PLANNING, STRATEGY & SYSTEM TRANSFORMATION WORKSHOP

Thursday, June 15, 2017
9:00 a.m.
AGENDA

BOARD OF DIRECTORS
PLANNING, STRATEGY &
SYSTEM TRANSFORMATION WORKSHOP
June 15, 2017 9:00 A.M.

Gulf Coast Medical Center – Boardroom (Medical Office Building)
13685 Doctors Way, Ft. Myers, FL 33912

9:00 a.m. CALL TO ORDER
(Sanford Cohen, M.D., Board Chairman)
The Board of Lee Memorial Health System, doing business as Lee Health, Gulf Coast Medical Center & Lee Memorial Hospital/HealthPark Medical Center and the Board of Directors of its subsidiary corporations, including but not limited to Cape Memorial Hospital, Inc. doing business as Cape Coral Hospital; Lee Memorial Home Health, Inc.; and HealthPark Care Center, Inc.

9:00 a.m. OPENING REMARKS
(Larry Antonucci, M.D., President/CEO)

9:05 a.m.
9:10 a.m.

9:15 a.m. SAFETY STORY
(TBD)

9:15 a.m.
10:00 a.m.

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9:15 a.m.
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9:15 a.m.
10:00 a.m.

9:15 a.m.
10:00 a.m.

10:00 a.m. STRATEGIC FINANCIAL PLANNING-10 YEAR OPERATING & CAPITAL FORECASTING
(Ben Spence, Chief Financial & Business Services Officer)
- Overview of Long Term Capital Projects
- Financial Projections and Scenario Analysis

11:30 a.m. DISCUSSION

12:00 p.m.

12:00 p.m.

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AGENDA (Page 2 of 2)

BOARD OF DIRECTORS WORKSHOP
June 15, 2017 9:00 A.M.
Gulf Coast Medical Center – Boardroom (Medical Office Building)
13685 Doctors Way, Ft. Myers, FL 33912

2:15 p.m.  2:45 p.m.  4:15 p.m.
ROLES IN THE LEAN MANAGEMENT SYSTEM
(John Toussaint, M.D.)

2:45 p.m.  4:15 p.m.
DISCUSSION
(John Toussaint, M.D.)

4:15 p.m.  4:30 p.m.
NEXT STEPS & CLOSING
(Donna Clarke, Board Vice Chairman)

4:30 p.m.  ADJOURN (Donna Clarke, Board Vice Chairman)
BOARD OF DIRECTORS

OPENING REMARKS

(Larry Antonucci, M.D., President/CEO)
BOARD OF DIRECTORS

WELCOME

(Donna Clarke, Board Vice Chairman)
NO DOCUMENTATION AT THIS TIME

Lee Memorial Health System Board of Directors
BOARD OF DIRECTORS

UTILIZATION TRENDS AND BED NEED

(Kevin Newingham, Chief Strategy Officer; Regina Eberwein, System Director Planning & Market Research)
Population Trends
Permanent Population – Lee County

61,785 New Pop 2010-2016

Growth Rate in Population

Total Population
Permanent Population Growth – Lee County

61,785 New Pop 2010-2016

Growth Rate


18,074 23,288 29,496 28,379 11,054 3,959 6,585 6,556 12,719 5,338 10,118 12,360 14,694 10,298 15,641

2010-2016 Avg 2016-2025 Avg
Projected Growth Rates | 2016 – 2025
Includes Snowbirds

- 0-17: 1.8%
- 18-54: 1.7%
- 55-64: 1.7%
- 65-79: 2.8%
- 80+: 3.8%
- Total: 2.1%
Forecasted Population Distribution - Permanent & Snowbirds
Use Rate Trends
Population Estimates by Different Sources
State Economists vs Census Economists

BEFR = University of Florida, Bureau of Economic and Business Research, used in Florida State budgets
Hospital Inpatient Use Rates Ages 65+

![Bar chart showing hospital inpatient use rates for different areas and years.](chart.png)
Hospital Inpatient Use Rates By Age Cohort

**Hospital Inpatient Use Rates Ages 65-79**

- Florida: 254, 243, 193
- Jacksonville MSA: 179, 149, 136
- Orlando MSA: 215, 243, 180
- Tampa MSA: 210, 146, 133

**Hospital Inpatient Use Rates Ages 80+**

- Florida: 426, 546, 429
- Jacksonville MSA: 453, 522, 300
- Orlando MSA: 405, 485, 307
- Tampa MSA: 304, 389, 304

**Hospital Inpatient Use Rates Ages 18+**

- Florida: 141, 160, 155, 135, 128
- Jacksonville MSA: 114, 156, 152, 133, 121
- Orlando MSA: 156, 156, 156, 133, 113

**Hospital Inpatient Use Rates Ages 65+**

- Florida: 249, 311, 306, 241, 190
- Jacksonville MSA: 270, 303, 301, 245, 236
- Orlando MSA: 241, 303, 268
- Tampa MSA: 182, 175
2014 Medicare Hospital Utilization by Hospital Referral Region (HRR)

- Average: 254.1 = Index 1.000
- Fort Myers HRR: 257.9 = Index 1.015
- Phoenix HRR: 226.2 = Index 0.890
2012 Hospital Beds per 1,000 Population by Hospital Referral Region (HRR)

- Average: 2.1
- Fort Myers HRR: 1.8
- Phoenix HRR: 1.8
IP Bed Need Modeling
## 12 Drivers - IP Bed Need Modeling

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Impact on Bed Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Growth</td>
<td>↑</td>
</tr>
<tr>
<td>Increasing Acuity</td>
<td>↑</td>
</tr>
<tr>
<td>Economic Growth</td>
<td>↑</td>
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<tr>
<td>Epidemiology</td>
<td>↑</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Drivers</th>
<th>Impact on Bed Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systems of Care/Population Health</td>
<td>↓</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>↓</td>
</tr>
<tr>
<td>Process Improvements</td>
<td>↓</td>
</tr>
<tr>
<td>Technology</td>
<td>↓</td>
</tr>
<tr>
<td>Readmissions</td>
<td>↓</td>
</tr>
<tr>
<td>Potentially Avoidable Admissions</td>
<td>↓</td>
</tr>
<tr>
<td>Long-Term Acute Care Facilities</td>
<td>↓</td>
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<tr>
<td>Policy</td>
<td>↓</td>
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</tbody>
</table>
12 Drivers applied to Patient and Illness

**Patient Characteristics**
- Age
- Gender
- Zip Code
- Admission Source
- Discharge Disposition

**Illness Characteristics**
- Specific to 700 Diagnosis-Related Groups (DRG)
- Clinical Trends
- Surgical Trends
- Length of Stay
- Inpatient vs Observation
- Bed type (General; Telemetry; ICU)
Scenario Modeling for Bed Need - Adults

<table>
<thead>
<tr>
<th>Model</th>
<th>2016 Bed Need</th>
<th>2026 Bed Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>1,223</td>
<td></td>
</tr>
<tr>
<td>2016 Pop Growth</td>
<td>+ 350</td>
<td></td>
</tr>
<tr>
<td>Upward Drivers</td>
<td>+ 72</td>
<td></td>
</tr>
<tr>
<td>Downward Drivers</td>
<td>- (463)</td>
<td></td>
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<tr>
<td></td>
<td>= 1,182</td>
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</table>

75% of Downward Drivers + 350 + 72 - (347) = 1,298

50% of Downward Drivers + 350 + 72 - (231) = 1,414
### Supply / Demand for IP Beds - Adults

