LEE MEMORIAL HEALTH SYSTEM

Quality/Safety Board & Full Board of Directors’ Meetings
Thursday, November 5, 2015
1:00 p.m.
AGENDA

Quality Safety Board & FULL BOARD OF DIRECTORS’ MEETINGS
November 5, 2015       1:00 p.m.

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

1. CALL TO ORDER  (Sanford Cohen, M.D., Board Chairman)
Lee Memorial Health System Board of Directors, sitting as the Lee Memorial Health System (LMHS)
Board of Directors for 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.

2. INVOCATION & PLEDGE OF ALLEGIANCE  (Rev. Mason Jackson, MDiv, BCC)

3. PUBLIC INPUT – Agenda Items:  Any Public Input is limited to three minutes and a “Request
to Address the Board of Directors” card must be completed and submitted to the Board Staff prior to
meeting. Individuals wishing to address the Board on a Non Agenda item must notify the Board Staff of the
subject matter at least three (3) days prior to the meeting.

4. PHYSICIAN’S LEADERSHIP COUNCIL (PLC) REPORT (Accept)
(William Hearn, D.O., PLC Chairman)

5. PRESIDENT’S REPORT
(Jim Nathan, CEO/President)

6. CONSENT AGENDA (Approve)
   A. Risk Management Report
   B. Medical Staff Services Bylaws
   C. Full Board minutes of 8/27/15

   RECESS to CALL TO ORDER Lee County Trauma Services District Board
of Directors Meeting (Sanford Cohen, M.D., Board Chairman)

   RECONVENE LEE MEMORIAL HEALTH SYSTEM BOARD MEETING
(Sanford Cohen, M.D., Board Chairman)

   Quality & Safety Portion:  Steve Brown M.D., Quality and Safety Liaison

7. Quality / Safety Board & Full Board of Directors Meeting minutes
of 9/10/15 (Approve)  (Diane Champion, Board Secretary)

8. Industrial Hygiene  (Lewis Johnson, Industrial Hygienist)

9. Medical Directors of Care Coordination - Role and Functions
(Chuck Krivenko, M.D., Chief Medical Officer/Clinical & Quality Services)

10. Discharge Planning  (Chris Nesheim, VP Care Management)

11. Leapfrog Update  (Marcelo Zottolo, System Director Process Analytics)

12. Nursing Staff Update  (Donna Giannuzzi, Chief Patient Care Officer)

OTHER ITEMS
Date of the next Quality/Safety Meeting
February 25, 2016 1:00 p.m. Gulf Coast Medical Center –Boardroom
(Medical Office Building) 13685 Doctors Way, Fort Myers, FL 33912

LMHS SYSTEM BUSINESS – SANFORD COHEN, M.D., BOARD CHAIRMAN
13. ACUTE CARE OPERATIONS REPORTS
   A. Cape Coral Hospital  (Scott Kashman, Chief Administrative Officer)
   B. Gulf Coast Medical Center  (Josh DeTilio, Chief Administrative Officer)
   C. HealthPark Medical Center  (Donna Giannuzzi, Chief Patient Care Officer)
   D. Lee Memorial Hospital  (Lisa Sgarlata, Chief Administrative Officer)
   E. Golisano Children’s Hospital of SWFL  (Kathy Bridge-Liles, Chief Administrative Officer)

14. HEART AND VASCULAR INSTITUTE UPDATE  (Richard Chazal M.D.)

15. COMPLIANCE REPORT  (Approve)
   (Cathy Kahle VP Legal Services and Corporate Compliance)

16. OLD BUSINESS
   A. Policy10.53 A Electronic Tablets  (Approve)

17. NEW BUSINESS

18. BOARD MEETING CRITIQUE

19. BOARD OF DIRECTORS REPORTS

   Date of the next Meeting:
   Thursday, November 19, 2015:  1:00pm
   Finance Board, Governance Board & Full Board of Directors
   Gulf Coast Medical Center – Boardroom
   13685 Doctors Way, Ft. Myers, FL 33912

20. ADJOURN  (Sanford Cohen, M.D., Board Chairman)
LEE MEMORIAL HEALTH SYSTEM

Invocation Prayer

&

Pledge of Allegiance
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 Staff prior to meeting.

Refer to Board Policy: 10:15F: 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 three (3) days prior to the meeting to allow staff time to prepare and to insure the matter is within the jurisdiction of the Board.
Physician Leadership Council Report

8/13/15

The Medical Staff, Administration Safety and Quality at LMHS

Hospitalist Services Reorganization: Requested by your MS at GCMC thru FMEC. Why?

Where are we in the process?

Why isn’t this re-organization finished before season has started, as we all wanted? Hint: Conundrum.

A. Either the MS or Administration has an agenda impeding progress.
B. Collaborative Leadership. It may work well, if implemented properly. Even so, at times it is laborious.
C. The “Leaders”, in their opinions, saw the obvious need for change and imposed their influence upon others. But, there has been resistance.
D. Due to the complexity of the issue. The Administration and MS together couldn’t solve this riddle!

