about Patient Care

- Early Intervention
- Family Status
- Employees

SCHOOLS

Emergency Medical Services
TIME SENSITIVE ISSUES
OTHER ITEMS
DATE OF THE NEXT
REGULARLY SCHEDULED
MEETING

QUALITY & EDUCATION
Committee of the Whole
MEETING

THURSDAY,
August 14, 2008
2:00pm

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