<table>
<thead>
<tr>
<th></th>
<th>Model</th>
<th>75% scenario</th>
<th>50% scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-yr Bed Need</td>
<td>1,182</td>
<td>1,298</td>
<td>1,414</td>
</tr>
<tr>
<td>2021 Available</td>
<td>1,273</td>
<td>1,273</td>
<td>1,273</td>
</tr>
<tr>
<td>Over / (Under)</td>
<td>91</td>
<td>(25)</td>
<td>(141)</td>
</tr>
</tbody>
</table>
# 2021 Beds by Campus

<table>
<thead>
<tr>
<th>2021 Available</th>
<th>CCH</th>
<th>GCMC</th>
<th>HPMC</th>
<th>LMH</th>
<th>Total</th>
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<tbody>
<tr>
<td>Adult Available</td>
<td>275</td>
<td>624</td>
<td>274</td>
<td>100</td>
<td>1,273</td>
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<tr>
<th>Model</th>
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<td>Model</td>
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<td>91</td>
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<tr>
<td>75% Scenario</td>
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<td>(25)</td>
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<tr>
<td>50% Scenario</td>
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All private rooms at LMH
Discussion
STRATEGIC FINANCIAL PLANNING – 10 YEAR OPERATING & CAPITAL FORECASTING
(Ben Spence, Chief Financial & Business Services Officer)

- Overview of Long Term Capital Projects
- Financial Projections & Scenario Analysis
Strategic Financial Planning
10 Year Operating and Capital Forecasting

Board Workshop
June 15, 2017
Strategic Financial Planning

Topics for Discussion

• Routine and Strategic Capital Allocation
• Resource Allocation Committee and IT Steering & Data Governance Committee
• Operating Assumptions and review of key variables
• Financial Forecasts – Funding the Capital Plan through Fiscal Fitness
  • Scenario Planning
    • Labor Productivity
    • Inpatient length of stay
    • Inpatient & ED Use Rates
• Other cost savings initiatives in the Fiscal Fitness Plan
Foundational Elements for building the Strategic Financial Plan

• **Consensus on point of view for the future**

  • What is the right allocation of our resources for strategic capital spend that will lead to the very best health outcomes, excellent patient experience and lower costs?

  • What are the key operational metrics we need to achieve financially to fund the capital plan?
Capital & Operating Expenses

**Capital Expenditures:** Asset that benefit the company for more than a year. Cost are depreciated over the useful life of the asset.

- **Building Cost:** $300,000,000
- **Useful Life:** 30 Years
- **Depreciation Expense per Year:** $10,000,000

**Funding:** Cash from Operations or Debt Financing

**Operating Expenses:**
Salaries, benefits, supplies, utilities, etc., expensed as utilized in full
10 Year Strategic Growth and Routine Capital Spending Forecast
10 Year Routine Capital & Information Technology

- Routine Capital Equipment $344 M
  - Acute Care, Surgery, Radiology, Lab, LPG, Post Acute, etc.

- Routine Building & Fixtures $136 M
  - i.e. Air Handlers, Electrical, Plumbing, etc., renovations

- Information Technology $150 M
  - Infrastructure
  - IT associated with new facilities & programs
  - Strategic Growth IT / New Technologies

Sub-total Routine Capital & IT $630 M
10 Year Capital for Potential Major Facility & Strategic Growth Capital Projects

- **Acute Care Bed Replacement, Expansion & Renovations**
  - Gulf Coast Medical Center Expansion $303 M
  - Lee Memorial Hospital Renovations $35 M
  - HealthPark Medical Center conversion of Pediatrics to Adult Beds & ED $14 M
  - Conversion of corporate offices in hospital space for clinical purposes $8 M
  - South Lee Inpatient Tower $60 M

  **Subtotal Acute Care:** $420 M
10 Year Capital for Potential Continuum of Care Projects: Outpatient, Physician and Post-Acute Expansion

• Lee Health at Coconut Point $104 M
• Gulf Coast 18 Acres Outpatient $ 36 M
• Regional Cancer Center Expansion $ 15 M
• Physician Office Expansion $ 30 M
• Skilled Nursing Unit Expansion $ 15 M

Subtotal Continuum $200 M
10 Year “All Other” Potential Capital Projects

- Population Health & Innovation $20 M
- Staff Office Consolidation & Education Space $14 M
- Leesar - Sterile Processing/Culinary $5 M
- Future Unassigned $45 M

Subtotal $84 M
10 Year Capital Spend Summary

- Routine Capital Equipment: $344 M
- Routine Building & Fixtures: $136 M
- Information Technology: $150 M - $630 M
- Acute Care Bed Replacement, Expansion & Renovations: $420 M
- Continuum of Care: $200 M
- All Other: $84 M - $704 M

Total: $1.34 B
Resource Allocation Committee

- New committee set up in October 2014 to establish a standardized process for review and approval of strategic growth projects.
- Committee is chaired by the Chief Financial & Business Service Officer with voting members as follows: Chief Medical & Clinical Integration Officer, Chief Executive Officer, Chief Strategy Officer, & Chief Population Health Officer.
- Provides clear process for all leaders to follow when bringing forward strategic growth projects.
- Requires review of strategic alignments, volume projections, impact on facilities and information technology, compliance and return on investment.
RAC (continued)

- Committee schedules presentation by project owner when all components are complete and signed off.
- Provides clear decision making rights on strategic capital and operational projects for allocation of annual Lee Health Board of Directors approved capital dollars.
- Owners receive prompt communication of decision with clear expectations on timeline and follow up to compare actual results to expected.
- Provides more timely and continuous opportunity to bring forward strategic growth projects with clear criteria and expectations – improved health, lower cost, improved access to right care, lower cost, and sufficient return on investment.
Information Technology and Data Governance Steering Committee

- Based on success of RAC and desire to have system consensus around strategic IT investments the IT&DGSC was created.
- Committee Chaired by Chief Financial & Business Service Officer and consists of Chief Information Officer, Chief Medical Informatics Officer, Chief Operating Officer, Chief Medical & Clinical Integration Officer, Chief Acute Care Officer, & Chief Patient Care Officer
- Establishment and adoption of IT guiding principles and process for reviewing and approving IT requests
Committee Structure

Current to Future State IT Associated Committee Migration Path

RAC/ Strategy & Growth/ Operations Council

IT Steering & Data Governance Committee

Enterprise Clinical IT Subcommittee

Enterprise Patient Access & Revenue Cycle IT Subcommittee

Enterprise General Financials, HR, and IT Subcommittee

Enterprise Technical & Infrastructure IT Subcommittee

HIPAA Steering

Enterprise Data Governance

IT Initiative Generating Groups

- Cardiovascular Steering
- Clinical Decision Support
- ED Physician & IT Leadership
- NCOD Workgroup
- Radiology PACS Steering
- Physician Impact Discussion
- PLC & MEC
- Clinical Advisory Committee (CAC)

- Order Set Committee
- LPG Physician Governance
- Clinical Practice Council (CPC)
- Clinical Education Council
- Interdisciplinary Practice Council
- NCOD Workgroup
- System Medical Informatics Workgroup

- Pharmacy IT Meeting
- Ancillary Leadership
- LPG Admin. Committee
- LPG Mgrs. Meeting
- South Lee County Steering
- Community Connect
- P2O

- SFHRIT Core Project Team
- SFHRIT Advisory Workgroups
- SFHRIT Subject Matter Experts
- TeleMedicine Task Force
- CMS Task Force
- Other/ additional UHS groups
- PUG

IT Initiative Generating - Staff/Huddle Boards
Deliver Results and Continuous Improvement

LEE HEALTH
Caring People. Inspiring Health
Funding the 10 Year Capital Plan through Fiscal Fitness
Lee Health has historically funded capital needs through cash flow from operations, debt (bonds/bank loans) and philanthropy.