Answer choices:

1. A and C only.
2. B and D only.
3. A, B and C only.
4. B only.
5. All of above.
LEE MEMORIAL HEALTH SYSTEM
BOARD OF DIRECTORS

PRESIDENT'S REPORT
Jim Nathan
CEO/President
CONSENT AGENDA

(Approve)

A. Risk Management Report
B. Medical Staff Services Bylaws
C. Full Board Minutes of 8/27/15
**DATE:** November 3, 2015

**NAME OF SERVICE LINE/ENTITY UPDATE:** Quarterly Risk Management Report

**PERSON RESPONSIBLE & TITLE:** Mary McGillicuddy, Chief Legal Officer and Mary Lorah, Risk Manager

<table>
<thead>
<tr>
<th>KEY ACCOMPLISHMENTS</th>
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<tr>
<td>See Risk Management Activities and Education</td>
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<tr>
<th>GOALS (MET)</th>
<th>GOALS (UNMET)</th>
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<tbody>
<tr>
<td>See Risk Management Goals</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

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

See Liability

**PROBLEMS/ISSUES**

See Reporting Rates, Categories, and Impact

**ANTICIPATED NEEDS**

See Risk Management Goals

**SUMMARY/COMMENTS**

Quarterly Risk Management Report including:

- Incident and Safety Reporting rate per 1,000 patient days
- Impact per 1,000 patient days
- Categories of reports
- Risk Management participation in LMHS System Committees and Education
- Liability Summary
- Goals

This UPDATE supports the following Strategic Initiative(s): Service, Safety & Quality and Financial Viability
Risk Management Report to the Board of Directors

July 2015 – September 2015

The disclosure of this document and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under the Patient Safety Quality Improvement Act of 2005 and implementing regulations.
Risk Management Program Elements

The Risk Management Program is designed to identify, evaluate and reduce the risk of injury to the patients, personnel, visitors and to reduce the risk of loss to the health system. Risk Managers:

- Review adverse incident reports, conduct investigations and analyze events in an effort to reduce risks to patients and the frequency and severity of medical malpractice claims; and
- Investigate patient care complaints, provide education, and provide direction in regards to regulatory compliance.

This report includes Risk Management activities for the quarter and includes a summary of incident and safety reporting rates; impact analysis; report categories; education; claims; general activities; and goals.
**Patient Safety Evaluation System**

Please Note: Separate from Florida law program requirements, Risk Managers play an integral role in the health system’s Patient Safety Evaluation System, a voluntary program created by federal law. Employees are encouraged to report patient safety or quality concerns by filing a Patient Safety Report which are utilized by Risk Managers who participate in health system patient safety initiatives.
Reporting Rates

This graph shows incident and safety report rate for the system for the last 15 months. The next page shows the reporting rates for each facility.

Total number of reports for the third quarter was 2903
Reporting Rates - continued

Cape Coral Hospital

HealthPark Medical Center

Gulf Coast Medical Center

Lee Memorial Hospital

Indicates a Linear Trend line
Analysis

This graph reflects the percentage of reports that have no impact on the patient. The graph for the third quarter indicates that 80% (2337) of the reports received involve situations which had no impact on the patient. Reporting “near misses” is highly encouraged to identify potential areas of improvement. This information allows us to provide data used in our quality improvement activities throughout the system.
Analysis

This graph reflects the reporting rate per 1000 patient days and the rate of patient impact for the four facilities during the quarter.
This graph shows the rate for the categories of reports from July through September 2015 at all four facilities. Rates per 1000 Patient Days are utilized to be consistent with other system reporting.

The top four categories are:

**Treatment & Testing** category includes reports of IV infiltrates, Delays and Omissions, Patient Identification Issues, Failure to Communicate, Documentation issues, etc.

**Other** category includes Complaints, Burns, Skin Breakdown, AMAs, Self-Extubation, etc.

**Patient Falls**

**Medication Errors**

More than 70% of all reported occurrences fall within one of these four categories.

During this quarter there were no reports to AHCA.
Education Activities

- Risk Management Orientation for new hires
- Annual HealthPark Care Center Risk Management Inservice
- Telemetry Safety / Safety in Heart Central
- Root Cause Analysis Training
- Safety Event Reporting
- Baker Act Presentation for CPC
- Consents Education for GCMC Nursing Leadership
- ProLaw Workshop
- Medication Safety for 3N LMH
- ED Case Managers EMTALA education
- Directors of Care Management EMTALA education
- ICU staff End of Life and Proxy Decision Making
- Managing of Patient Extravasation
- Safety During Transport
Liability

The fourth fiscal quarter 2015 (July - September, 2015) ended with 35 pending claims. The quarter saw 13 claims closed and 2 claims opened. Malpractice prevention, patient safety and quality of care improvement continue to be the primary focus of the Health System’s risk managers.
Risk Management Activities