Strong financial performance has led to significant improvements in our cash position providing a great foundation for investments in the future of Lee Health.

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<th>FY 2007</th>
<th>FY 2017</th>
<th>Change</th>
<th>% change</th>
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<tr>
<td>Cash</td>
<td>$492,000,000</td>
<td>$1,005,706,000</td>
<td>$513,706,000</td>
<td>104%</td>
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<tr>
<td>Debt</td>
<td>$665,300,000</td>
<td>$687,107,000</td>
<td>$21,807,000</td>
<td>3%</td>
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<tr>
<td>Cash to Debt</td>
<td>74%</td>
<td>146%</td>
<td>98%</td>
<td>132%</td>
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<td>Days Cash On</td>
<td>134</td>
<td>233.4</td>
<td>74%</td>
<td>1%</td>
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Standard & Poor's Rating: A with positive outlook
Moodys Rating: A2 with stable outlook
## Lee Health Fiscal Fitness Plan

### Key Revenue Assumptions and Variables

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<th>VARIABLE</th>
<th>ASSUMPTION</th>
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<tr>
<td>Population Growth</td>
<td>2.1 % growth per year</td>
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<tr>
<td>Inpatient Admission Rate per 1,000 persons</td>
<td>-1% per year</td>
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<tr>
<td>Average Length of Stay</td>
<td>5.07 to 5.01 by 2020</td>
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<td>Observation Days % of Total Census Days</td>
<td>12% of total days</td>
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<tr>
<td>Outpatient Growth Rate by Service</td>
<td>5% growth per Year</td>
</tr>
<tr>
<td>Reimbursement rate changes</td>
<td>1% - 1.25% per year</td>
</tr>
<tr>
<td>• Fee for Service changes</td>
<td>anticipated decrease</td>
</tr>
<tr>
<td>• Value Based Payments</td>
<td>anticipated increase</td>
</tr>
<tr>
<td>• Payer Mix</td>
<td>no change / uncertain</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>3% growth</td>
</tr>
<tr>
<td>Non Operating Investment Income Projections</td>
<td>5% return</td>
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Key Operating Expense Assumptions and Key Variables

Salaries & Wages

- Average Hourly Rate
  
- Labor Productivity

Supply Cost per Case

- Includes Drugs, Implants, Medical, Surgical, Office

Assumption

- 3% merit per year
- 1.1% improvement per year average
- +2.0% increase
Operating Expense Assumptions and Key Variables (continued)

- **Contracted & Other Services**: 2.0% - 2.4% increase per year
  - Consulting, Equipment Maintenance Agreements, Contract services, etc.
  - Lease Expense, Utilities, Legal, etc.

- **Depreciation Expense**: Projected based on capital spending forecast depreciated over estimated useful life

- **Interest Expense**: Projected based on existing debt schedules
  - No new debt assumed
Financial Forecasting Scenario Planning

Sensitivity Analysis Impact
1) Labor Productivity
2) Average Length of Stay
3) Inpatient Use Rates
LABOR PRODUCTIVITY
Fiscal Fitness Plan vs. Status Quo
Sensitivity Analysis - Labor Productivity

<table>
<thead>
<tr>
<th>Income Statement &amp; Cash Impact</th>
<th>Fiscal Fitness Plan Productivity Improvements</th>
<th>No Labor Productivity Improvement</th>
<th>$ Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>21,347,846</td>
<td>21,347,846</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Expenses</td>
<td>19,276,185</td>
<td>20,119,926</td>
<td>843,741</td>
<td>4%</td>
</tr>
<tr>
<td>Earnings Before Depreciation &amp; Interest</td>
<td>2,071,662</td>
<td>1,227,920</td>
<td>(843,741)</td>
<td>-41%</td>
</tr>
<tr>
<td>EBDITA %</td>
<td>10%</td>
<td>6%</td>
<td>-4%</td>
<td>-41%</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,195,741</td>
<td>1,195,741</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Interest</td>
<td>221,153</td>
<td>221,153</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Gain / (Loss from Operations)</td>
<td>654,768</td>
<td>(188,974)</td>
<td>(843,741)</td>
<td>-129%</td>
</tr>
<tr>
<td>Gain from Operations %</td>
<td>3.1%</td>
<td>-0.9%</td>
<td>-4.0%</td>
<td>-129%</td>
</tr>
<tr>
<td>Investment/Non Operating Income</td>
<td>599,299</td>
<td>468,049</td>
<td>(131,250)</td>
<td>-22%</td>
</tr>
<tr>
<td>Excess of Revenues over Expenses</td>
<td>1,254,067</td>
<td>279,075</td>
<td>(974,992)</td>
<td>-78%</td>
</tr>
<tr>
<td>Margin</td>
<td>6%</td>
<td>1%</td>
<td>-5%</td>
<td>-78%</td>
</tr>
<tr>
<td>Cash Balance 2027</td>
<td>1,771,624</td>
<td>796,632</td>
<td>(974,992)</td>
<td>-55%</td>
</tr>
<tr>
<td>Debt Balance 2027</td>
<td>333,628</td>
<td>333,628</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Cash to Debt</td>
<td>531%</td>
<td>239%</td>
<td>-292%</td>
<td>-55%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>279</td>
<td>117</td>
<td>(162)</td>
<td>-58%</td>
</tr>
</tbody>
</table>
## Sensitivity Analysis – Length of Stay

<table>
<thead>
<tr>
<th>Income Statement &amp; Cash Impact</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scenario 1</strong></td>
<td>Fiscal Fitness Plan - Length of Stay Improvement resulting from care standardization and reductions in delay days</td>
<td>Status Quo - No Length of Stay Improvements</td>
<td>$ Change</td>
</tr>
<tr>
<td>Revenues</td>
<td>21,347,846</td>
<td>21,347,846</td>
<td>0</td>
</tr>
<tr>
<td>Expenses</td>
<td>19,276,185</td>
<td>19,408,826</td>
<td>132,641</td>
</tr>
<tr>
<td>Earnings Before Depreciation &amp; Interest</td>
<td>2,071,662</td>
<td>1,939,020</td>
<td>(132,641)</td>
</tr>
<tr>
<td>EBDITA %</td>
<td>10%</td>
<td>9%</td>
<td>-1%</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,195,741</td>
<td>1,195,741</td>
<td>0</td>
</tr>
<tr>
<td>Interest</td>
<td>221,153</td>
<td>221,153</td>
<td>0</td>
</tr>
<tr>
<td>Gain / (Loss from Operations)</td>
<td>654,768</td>
<td>522,127</td>
<td>(132,641)</td>
</tr>
<tr>
<td>Gain from Operations %</td>
<td>3.1%</td>
<td>2.4%</td>
<td>-0.6%</td>
</tr>
<tr>
<td>Investment/Non Operating Income</td>
<td>599,299</td>
<td>571,479</td>
<td>(27,820)</td>
</tr>
<tr>
<td>Excess of Revenues over Expenses</td>
<td>1,254,067</td>
<td>1,093,605</td>
<td>(160,461)</td>
</tr>
<tr>
<td>Margin</td>
<td>6%</td>
<td>5%</td>
<td>-1%</td>
</tr>
<tr>
<td>Cash Balance 2027</td>
<td>1,771,624</td>
<td>1,611,163</td>
<td>(160,461)</td>
</tr>
<tr>
<td>Debt Balance 2027</td>
<td>333,628</td>
<td>333,628</td>
<td>0</td>
</tr>
<tr>
<td>Cash to Debt</td>
<td>531%</td>
<td>483%</td>
<td>-48%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>279</td>
<td>252</td>
<td>(27)</td>
</tr>
<tr>
<td>Average Daily Census 2027</td>
<td>1,385</td>
<td>1,402</td>
<td>17</td>
</tr>
</tbody>
</table>
Sensitivity Analysis - Inpatient & ER Use Rate
(assumes 40% of reimbursement is value based by 2027 resulting from our population health initiatives)

<table>
<thead>
<tr>
<th>Income Statement &amp; Cash Impact</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>$ Change</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>21,347,846</td>
<td>22,028,787</td>
<td>680,940</td>
<td>3%</td>
</tr>
<tr>
<td>Expenses</td>
<td>19,276,185</td>
<td>20,364,408</td>
<td>1,088,224</td>
<td>6%</td>
</tr>
<tr>
<td>Earnings Before Depreciation &amp; Interest</td>
<td>2,071,662</td>
<td>1,664,378</td>
<td>(407,283)</td>
<td>-20%</td>
</tr>
<tr>
<td>EBDITA %</td>
<td>10%</td>
<td>8%</td>
<td>-2%</td>
<td>-22%</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,195,741</td>
<td>1,195,741</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Interest</td>
<td>221,153</td>
<td>221,153</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Gain / (Loss from Operations)</td>
<td>654,768</td>
<td>247,484</td>
<td>(407,283)</td>
<td>-62%</td>
</tr>
<tr>
<td>Gain from Operations %</td>
<td>3.1%</td>
<td>1.1%</td>
<td>-1.9%</td>
<td>-63%</td>
</tr>
<tr>
<td>Investment/Non Operating Income</td>
<td>599,299</td>
<td>610,046</td>
<td>10,747</td>
<td>7%</td>
</tr>
<tr>
<td>Excess of Revenues over Expenses</td>
<td>1,254,067</td>
<td>857,530</td>
<td>(396,536)</td>
<td>-29%</td>
</tr>
<tr>
<td>Margin</td>
<td>6%</td>
<td>4%</td>
<td>-2%</td>
<td>-31%</td>
</tr>
<tr>
<td>Cash Balance 2027</td>
<td>1,771,624</td>
<td>1,375,088</td>
<td>(396,536)</td>
<td>-22%</td>
</tr>
<tr>
<td>Debt Balance 2027</td>
<td>333,628</td>
<td>333,628</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Cash to Debt</td>
<td>531%</td>
<td>412%</td>
<td>-119%</td>
<td>-22%</td>
</tr>
<tr>
<td>Days Cash on Hand</td>
<td>279</td>
<td>197</td>
<td>(82)</td>
<td>-29%</td>
</tr>
<tr>
<td>Average Daily Census 2027</td>
<td>1,385</td>
<td>1,544</td>
<td>158</td>
<td>11%</td>
</tr>
</tbody>
</table>

Fiscal Fitness Plan - Population Health Improvement Results in Reduction of Inpatient & ED Use Rate
Status Quo - No change from current inpatient & ED use rates

Impact
Additional Fiscal Fitness Plan cost savings initiatives to slow rate of cost growth

- Expansion of in-house training programs to “grow our own” - i.e. graduate nurse program, advanced provider /physician assistant, pharmacy residents, medical student/ graduate medical education, etc.
- LINK project savings from standardization of hardwiring of pay policies and procedures consistent with national best and fair practices
- Supply Chain management opportunities to improve pricing and rebates, improve inventory management with LINK
- Pharmacy 340 B discount drug program expansion
- Purchased services reductions
- Lease savings
- Interest expense savings
Summary

• Strategic financial planning is critical for future success as it provides understanding of how we need to allocate our resources and why

• Our Fiscal Fitness Plan is essential to fund our short and long term capital needs and will require desire, discipline and determination.

• System wide adoption of lean operations management a culture of continuous improvement will be key to our success
Thank You
Discussion
BOARD OF DIRECTORS

LUNCH
12:00 P.M. – 1:00 P.M.
LEE HEALTH

BOARD OF DIRECTORS

LEAN MANAGEMENT SYSTEM OVERVIEW & LEE HEALTH LEAN JOURNEY

(Roger Chen, VP Organization Transformation)

Lee Memorial Health System Board of Directors
Board Planning Workshop
June 15, 2017

Dr. John Toussaint, CEO, Catalysis
Roger Chen, VP Organization Transformation
Dr. Scott Nygaard, CMO
CEO Perspective
Dr. Larry Antonucci
Board Planning and Lean Workshop

What are examples of good Operational Excellence across the country, and how does Lee Health compare with strengths and opportunities?

What is role of Board in supporting Lean journey. What knowledge and training does the Board need? Compare and contrast to other health systems.

How does our Lean Management Operating System prepare us better for the future? What does it mean to be a rapidly adaptable management system?

How Lean helps CMS Stars, update on current performance and go forward expectations on performance and timing
-Show how improvement work ties to CMS Star Ratings

What is the on-going training to connect Strategy to Operations, for Board, Sr. Leadership and Medical Staff?

Connect Strategic Plan to top priority programs - Capital needs, configuration of assets, operating model - **Productivity, Standardization, PHO, Utilization of Services**
<table>
<thead>
<tr>
<th>Strategic Initiative</th>
<th>Key Performance Indicator</th>
<th>Meets Goal 2017</th>
<th>Better Than Goal 2017</th>
<th>Desired Direction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service, Safety &amp; Quality</strong></td>
<td>Patient Experience (Systemwide rollup of &quot;Overall Rate&quot; top box)</td>
<td>50th %tile</td>
<td>60th %tile</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Sepsis Mortality Rate (LHHS)</td>
<td>20.70%</td>
<td>19.60%</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Clostridium difficile infection (C. difficile)</td>
<td>0.794</td>
<td>0.364</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Surgical Site Infection - Colon Surgery</td>
<td>0.824</td>
<td>0.300</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Catheter-Associated Urinary Tract Infection (CAUTI)</td>
<td>0.469</td>
<td>0.279</td>
<td>Down</td>
</tr>
<tr>
<td></td>
<td>Medicare Payor Postoperative Pulmonary Embolism or Deep Vein Thrombosis (PE or DVT)</td>
<td>3.88</td>
<td>2.54</td>
<td>Down</td>
</tr>
<tr>
<td><strong>Clinical Integration</strong></td>
<td>Medicare Payor 30-day Readmission Rate (LHHS facilities only)</td>
<td>15.5%</td>
<td>14.6%</td>
<td>Down</td>
</tr>
<tr>
<td><strong>Aligned Multispecialty Group</strong></td>
<td>Year over year freestanding outpatient net revenue growth (2016 vs 2017)</td>
<td>10.0%</td>
<td>15.0%</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Increase the LPG Primary Care Patient Base (net new patients)</td>
<td>10,000</td>
<td>12,000</td>
<td>Up</td>
</tr>
<tr>
<td><strong>Caring People</strong></td>
<td>Employee Engagement</td>
<td>80th %tile</td>
<td>81st %tile</td>
<td>Up</td>
</tr>
<tr>
<td><strong>Financial Viability</strong></td>
<td>Operating Margin %</td>
<td>4.5%</td>
<td>5.0%</td>
<td>Up</td>
</tr>
<tr>
<td></td>
<td>Labor &amp; Purchased Services (Per Case Mix Index Adjusted Admission)</td>
<td>4,047</td>
<td>3,966</td>
<td>Down</td>
</tr>
</tbody>
</table>
Lee Health Shared Vision: “One Lee Health”

Quality

Patient

$/Cost

Experience
Lee Health Operating System

What is it?

• The process of implementing our strategic plan
• Aligning systems (resources), enabling people (process standardization) and improving outcomes (high reliability).