Continued participation in system activities including:

• Evaluation and implementation of a new Patient Safety Reporting System
• Individual Hospital Quality & Safety Committees
• Daily Safety Check-In Calls
• System Quality Safety Management Council
• Participated in various Intense Analysis Teams/ Common Cause Analysis Teams
• System Medication Safety Committee
• CCH Strategy and Operations Meeting
• Campus Specific Medication Safety Work Groups
• Quality and Conformance
• LMHS Ethics Committee
• CCH Ethics Committee
• Genetic Telemedicine Cart Design
• PDCA Team working on Complaint/Grievance process for LPG
• CCH Grievance Committee
• OB Hospitalist Group Meeting
• CARF Survey Team
• IT Telemedicine Project
• Leadership Accountability
• Heart Central Accountability Team
• Pediatrics Ethics
Risk Management Goals

• Evaluation and implementation of a Patient Safety Reporting System with emphasis on compatibility with patient record and standardized PSO reporting (common formatting)
• Continue to track and trend events, provide summary data and work closely with various departments and committees engaged in performance improvement and patient safety activities.
• Continue to work with Education and Organizational Development and management staff to assure that all employees are meeting the annual education requirement for risk management and to provide a module for the Competency activities.
• Continue to utilize pre-litigation procedures to resolve meritorious claims in a timely manner.
• Monitor the 3M/Softmed Risk Management System
• Continue to collaborate with others in the Health System with regard to patient safety initiatives and make recommendations based on trends.
**DATE:** 10-6-15  
**LEGAL SERVICE REVIEW?** YES X  NO __  

**SUBJECT:** Revision to the Medical Staff Bylaws relating to email and cellphone usage.  

**REQUESTOR & TITLE:** Lori Fermanich, Director, M.S. Administrative Affairs  

**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 Board of Directors adopted Medical Staff Bylaws for Gulf Coast Medical Center, HealthPark Medical Center, Cape Coral Hospital, Golisano Children’s Hospital of Southwest Florida, and Lee Memorial Hospital as recommended by the Medical Staff on 5-28-2009. The Bylaws have been amended from time to time.  

**SPECIFIC PROPOSED MOTION:**  
To adopt the recommended revision to Part I, 2.7, Basic Responsibilities of Applicants and Appointees, 2.7.2.1.of the Medical Staff Bylaws for Cape Coral Hospital, Gulf Coast Medical Center, Lee Memorial Hospital, Golisano Children’s Hospital of Southwest Florida, and HealthPark Medical Center as presented.  

**PROS TO RECOMMENDATION**  
Improves communication while retaining appropriate limitations on the use of email and cell phone numbers according to Medical Staff Services Department policy.  

**CONS TO RECOMMENDATION**  
None identified  

**LIST AND EXPLAIN ALTERNATIVES CONSIDERED**  
None  

**FINANCIAL IMPLICATIONS**  
Budgeted ____  Non-Budgeted ____  
(including cash flow statement, projected cash flow, balance sheet and income statement)  
N/A  

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

**SUMMARY**  
The Medical Executive Committees and the Medical Staffs for Cape Coral Hospital, Gulf Coast Medical Center, Lee Memorial Hospital and HealthPark Medical Center and the Golisano Children’s Hospital of Southwest Florida approved the revision to their respective Medical Staff Medical Staff Bylaws relating expanded use of email and cell phone numbers.
2.7 Basic Responsibilities of Applicants and Appointees

The following basic responsibilities and requirements shall be applicable to every applicant and appointee for Medical Staff appointment or reappointment as a condition of consideration of such application and as a condition of continued Medical Staff appointment if granted:

2.7.1 an obligation to provide for appropriate and timely care and supervision to all patients in the hospital for whom the individual has responsibility (Standard of Care);

2.7.2 an agreement to abide by all Bylaws, Rules and Regulations and Policies of the Medical Staff and the Hospital, as shall be in force during the time the individual is appointed to the Medical Staff (Conformance to Rules);

2.7.2.1 Provide a current cell phone number and email address to be used for emergency or disaster purposes in accordance with Medical Staff Services Department policy.
**DATE:** 10-6-15  
**LEGAL SERVICE REVIEW?** YES X  NO __

**SUBJECT:** Revision to the Medical Staff Bylaws relating to Temporary Privileges and Clean Application

**REQUESTOR & TITLE:** Lori Fermanich, Director, M.S. Administrative Affairs

**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 Board of Directors adopted Bylaws for Gulf Coast Medical Center, HealthPark Medical Center, Cape Coral Hospital, Golisano Children’s Hospital of Southwest Florida, and Lee Memorial Hospital as recommended by the Medical Staff on 5-28-2009. The Bylaws have been amended from time to time.