“...perfect care, zero harm and continuous improvement” – Larry Antonucci, MD
Lee Health Operating System

Strategic/Operational Priorities
Performance Targets (KPI)
Actionable Projects (PDCA)
Review Discipline (Calendar)
Standardize and Spread

One Lee Health

Strategy – Mission, Vision, Values
Tier 1

Clinical and Business Operations
Tier 2

Daily Management and Improvement Projects
Tier 3

Outcomes – Improve Quality, Cost, Experience
Tier 4

LH Operating System
Lee Health Operating System

Information flows through councils, dyads, and groups at each tier to the front line

Structure (What?)

- **Tier 1**: Strategy – Mission, Vision, Values, Governance and Alignment
- **Tier 2**: Clinical and Business Operations, Systems Design
- **Tier 3**: Daily Management and Improvement Projects, Operations Management
- **Tier 4**: Outcomes – Improve Quality, Cost, Experience, Continuous Improvement

Roles (Who?)

- **Tier 1**: Board of Directors, Physician Leadership Council, Medical Executive Committee, Clinical Collaboration Council, Strategy & Growth Council, System Operating Council, System Leadership Council
- **Tier 2**: Clinical Consensus Group, Ambulatory Operations Leadership Council, Acute Care Leadership Council, System Ancillary Services Council, IT Steering Committee
- **Tier 3**: Clinical Implementation Team, Ambulatory Dyads, Acute Dyads
- **Tier 4**: Department Managers, Practice Managers, Front Line Huddles
**Leadership Principles and Ideal Behaviors**
Guiding principles that govern decisions and behaviors for a self-organizing system

<table>
<thead>
<tr>
<th>System Dimension Principles</th>
<th>Strategic Leadership</th>
<th>Operational Leadership</th>
<th>Operating Teams</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Align</strong></td>
<td><strong>Establish Direction</strong></td>
<td><strong>Organizing and Translating</strong></td>
<td><strong>Setting and Achieving goals</strong></td>
</tr>
<tr>
<td>Create value for the patient</td>
<td>Create constancy of purpose</td>
<td>Think systemically</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Enable</strong></th>
<th><strong>Motivate, Mentor, Inspire</strong></th>
<th><strong>Empower, Involve &amp; Coach</strong></th>
<th><strong>Develop and Share</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead with humility</td>
<td>Respect every individual</td>
<td>Learn continuously</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Improve</strong></th>
<th><strong>Break-through Thinking</strong></th>
<th><strong>Maintain Predictability</strong></th>
<th><strong>Adapt and Adjust</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on process</td>
<td>Embrace scientific thinking</td>
<td>Flow and pull value</td>
<td>Understand and manage variation</td>
</tr>
<tr>
<td>Maintain quality at the source</td>
<td>Seek perfection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tier 1**  **Tier 2**  **Tier 3**  **Tier 4**

*Institute for Enterprise Excellence*
Lee Health Operating System

How we take our strategy to the front line to impact outcomes

**Structure (Where)**
- **Tier 1**: Strategy – Mission, Vision, Values, Governance and Alignment
- **Tier 2**: Clinical and Business Operations, Systems Design
- **Tier 3**: Daily Management and Improvement, Projects Operations Management
- **Tier 4**: Outcomes – Improve Quality, Cost, Experience, Continuous Improvement

**Roles (Who)**
- **BOD, PLC, MEC, CCC, SGC, SOC, SLC**: Performance Analytics, Board Scorecard
- **CCG, AOLC, ACLC, SASC, ITSC**: Process KPI Dashboard
- **CIT, Ambulatory Dyads, Acute Dyads**: Facility or Business Dashboard
- **Department Managers, Practice Managers, Front Line Huddles**: Front line Process Data

**System Elements (How)**
- **Leadership Principles and Behaviors**: Leadership Principles and Behaviors
- **Leader Standard Work**: Leader Standard Work
- **VP/Manager Stat Sheets**: VP/Manager Stat Sheets
- **Front line Huddles**: Front line Huddles

**System Program Portfolio**
- **Program and Project Resources**
- **Project Execution Teams**
- **Front Line Standardization**
Board Role in System Transformation

Dr. John Toussaint presentation

Separate file with videos
Lee Health Lean Journey 2013 to 2017
Roger Chen
Becoming a Lean Learning Organization

Roger Chen
(originally presented April 29, 2013)
Archimedes

GIVE ME A LEVER LONG ENOUGH....
AND I WILL MOVE THE EARTH
Lean Transformation Timeline

Transformation = Everyone Continuously Improving

2013
Facilitated projects
Lean Coach

2014
Facilitated projects
Lean Coach

2015
Individual improvement
Department projects Director / Supervisor
Facilitated projects
Lean Coach

2016
Individual and team improvement
Department projects
Director / Supervisor

Quality and Productivity
Effort
Organization Transformation

80%
20%
Lean Management System Blueprint

“Developing people...to develop people”

People

- **Strategy Deployment**
- **Change Management**
- **5S and Visual Management**
- **Value Stream Mapping**

Technical

- **Operating System**
- **Lean Leadership**
- **Level Scheduling**
- **Pull and Flow**
- **Rapid Improvement Workshops**

- **Job Instruction Training**
- **Job Relations**
- **Problem Solving**
- **Critical Thinking**
- **(Plan Do Check Act)**
- **“Empowerment”**

Daily Management (Focus)

- **Continuous Improvement (Engagement)**
- **Standard Work (Reliability)**

Focus

Process Measures and Preparation

Results
Lean Transformation Critical Path

1. Strategy Deployment...process to deploy Mindset

2. Standard Work...encourage and develop Skill set

3. Organization Report-out...reinforce principles Tool set

4. Plan-Do-Check-Act is the organizational currency for communicating ideas and solving problems
Lean Management System x 1000 leverage

Front Line Teams

Mind Set

Skill Set

Tool Set

Middle Managers

1200

x10

120

x10

12,000

Lean Transformation Office

Executives/Physicians

“Cultural Tipping Point”
Application to CMS
Dr. Scott Nygaard
## CMS Overall Hospital Quality 5-Star Rating