**SPECIFIC PROPOSED MOTION:**

To adopt the recommended revision to Medical Staff Bylaws, Part III, Credentialing Procedures, Section 7, Clinical Privileges, 7.7 Temporary Privileges and 7.7.3 Clean Application for Cape Coral Hospital, Gulf Coast Medical Center, Lee Memorial Hospital, Golisano Children’s Hospital of Southwest Florida, and HealthPark Medical Center as presented.

**PROS TO RECOMMENDATION**  
Provides for the timely assignment of temporary privileges to applicants in critical specialty needs with a clean comprehensive application.

**CONS TO RECOMMENDATION**  
None identified

**LIST AND EXPLAIN ALTERNATIVES CONSIDERED**  
None

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

N/A

**OPERATIONAL IMPLICATIONS**  
(including FTEs, facility needs, etc.)

N/A

**SUMMARY**

The health system Medical Executive Committees and the Medical Staffs approved the revision to their respective Medical Staff Bylaws relating Temporary privileges and clean applications to allow for an extension of time for assignment of temporary privileges to applicants in critical specialty needs with a clean comprehensive application (as determined by the relevant Department Chair, System Credentials Chair, and VP of Medical Affairs). The revision is especially important to cover those months when the Board of Directors and Facility Medical Executive Committees do not convene.
7.7 Temporary Privileges

7.7.3 – Clean Application (Expedited) Awaiting Approval: Temporary privileges may be granted for up to 30 \textit{90} calendar days (from date privileges are issued) approved by the Executive Committee with two 30-day extensions approved by the Board (see \textit{as per} the policy and procedure on Expedited Credentialing) when the new applicant for Medical Staff membership and/or privileges is waiting for review and recommendation by the FMEC and approval by the Board.
DATE: 10/6/15

LEGAL SERVICE REVIEW? YES X NO __

SUBJECT: Revision to the Medical Staff General Rules & Regulations relating the Performance Review Program for New Medical Staff Members.

REQUESTOR & TITLE: Lori Fermanich, Director, M.S. Administrative Affairs

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 Board of Directors adopted the General Rules and Regulations as recommended by the Medical Staff on April 12, 2012. The General Rules and Regulations have been amended from time to time.

SPECIFIC PROPOSED MOTION:
To adopt the recommended revision to Rule #10, c.iv. Performance Review Program for New Medical Staff Members of the General Rules & Regulations for Cape Coral Hospital, Gulf Coast Medical Center, Lee Memorial Hospital, Golisano Children’s Hospital of Southwest Florida, and HealthPark Medical Center as presented.

<table>
<thead>
<tr>
<th>PROS TO RECOMMENDATION</th>
<th>CONS TO RECOMMENDATION</th>
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<tbody>
<tr>
<td>Reflect current best practice</td>
<td>None identified</td>
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LIST AND EXPLAIN ALTERNATIVES CONSIDERED
None

FINANCIAL IMPLICATIONS
Budgeted ____  Non-Budgeted ____
(including cash flow statement, projected cash flow, balance sheet and income statement)
N/A

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

SUMMARY
The health system Medical Executive Committees and the Medical Staffs approved the revision to their respective Medical Staff General Rules and Regulations 10.c.iv. in order to replace an outdated reference to a retrospective review and reflect the current best practice of a comprehensive performance review for new Medical Staff Members.
c. As applicable, the Department Chair, or as designated by the Department Chair the relevant Section Chief, shall be responsible to do the following regarding all new Medical Staff members assigned to a given section:

i. Review all available information regarding professional performance not less than every six (6) months for the first year of membership, to include, but not limited to:
   1. Quality and Patient Outcome reports
   2. Activity (admissions, consultations, outpatients)
   3. Procedure report
   4. Medical records compliance
   5. Quality management summary
   6. Reports from hospital departments
   7. Complaints
   8. Reports of any proctor appointed

ii. Receive, review and evaluate complaints of any nature or any reports of substandard professional performance, and determine an appropriate action, including but not limited to:
   1. appointing a proctor to scrub with or be present during procedures or treatment performed by the new Medical Staff member;
   2. personally observing the new Medical Staff member’s performance during surgery or other procedures or treatments;
   3. reviewing or requesting others to review medical records of the new Medical Staff member’s patients; and
   4. recommending a summary suspension of the new Medical Staff member’s privileges in whole or in part.

iii. Confer, as deemed necessary, with other members of the Section regarding the performance of any new Medical Staff member.