<table>
<thead>
<tr>
<th>Measure Group</th>
<th>Performance Period</th>
<th>Weight</th>
<th>CCH Group Score</th>
<th>GCMC Group Score</th>
<th>LMH/HPMC Group Score</th>
<th>National Group Score</th>
<th>Number of Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Outcomes: Mortality</td>
<td>3Q2011 to 2Q2014</td>
<td>22%</td>
<td>0.45</td>
<td>0.82</td>
<td>0.68</td>
<td>0.00</td>
<td>7</td>
</tr>
<tr>
<td>(2) Outcomes: Readmission</td>
<td>3Q2013 to 2Q2014</td>
<td>22%</td>
<td>-1.03</td>
<td>-2.08</td>
<td>-2.24</td>
<td>-0.03</td>
<td>8</td>
</tr>
<tr>
<td>(3) Outcomes: Safety</td>
<td>PSIs: 3Q2012 to 4Q2014, HAIs: 3Q2014 to 2Q2015</td>
<td>22%</td>
<td>-2.26</td>
<td>-1.36</td>
<td>-1.68</td>
<td>0.00</td>
<td>8</td>
</tr>
<tr>
<td>(4) Patient Experience</td>
<td>3Q2014 to 2Q2015</td>
<td>22%</td>
<td>-0.95</td>
<td>-1.30</td>
<td>-0.72</td>
<td>-0.14</td>
<td>11</td>
</tr>
<tr>
<td>(5) Process: Effectiveness</td>
<td>3Q2014 to 2Q2015</td>
<td>4%</td>
<td>0.70</td>
<td>0.18</td>
<td>-0.09</td>
<td>0.06</td>
<td>16</td>
</tr>
<tr>
<td>(6) Process: Timeliness</td>
<td>3Q2014 to 2Q2015</td>
<td>4%</td>
<td>-1.31</td>
<td>-1.83</td>
<td>-1.42</td>
<td>0.04</td>
<td>7</td>
</tr>
<tr>
<td>(7) Efficiency: Imaging</td>
<td>4Q2013 to 3Q2014</td>
<td>4%</td>
<td>-3.51</td>
<td>-3.41</td>
<td>-3.64</td>
<td>0.00</td>
<td>5</td>
</tr>
<tr>
<td>Overall Summary Score</td>
<td>100%</td>
<td></td>
<td>-1.00</td>
<td>-1.07</td>
<td>-1.08</td>
<td>N/A</td>
<td>62</td>
</tr>
<tr>
<td>Overall Star Rating</td>
<td>100%</td>
<td></td>
<td>1 Star</td>
<td>1 Star</td>
<td>1 Star</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**
- Numeric scores represent the number of standard deviations above or below the National mean. Higher is better.
- PSIs: AHRQ Patient Safety Indicators
- HAIs: Hospital-Associated Infections
<table>
<thead>
<tr>
<th>Group</th>
<th>Process</th>
<th>FY15</th>
<th>FY16</th>
<th>15-16 Variance</th>
<th>FY17 TD</th>
<th>16-17TD Variance</th>
<th>Performance Star Rating</th>
<th>3 Star Goal</th>
<th>Δ to reach 3 Star</th>
<th>5 Star Goal</th>
<th>Δ to reach 5 Star</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Experience 22%</td>
<td>InPatient Patient Experience (Catalyst Data) Overall Rating of Hospital (% responses of 9 or 10)</td>
<td>66.3</td>
<td>67.8</td>
<td>2.26%</td>
<td>68.6</td>
<td>1.18%</td>
<td>**</td>
<td>71.1</td>
<td>3.6%</td>
<td>83</td>
<td>21%</td>
</tr>
<tr>
<td>Safety 22%</td>
<td>PSI-90 Complication / patient safety for selected indicators (composite)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare PE/DVT (PSI 12)</td>
<td>5.04</td>
<td>3.68</td>
<td>-26.98%</td>
<td>2.45</td>
<td>-33.42%</td>
<td>*****</td>
<td>3.88</td>
<td></td>
<td>2.54</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medicare Post Op Sepsis (PSI 13)</td>
<td>7.12</td>
<td>8.67</td>
<td>21.77%</td>
<td>0.86</td>
<td>-90.08%</td>
<td>*****</td>
<td>9.77</td>
<td></td>
<td>N/A</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Comp Rate Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAUTI SIR (ICU + select Wards)</td>
<td>0.75</td>
<td>0.86</td>
<td>14.67%</td>
<td>0.605</td>
<td>-29.65%</td>
<td>***</td>
<td>0.822</td>
<td>-0.201</td>
<td>-67%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLABSI SIR (ICU + select Wards)</td>
<td>1.21</td>
<td>0.56</td>
<td>-53.72%</td>
<td>0.574</td>
<td>2.50%</td>
<td>****</td>
<td>0.860</td>
<td></td>
<td>0.291</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSI-Colon Surgery SIR</td>
<td>1.78</td>
<td>0.83</td>
<td>-53.37%</td>
<td>1.567</td>
<td>88.80%</td>
<td>*</td>
<td>0.783</td>
<td>-50%</td>
<td>0.343</td>
<td>-78%</td>
</tr>
<tr>
<td></td>
<td>CDIFF SIR (Quarterly Measure)</td>
<td>1.35</td>
<td>0.86</td>
<td>-36.30%</td>
<td>0.591</td>
<td>-31.28%</td>
<td>****</td>
<td>0.924</td>
<td></td>
<td>0.488</td>
<td>-17%</td>
</tr>
<tr>
<td>Readm 22%</td>
<td>Medicare Readm-30-All Cause</td>
<td>16.8%</td>
<td>16.5%</td>
<td>-1.79%</td>
<td>15.9%</td>
<td>-3.64%</td>
<td>**</td>
<td>15.50%</td>
<td>-3%</td>
<td>14.60%</td>
<td>-8%</td>
</tr>
<tr>
<td></td>
<td>Medicare Readm-30-HF</td>
<td>25.1%</td>
<td>24.3%</td>
<td>-2.19%</td>
<td>22.7%</td>
<td>-6.58%</td>
<td>**</td>
<td>22.40%</td>
<td>-1%</td>
<td>20.70%</td>
<td>-9%</td>
</tr>
<tr>
<td></td>
<td>Medicare Readm-30-PN</td>
<td>19.1%</td>
<td>16.8%</td>
<td>-12.04%</td>
<td>13.8%</td>
<td>-17.86%</td>
<td>****</td>
<td>14.70%</td>
<td></td>
<td>13.50%</td>
<td>-2%</td>
</tr>
<tr>
<td></td>
<td>Medicare Readm-30-COPD</td>
<td>23.1%</td>
<td>23.6%</td>
<td>2.16%</td>
<td>21.7%</td>
<td>-8.05%</td>
<td>**</td>
<td>21.30%</td>
<td>-2%</td>
<td>19.90%</td>
<td>-8%</td>
</tr>
<tr>
<td></td>
<td>Medicare Readm-30-AMI</td>
<td>18.5%</td>
<td>13.9%</td>
<td>-24.86%</td>
<td>17.0%</td>
<td>22.30%</td>
<td>**</td>
<td>16.50%</td>
<td>-3%</td>
<td>15.20%</td>
<td>-11%</td>
</tr>
<tr>
<td></td>
<td>Medicare Readm-30-Hip-Knee</td>
<td>5.4%</td>
<td>4.7%</td>
<td>-12.96%</td>
<td>4.7%</td>
<td>0.00%</td>
<td>***</td>
<td>4.70%</td>
<td></td>
<td>4.00%</td>
<td>-15%</td>
</tr>
<tr>
<td>Mortality 22%</td>
<td>Death among Surgical Inpatients with Serious Treatable Complications (PSI 4) (NEW)</td>
<td>121.99</td>
<td>130.06</td>
<td>6.62%</td>
<td>144.44</td>
<td>11.06%</td>
<td>*</td>
<td>118.62</td>
<td>-18%</td>
<td>94.86</td>
<td>-34%</td>
</tr>
<tr>
<td></td>
<td>IP PN Mortality Rate (NEW)</td>
<td>N/A</td>
<td>2.29%</td>
<td>0.00%</td>
<td>1.04%</td>
<td>-54.59%</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IP STK Mortality Rate (NEW)</td>
<td>N/A</td>
<td>3.84%</td>
<td>0.00%</td>
<td>2.09%</td>
<td>-45.57%</td>
<td>TBD</td>
<td>TBD</td>
<td></td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Timeliness 4%</td>
<td>OP-18b Median Time from ED Arrival to ED Departure for Discharged ED Patients</td>
<td>192</td>
<td>212</td>
<td>10.42%</td>
<td>205</td>
<td>-3.30%</td>
<td>*</td>
<td>148</td>
<td>57 Min</td>
<td>92</td>
<td>113 Min</td>
</tr>
<tr>
<td></td>
<td>ED-2b Admit Decision Time to ED Departure for Admitted Patients</td>
<td>222</td>
<td>151</td>
<td>-31.98%</td>
<td>147</td>
<td>2.65%</td>
<td>*</td>
<td>100</td>
<td>47 Min</td>
<td>40</td>
<td>107 Min</td>
</tr>
</tbody>
</table>