b. The Facility Medical Executive Committee may determine and direct, on an individual basis, the use or implementation of additional or special methods of review of a particular new Medical Staff member’s performance or activities. The same, however, shall in no case be less stringent than the performance review program described in this rule.
<table>
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<tr>
<th>SUBJECT</th>
<th>DISCUSSION</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>MEETING CALLED TO ORDER</td>
<td>The LEE MEMORIAL HEALTH SYSTEM FULL BOARD OF DIRECTORS MEETING was CALLED TO ORDER at 1:03 p.m. by Sanford N. Cohen, M.D., Board Chairman.</td>
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<tr>
<td>INVOCATION and PLEDGE OF ALLEGIANCE</td>
<td>Chaplain Susan Crowley gave the Invocation and Pledge of Allegiance.</td>
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<tr>
<td>PUBLIC INPUT</td>
<td>None at this time.</td>
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<tr>
<td>PRESIDENT’S REPORT</td>
<td>Jim presented the President’s Report.</td>
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<td>CONSENT AGENDA</td>
<td>Dr. Cohen asked for approval of the Consent Agenda consisting of: A. Equipment Loan</td>
<td>A motion was made by David Collins to approve the Consent Agenda consisting of: A. Equipment Loan. The motion was seconded by Diane Champion and it carried with no opposition.</td>
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<td>RECESS MEETING</td>
<td>MEETING RECESSED at 1:51 p.m. to Convene Lee County Trauma Services District Meeting.</td>
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<td>RECONVENE MEETING</td>
<td>RECONVENED FULL BOARD MEETING at 2:47 p.m. by Sanford N. Cohen, M.D., Board Chairman.</td>
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<td>PRODUCTIVITY SUCCESS</td>
<td>Ben Spence presented the Productivity Success Bonus and asked for Board approval.</td>
<td>A motion was made by Therese Everly to Board approval is requested to award a Productivity Success Bonus to our full-time, part-time and eligible PRN staff members who were hired by April 4th, 2015 and continue to be actively employed on August 23, 2015 to reward them for increased productivity during this high census fiscal year. PRN staff members eligible would be employed by April 4th, 2015 and have worked 416 hours prior to August 23, 2015. Approval would include paying this bonus on the pay deposit of September 10, 2015. The motion was seconded by Donna Clarke and it carried with no opposition.</td>
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<td>LEGISLATIVE PRIORITIES</td>
<td>Sally Jackson presented the Legislative Priorities.</td>
<td>A motion was made by Chris Hansen to approve the Legislative Priorities. The motion was seconded by Nancy McGovern and it carried with no opposition.</td>
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<tr>
<td>SUBJECT</td>
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<td>A motion was made by Steve Brown to send the state legislature a thank you note from the board for the $450 million they made possible to Lee Memorial Health System. The motion was seconded by Therese Everly and it carried with no opposition.</td>
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**INFORMATICS UPDATE**  
Mike Smith and Dr. Bill Carracino presented the Informatics Update.

**ICD 10 UPDATE**  
Tricia Parker presented the ICD 10 Update. Dr. Cohen would like an update on how the ICD-10 is working after the first of the year.

**MEDICAL STAFF RECOMMENDATIONS**  
Dr. Cohen requested a motion to approve the Medical Staff recommendations for the following:
1. Lee Memorial Hospital
2. Cape Coral Hospital
3. Gulf Coast Medical Center
4. HealthPark Medical Center
5. Golisano Children’s Hospital of SW FL  
A motion was made by Nancy McGovern to approve the Medical Staff Recommendations of August 26, 2015. The motion was seconded by Therese Everly and it carried with no opposition.

**OLD BUSINESS**  
None at this time.

**NEW BUSINESS**  
None at this time.

**BOARD MEETING CRITIQUE**  
All were in agreement that the meeting had great, informative information.

**BOARD OF DIRECTORS REPORTS**  
Donna Clarke stated she heard from the Governor’s office regarding the Governor’s Commission letter listing the hospitals that did not submit their financial reports on time. She thanked leadership for submitting this information by the deadline.  
Nancy McGovern thanked Dr. Cohen for approving her attendance at the recent Risk Management conference in Orlando. She also informed the Board that area legislators will be at a Town Hall meeting September 9th at Six Bends Harley starting at 6 pm.  
Diane Champion thanked the Board office staff for coordinating the Doc Coggins Prize Patrols.  
David Collins commented on his recent attendance at the Physician Leadership Institute and stated that it’s a phenomenal program.  
Therese Everly stated she attended the recent Care Management Vendor Fair. She also stated the RFQ process for Coconut Point was completed yesterday and will come to the September 10th meeting for approval.  
Steve Brown attended the GCHSWFL Med Exec meeting recently where behavioral health discussed. Steve informed them that this issue has been brought to the Board level to be looked at.
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| NEXT MEETING     | The date of the next Lee Memorial Health System Board of Directors Meetings are:  
  QUALITY/SAFETY BOARD & FULL BOARD, September 10, 2015 at 1:00 p.m.  
in the Gulf Coast Medical Center, Medical Office Building, Boardroom  
13685 Doctors Way, Fort Myers, FL 33912                                                                                                                                                                                                 |                                                                                                                                                                                                                           |           |
| ADJOURNMENT      |                                                                                                                                                                                                                                                                                                                                                                                                     | The LEE MEMORIAL HEALTH SYSTEM  
FULL BOARD OF DIRECTORS MEETING  
was ADJOURNED at 4:44 p.m.  
by Sanford N. Cohen, M.D., Board Chairman.                                                                                                                                                                                                                                 |           |

Minutes were recorded by Katie Fournier, Board Assistant/Board of Directors Office

Diane Champion  
Board Secretary
RECESS

To Call to Order the:
Lee County Trauma Services District
Board of Directors Meeting

Board Chairman:
Sanford Cohen, M.D.
TRAUMA DISTRICT MEETING TO
CHAIRMAN:

RECONVENE
Lee Memorial Health System
FULL BOARD OF
DIRECTORS MEETING
Thursday, November 5, 2015

BOARD CHAIRMAN:
Sanford Cohen, M.D.
QUALITY/SAFETY

BOARD OF DIRECTORS
MEETING
Thursday, November 5, 2015
### LEE MEMORIAL HEALTH SYSTEM
#### QUALITY/SAFETY BOARD & FULL BOARD OF DIRECTORS MEETING MINUTES
Thursday, September 10, 2015

**LOCATION:** Gulf Coast Medical Center, Medical Office Building, Board of Directors Boardroom, 13685 Doctors Way, Fort Myers, FL 33912  
**MEMBERS PRESENT:** Sanford N. Cohen, M.D., Board Chairman; Chris Hansen, Board Vice Chairman; Diane Champion, Board Secretary; Donna Clarke, Board Member; Nancy McGovern, RN, MSM, Board Member; Therese Everly, Board Member; Jessica Carter Peer, Board Member; Stephanie Meyer, BSN, RN, Board Member  
**MEMBERS ABSENT:** David Collins, Board Treasurer; Steven Brown, M.D., Board Member

**NOTE:** Documents referred to in these minutes are on file by reference to this meeting date in the Office of the Board of Directors and on the Board of Directors website at [www.leememorial.org/boardofdirectors](http://www.leememorial.org/boardofdirectors), for public inspection.

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<tr>
<td>MEETING CALLED TO ORDER</td>
<td></td>
<td>The LEE MEMORIAL HEALTH SYSTEM QUALITY/SAFETY BOARD &amp; FULL BOARD OF DIRECTORS MEETINGS were CALLED TO ORDER at 1:02 p.m. by Sanford Cohen, M.D., Board Chairman.</td>
<td></td>
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<tr>
<td>INVOCATION AND PLEDGE OF ALLEGIANCE</td>
<td>Rev. Mason Jackson gave the Invocation, followed by the Pledge of Allegiance.</td>
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<td>PUBLIC INPUT</td>
<td>None at this time.</td>
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<tr>
<td>PRESIDENT’S REPORT</td>
<td>Jim Nathan presented the President’s Report and showed a short video.</td>
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<td>COCONUT POINT SHORTLIST</td>
<td>Dave Kistel presented the Coconut Point short list for approval.</td>
<td>A motion was made by Donna Clarke to 1) Approve of rankings as submitted for Architectural Design Services for LMHS at Coconut Point Project: First ranked, FLAD &amp; ASSOCIATES OF FLORIDA, INC. − 1191 points; second ranked, STANLEY BEAMAN &amp; SEARS, INC. − 1023 points; third ranked, HDR ARCHITECTURE, INC. − 985 points. Proceed with contract negotiations per Board Policy, starting with highest numerical ranked firm, FLAD &amp; ASSOCIATES OF FLORIDA, INC. 2) Approve of rankings as submitted for Construction Management at Risk for Lee Memorial Health System at Coconut Point: First ranked, DEANGELIS DIAMOND HEALTHCARE GROUP, LLC − 1009 points; second ranked, SKANNSKA USA BUILDING, INC. − 961 points; third ranked, THE ROBINS &amp; MORTON GROUP − 912 points. Proceed with contract negotiations per Board Policy, starting with highest numerical ranked firm, DEANGELIS DIAMOND HEALTHCARE GROUP. The motion was seconded by Diane Champion and it carried with no opposition.</td>
<td></td>
</tr>
<tr>
<td>QUALITY/SAFETY PORTION</td>
<td></td>
<td>The Quality/Safety portion of the meeting CONVENED at 1:41 p.m.</td>
<td></td>
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</tbody>
</table>
| CONSENT AGENDA | Dr. Cohen asked for approval of the consent agenda. | A motion was made by Nancy McGovern to approve the consent agenda consisting of:  
A. Quality Board and Full Board meeting minutes of 5/28/15  
B. Renal Transplant Quality Plan and Related Policies  
The motion was seconded by Diane Champion and it carried with no | |
<table>
<thead>
<tr>
<th>SUBJECT</th>
<th>DISCUSSION</th>
<th>ACTION</th>
<th>FOLLOW-UP</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOSPITAL ACQUIRED CONDITIONS REDUCTION PROGRAM</td>
<td>Dr. Marilyn Kole presented an update on the Hospital Acquired Conditions Reduction program.</td>
<td>opposition.</td>
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<tr>
<td>QUALITY PERFORMANCE INDICATORS</td>
<td>Susan Ryckman presented the Golisano Children’s Hospital of SWFL Performance Indicators. Dr. Krivenko presented the System Board Performance Indicators, 3rd Qtr. FY 2015</td>
<td>A motion was made by Therese Everly to accept the Golisano Children’s Hospital of SWFL Performance Indicators. The motion was seconded by Donna Clarke and it carried with no opposition. A motion was made by Therese Everly to accept the System Board Performance Indicators, 3rd Qtr. FY 2015. The motion was seconded by Donna Clarke and it carried with no opposition.</td>
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<tr>
<td>FLU POLICY UPDATE</td>
<td>Steve Streed gave an update on the Flu Policy</td>
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<tr>
<td>NEXT QUALITY/SAFETY MEETING</td>
<td>The next Lee Memorial Health System Quality/Safety Board Meeting is: Thursday, November 5, 2015, 1:00 p.m. Gulf Coast Medical Center, Medical Office, Boardroom 13685 Doctors Way, Fort Myers, FL 33912</td>
<td>The Lee Memorial Health System Quality/Safety portion of the Meeting was ADJOURNED at 2:45 p.m. by Sanford Cohen, M.D., Board Chairman, to RECONVENE the LMHS Full Board portion of the meeting.</td>
<td></td>
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<tr>
<td>OLD BUSINESS</td>
<td>None at this time.</td>
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<td></td>
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<tr>
<td>NEW BUSINESS</td>
<td>None at this time.</td>
<td></td>
<td></td>
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<tr>
<td>BOARD MEETING CRITIQUE</td>
<td>Board members were in agreement this was a great meeting and they appreciated the details of the presentations.</td>
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<tr>
<td>BOARD OF DIRECTORS REPORTS</td>
<td>Jessica Carter Peer stated the Topping Off ceremony was a great event. Nancy McGovern agreed with Jessica that the Topping Off ceremony was a wonderful event. Donna Clarke thanked Mike Smith for the EPIC invite in Wisconsin and spoke about the trip. Therese Everly echoed Donna’s comments on the EPIC trip and also discussed her recent attendance at the United Way event and Quality Life Center Luncheon.</td>
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<td>NEXT REGULAR MEETING</td>
<td>The next LEE MEMORIAL HEALTH SYSTEM FINANCE BOARD &amp; FULL BOARD MEETING will be held on September 24, 2015, 1:00 p.m. in the Gulf Coast Medical Center, Medical Office Building, Boardroom 13685 Doctors Way, Fort Myers, FL 33912</td>
<td>The LEE MEMORIAL HEALTH SYSTEM PLANNING BOARD &amp; FULL BOARD OF DIRECTORS MEETINGS ADJOURNED at 3:06 p.m. by Sanford Cohen, M.D., Board Chairman.</td>
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<td>ADJOURNMENT</td>
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</table>
Industrial Hygiene at LMHS