Better Than National Average
Worse Than National Average

CAUTI, CLABSI, SSI and CDIFF measures from CY15 and CY16 to account for updated NHSN baseline.
System Programs and Projects

- Clinical Collaboration Council and PLC set priorities
- Clinical Consensus Groups deployment structure
- CCG Infection Prevention project teams for Hospital Acquired Conditions
  - CAUTI
  - CLABSI
  - CDIFF
P3DCA for System Project Management

- Process for managing change and spreading best practices
- Clear metrics, targets and timelines
- Communication and training plans developed in assessment phase
- De-selection of projects may occur at any time if not effective
- **Deliverables**: defined outcomes or expectations in each phase
- **Tollgates**: decision point that determines if the next phase can begin

Diagram:

- Plan 1: Initiate
- Plan 2: Assess
- Plan 3: Design
- Do: Pilot
- Check: Validate
- Act: Go Live

90 days

90 days
Senior Leadership Lean Coaching and next steps
Dialogue and Questions
BOARD OF DIRECTORS

LEAN NATIONAL LANDSCAPE AND LEAN TRANSFORMATION

(John Toussaint, M.D.)
The Board’s role in system transformation

John S. Toussaint M.D.
CEO Catalysis
• Founded as the ThedaCare Center for Healthcare Value founded in 2008, by John Toussaint, MD, CEO emeritus of ThedaCare.

• An independent 501(c)3 education institute.

• Headquarters in Appleton, WI with offices in Traverse City, MI, Akron, OH, Ogden, UT, Phoenix, AZ, Marco Island, FL, and Boston, MA.
Mission - Transform the Industry

- Care Delivery: Focus on the patient
- Transparency: Cost, quality and risk
- Payment Models: Reward value
Questions We Will Cover Today

- What are new government financial incentives designed to accomplish?
- What is the board’s role in a Lean transformation?
- What should the board be looking for from management?
- What should management be looking for from the board?
CMS Has Adopted a Framework That Categorizes Payments to Providers

<table>
<thead>
<tr>
<th>Description</th>
<th>Category 1: Fee for Service - No Link to Value</th>
<th>Category 2: Fee for Service - Link to Value</th>
<th>Category 3: Alternative Payment Models Built on Fee-for-Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payments are based on volume of services and not linked to quality or efficiency</td>
<td>At least a portion of payments vary based on the quality or efficiency of healthcare delivery</td>
<td>Some payment is linked to the effective management of a population or an episode of care</td>
<td>Payment is not directly triggered by service delivery so volume is not linked to payment</td>
<td></td>
</tr>
<tr>
<td>Limited in Medicare Fee-for-Service</td>
<td>Hospital value-based purchasing</td>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g., ≥1 year)</td>
<td></td>
</tr>
<tr>
<td>Majority of Medicare payments now are linked to quality</td>
<td>Physician Value Modifier</td>
<td>Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</td>
<td>Eligible Pioneer Accountable Care Organizations in years 3-5</td>
<td></td>
</tr>
<tr>
<td>Medicare Fee-for-Service examples</td>
<td>Readmissions/Hospital Acquired Condition Reduction Program</td>
<td>Accountable Care Organizations</td>
<td>Maryland hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medical homes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bundled payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive Primary Care Initiative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Comprehensive ESRD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicare - Medicaid Financial Alignment Initiative Fee-for-Service Model</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Target percentage of payments in ‘FFS linked to quality’ and ‘alternative payment models’ by 2016 and 2018

<table>
<thead>
<tr>
<th>Year</th>
<th>FFS linked to quality (Categories 2-4)</th>
<th>Alternative payment models (Categories 3-4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>0%</td>
<td>~70%</td>
</tr>
<tr>
<td>2014</td>
<td>&gt;80%</td>
<td>~20%</td>
</tr>
<tr>
<td>2016</td>
<td>85%</td>
<td>30%</td>
</tr>
<tr>
<td>2018</td>
<td>90%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Goals

- All Medicare FFS (Categories 1-4)
- FFS linked to quality (Categories 2-4)
- Alternative payment models (Categories 3-4)
Quality Measures

Instructions

1. Review and select measures that best fit your practice.

2. Add up to six measures from the list below, including one outcome measure. You can use the search and filters to help find the measures that meet your needs or specialty.

3. If an outcome measure is not available that is applicable to your specialty or practice, choose another high priority measure.

4. Download a CSV file of the measures you have selected for your records.

Groups in APMs qualifying for special scoring standards under MIPS, such as Shared Savings Program Track 1 or the Oncology Care Model: Report quality measures through your APM. You do not need to do anything additional for the MIPS quality category.

2017 MIPS Performance

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)
7 Ways Lean Principles Can Help Manage Population Health

It's an opportune moment for health leaders to focus on 'Lean' at a communitywide level, says John Toussaint, M.D., CEO of the ThedaCare Center for Healthcare Value

March 9, 2016   John Toussaint, M.D.   1 Comment

Lean principles and processes have become important tools for transforming health care delivery, transparency and cost. Yet, while more and more success stories are emerging on the system side, there's an opportunity for "Lean" in managing population health.

Population health — whether it’s caring for a specific patient population by condition or
Board Key Roles

• Earn your board seat by making the tough decisions
• Take the long view and don’t panic
• Take advantage of board diversity and engagement
• Favor internal succession
• Stay strategic and let managers do the managing
What should the board be looking for from management

- True North
- Fewer initiatives
- Balanced focus (quality, cost, morale)
- Leadership behavior
- Management system that supports continuous improvement
The methodology of Lean is about creating value for the customer.
Our Approach to Transformation

CUSTOMER VALUE

MANAGEMENT SYSTEM | LEADERSHIP BEHAVIORS

Integrated Human Development, Finance, and Information Flow Systems

New Operations System
Model cell experiments with subsequent comprehensive spread

Scientific Problem-Solving Systems

PURPOSE | VALUES | PRINCIPLES
Value = \frac{Q}{C}
<table>
<thead>
<tr>
<th>[principles]</th>
<th>[leadership]</th>
<th>[management]</th>
<th>[front-line]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALIGN</strong></td>
<td><strong>Establish Direction</strong></td>
<td><strong>Organizing &amp; Translating</strong></td>
<td><strong>Setting &amp; Achieving Goals</strong></td>
</tr>
<tr>
<td>Create value for the patient</td>
<td>Develop a vision and strategies to achieve that vision. Set high but reasonable targets. Communicate the direction on a regular basis.</td>
<td>Establish a structure to achieve the plan. Organize and allocate resources. Monitor structure to ensure consistency and alignment to plan.</td>
<td>Identify meaningful goals that can be accomplished in their area that directly affect the overall vision and strategy. Daily report on status and needed support.</td>
</tr>
<tr>
<td>Create constancy of purpose</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Think systemically</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>ENABLE</strong></th>
<th><strong>Motivate, Mentor, Inspire</strong></th>
<th><strong>Empower, Involve &amp; Coach</strong></th>
<th><strong>Develop &amp; Share</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead with humility</td>
<td>Energize people to develop and overcome barriers to change. Daily be in the work area to listen to understand. Embrace failure; celebrate success.</td>
<td>Empower authority within parameters of area to improve and solve problems. Break-down silos by involving cross-functional teams to solve value stream issues. Coach problem solving daily.</td>
<td>Be a self-developer. Find opportunities to grow and develop to better support the organization. Share with others what is working and what is not working.</td>
</tr>
<tr>
<td>Respect every individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learn continuously</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>IMPROVE</strong></th>
<th><strong>Break-through Thinking</strong></th>
<th><strong>Monitor &amp; Maintain Predictability</strong></th>
<th><strong>Adapt &amp; Adjust</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus on process</td>
<td>Continuously learn by listening, seeing and translating observations. Support new models of care delivery developed by front line.</td>
<td>Monitor the outputs of each system to ensure stability and a standard outcome. Continuously challenge the process to identify areas of improvement.</td>
<td>Adapt the tools by making incremental adjustments that all shifts agree with. Treat tools as a countermeasure not a solution. Structurally solve area problems daily.</td>
</tr>
<tr>
<td>Embrace scientific thinking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flow &amp; pull value</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understand &amp; manage variation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assure quality at the source</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seek perfection</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Institute for Enterprise Excellence
Lehigh Valley ER Model Cell Results

• Avoided spending $18 million on a new facility while serving a growing population.