Epidemiology/Infection Prevention

Lewis Johnson, MS, CIH
What is an Industrial Hygienist?

• Trained to anticipate, recognize, evaluate, and recommend controls for environmental and physical hazards.

  – Chemistry
  – Physics
  – Engineering

  – Epidemiology
  – Environmental Health
  – Toxicology
Construction
Other Tasks

• Pharmacy Compliance
  – USP 797, USP 800

• High Level Disinfectants and Hazardous Gasses
  – Exposure Assessment, Engineering Controls

• Indoor Air Quality Evaluation

• Environmental Infection Prevention
Policy Development

- System and Department Policy Development
- DNV-GL Accreditation
MEDICAL DIRECTORS OF CARE COORDINATION

(Chuck Krivenko, M.D., Chief Medical Officer Clinical & Quality Services)
Position Summary

The main role of the Medical Director of Care Coordination (MDCC) is to facilitate safe, efficient, appropriate patient flow within the hospital setting and the community, ensuring timely and proper care transitions, limiting readmissions, and guiding the healthcare team in proper compliance with payer regulations and policies.

Organizational Design

Each campus of Lee Memorial Health System will have an MDCC. One will serve as Lead MDCC to facilitate MDCC discussions of structure, plans, policies, and projects, and the Lead will serve as a unified voice for the group. All MDCCs report directly to the CMO of Clinical and Quality Services. They will serve in dyad relationships with the CAO and Director of Care Management at their respective campuses. The Lead MDCC will also interface in a dyad relationship with the System’s VP of Care Management. The MDCCs will be responsible for their scheduling and call coverage.

Metrics

*Note: As the application and pertinence of Healthcare Data is constantly changing, new metrics may be added, and the ones noted here may be modified or deleted.