• Six months before implementation of the ER model cell in 2011, the Muhlenberg ED diverted ambulances to other hospitals 50 hours each month. For 12 consecutive months after implementation there were zero diversion hours.

• The rapid assessment unit has maintained an average of 26 minutes between the time a patient arrives and sees a provider.

• Time-to-treatment has decreased by 30 minutes.
Management Roles

Status of the Business:
- Information
- Continuous Improvement
- Metrics
- Escalation

Strategy Goals Purpose
- Mentoring
- Teaching
- Barrier Removal
- Strategy
- True North

- Executive Functions
- Strategic
- Innovative
- Weekly / Monthly Assessment
- 10-25% Standard Work

CEO
SrVP
VP
Manager
Supervisor
Lead
Staff

Level 1
Level 2
Level 3
Level 4
Level 5
Level 6
Level 7

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Catalysis
How Does A Lean Leader Behave

Traditional Manager

Technical specialists solving problems using complex methods

Lean Manager

Everyone solving problems using simple methods

Source: Lean Enterprise Institute
How Does A Lean Leader Behave

Traditional Manager
Managers do not like problems

Lean Manager
Managers make problems visible

Source: Lean Enterprise Institute
100% of employees are problem solvers improving something every day!!!
Great Leaders Ask Great Questions

• Focus on questions that start with “what” and “how”
• Avoid “yes” “no” questions
• Questions should be open ended
• Avoid asking questions that have an embedded solution (your solution) implied

<table>
<thead>
<tr>
<th>White Coat Leadership</th>
<th>Improvement Leadership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exhibits an “all knowing” attitude</td>
<td>Demonstrates humility</td>
</tr>
<tr>
<td>Adopts an “in charge” posture</td>
<td>Exhibits curiosity</td>
</tr>
<tr>
<td>Demonstrates autocratic tendencies</td>
<td>Facilitates improvement efforts</td>
</tr>
<tr>
<td>Adopts a “buck stops here” approach</td>
<td>Teaches others</td>
</tr>
<tr>
<td>Shows impatience</td>
<td>Learns from others</td>
</tr>
<tr>
<td>Blames others</td>
<td>Communicates effectively</td>
</tr>
<tr>
<td>Controls others</td>
<td>Perseveres</td>
</tr>
</tbody>
</table>
What should management be looking for from the board?

• An advocate in the community for what’s happening at St. Charles Health System.
• Support for decisions at the board.
  (No undermining outside of the board room.)
• Willing to listen to physician frustrations, but always redirecting the physicians back to management.
4 years of declining operating performance

Source: Audited Financials
What would you do?
UMMHC Framework for Performance Excellence

True North
Best Place To Give Care - Best Place To Get Care

Measurement System Aligned with True North (True North Metrics)
10 system level True North Metrics set yearly (Level 1 VMS)
Each level 2 and level 3 VMS has set of True North Metrics aligned with Level 1 metrics

Strategic and Operating Plan Aligned with True North
UMMHC/UMMS joint strategic plan updated every 5 years. UMMHC strategic plan updated twice yearly as informed by ~ 25 different strategic planning events held across the organization each year

Project Management
Strategy is broken down into 10 Mother A3s at system level each assigned to one executive (Level 1 VMS).
Each level 2 and level 3 VMS has baby A3s aligned with mother A3s

Performance Management
Individual Goals Aligned with True North Metrics and Key Behavioral Indicators

Engage Everyone Everyday in Improving Our Processes and Executing Our Strategic Plan
Unit Based Idea System (level 3 VMS)
“Catch Ball” Information Flows

Status of Goal Success
Information, Updates, Barriers, Metrics

- Caregivers
- Leads
- Coordinators
- Managers
- Directors
- Executives
- System CEO
- Core Executives

Goals Defined, Metrics, KBI’s
Mentor, Coach, Resources

System
Entity
Department
How do you get your board to understand this?

**True North**
Best Place To Give Care - Best Place To Get Care

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**Performance Management**
Individual Goals Aligned with True North Metrics and Key Behavioral Indicators

**Engage Everyone Everyday in Improving Our Processes and Executing Our Strategic Plan**
Unit Based Idea System (level 3 VMS)
• Recruit people that get it or are at least open to it
• Onboard them to the management system on day one
• Visit a high performer
• Gemba walks
• Develop them the same way you develop your people
• Make it visual, make it visual, make it visual
Level 1 Visual Management System

The Best Place to Give Care – The Best Place to Get Care
Core Team Key Behaviors

CEO:
- Lead by asking questions
- Let CSS run the meeting
- Get input before making decision
- Be clear about expectations and hold to
- Align Metrics/Support Systemic Changes

Team Members:
- Be Prepared
- Be Concise (A3 Presentations)
- Be honest (but tell the CEO/Team members what to "They want to hear"
- Trust Your Team Members (No meetings after the meeting)
- Maintain the System Internally Central and update them regularly
St. Mary’s No. 1 after acting on flow of staff ideas

Hospital

Brent Davis/Record staff
St. Mary’s Hospital.

Waterloo Region Record
By Johanne Weidner

WATERLOO REGION — St. Mary’s General Hospital ranked first in Canada in a comparison of patient survival rates.
VISION: St. Mary’s will be the safest and most effective hospital in Canada characterized by innovation, compassion and respect.

We will eliminate preventable harm

We will improve the patient experience

We will develop, support and sustain a culture of problem solvers

We will reduce the cost of quality healthcare
HSMR for St. Mary's General Hospital (Kitchener, Ontario)

08/09  09/10  10/11  11/12  12/13  13/14  14/15  15/16
The board’s role is strategy and governance, not management.

- Management expects help with strategy development and strategic direction.
- Taking the long view doesn’t allow short term bumps to derail transformation.
Support Management

• The Lean transformation road is not easy and sometimes things don’t go so well.
• Educate each other on the journey and what to expect.
• Ask: What can the board do to improve it’s management support?
• Sometimes stretch goals aren’t met, but as long as there is improvement, patience is best.
BOARD OF DIRECTORS

CASE STUDY-CMS STAR RATINGS

(Scott Nygaard, M.D., Chief Medical & Clinical Integration Officer)

NO DOCUMENTATION AT THIS TIME

Lee Memorial Health System Board of Directors
BOARD OF DIRECTORS

ROLES IN THE LEAN MANAGEMENT SYSTEM

(John Toussaint, M.D.)
Discussion

(John Toussaint, M.D.)
BOARD OF DIRECTORS

NEXT STEPS & CLOSING

(Donna Clarke, Board Vice Chairman)
ADJOURNMENT

DATE OF THE NEXT
REGULARLY SCHEDULED
MEETING

GOVERNANCE BOARD
AND FULL BOARD OF DIRECTORS

THURSDAY,
JUNE 29, 2017
1:00 P.M.

Gulf Coast Medical Center- Boardroom
Medical Office Building
13685 Doctors Way
Ft. Myers, FL 33912