The MDCC will work to improve utilization patterns within the Health System as measured by:

1) ALOS
2) 30 Day Readmissions
3) Condition Code 44 Cases executed
4) Consultation Rate of Hospitalists
5) Appropriate intrasystem transfers

Functions

To have meaningful impact on the goal of facilitating safe, efficient, appropriate patient flow within the hospital setting and the community, ensuring timely and proper care transitions, limiting readmissions, and guiding the healthcare team in proper compliance with payer regulations and policies, the MDCC will engage in the following primary functions:

1) Serve as resource to, advocate for, and educator of the Medical Staff on utilization and care transition issues
2) Serve as resource to, advocate for, and educator of the Utilization/Case Management Department on utilization and care transition issues
3) Serve as resource to, advocate for, and educator of the Administration of each campus on utilization and care transition issues and the policies/practices that affect them
4) Actively champion proper documentation practices

Specific examples of activities that reflect these functions include, but are not limited to:
• Actively participates in physician-driven multidisciplinary rounds to identify and address any barriers to care transitions, ensure appropriate utilization of resources, and promote patient safety and quality of care based on Best Practices
• Provides feedback to attending and consulting physicians regarding level of care, length of stay, and quality issues. Recommends next steps in coordination of care and evidence-based medicine indicators.
• Reviews medical records of patients identified by care managers or as requested by the healthcare team in order to:
  ◦ Assist with level of care and length of stay management
  ◦ Assist with the denial management process
  ◦ Review and make suggestions related to resource and service management
  ◦ Assist staff with the clinical review of patients
  ◦ Determine if professionally recognized standards of quality care are met

• Documents patient care reviews, decisions, and other pertinent information. Understands and uses appropriate criteria. Documents response to case management referrals.
• Provides feedback and education to physicians and other clinicians related to regulatory requirements, appropriate utilization, alternative levels of care, community resources, and end of life care. Works with physicians to facilitate referrals within the continuum of care.
• Works with the EHR team to ensure the system appropriately supports the physician’s ability to provide best-practice medicine by creating logical processes and providing the necessary order sets and practice guidelines.
• Maintains current knowledge of federal, state, and payer regulatory and contract requirements.
• Identifies quality, safety, patient satisfaction and efficiency issues leading to suboptimal care. Leads appropriate actions to resolve.
• Reviews cases that indicate a need for issuance of a hospital notice of non-coverage/Important Message from Medicare. Discusses the case with the attending physician and if additional clinical information is not available, discusses the process for issuance and appeal to the physician.
• Participates as part of the physician advisory council to assist IT with clinical decisions for the EHR.
• Assists with order set development, review, and implementation to coordinate quality, efficiency, and utilization of the order sets.
Lee Memorial Health System

Skilled Nursing Facility Discharge Planning

Board of Directors Meeting
11/5/15
Chris Nesheim, VP Care Management

The disclosure of this document and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under the Patient Safety Quality Improvement Act of 2005 and implementing regulations.
Care Management Org Chart

1. Denials Management located at CCH
   1. Initial and Continued stay reviews using IQ criteria
   2. 3rd party Insurance Request, including Medicaid
   3. LOS Management/ GMLOS evaluation
   4. Collaborate with CM and PBS for HINN 12, Detailed Notice of Discharge; UM completes CC 44.
   5. Centralized UM Department and Telecommuting staff

1. High risk patient screening within 24 hours. In depth assessment including cognition, mental health, psych/social, homeless, transportation, access/availability to community services
2. High risk stratification
3. Clinical coordination for progression of care
5. Comprehensive Education: disease process, community services, LMHS post acute entities, staff communication skills
6. Advocates for the patient and identifies decision maker
7. Comprehensive analysis of readmission reasons & system delays
8. Coordinate the continued stay- UM & IM
9. Advance Directives- education upon request
10. Continued stay reviews
11. Medication assistance
12. Rounding with physicians
13. Obs brocures-CMA and Nursing collaborative
Case Management Clinical Coordination

- High risk stratification
- Clinical coordination for progression of care
- Comprehensive D/C plan: Outpatient plans, Transition Plan
- Ensures comprehensive education: community services
- Knowledgeable staff re post acute entities, effective communication skills
- Advocates for the patient and identifies decision maker
- Comprehensive analysis of readmission reasons & system delays
- Coordinate the continued stay
- Advance directives-education upon request
- Medication assistance
- Rounding with physicians when available
Core Functions Triad
Assigned Geographically-Unit Based

Clinical Case Manager
• Discharge Planning – HHA, SNF, IV Infusion
• Clinical Coordination of Complex cases
• Notice of Discharge Coordination
• Initiate Quality Reporting
• Community Resources

Medical Social Worker
• Discharge Planning – SNF
• Notice of Discharge Coordination
• Self Pay – Resources, Medication
• Community Resources
• Hospice
• Complex Social
  – Homeless, Alcohol & Drug Abuse, Baker Acts, Child and Elder Abuse
• Adoptions
System-wide High Risk Indicators

- Age 80 or older
- Chronic conditions (CHF, AMI, pneumonia, diabetes, etc.)
- Polypharmacy
- Takes anticoagulants, anti-platelet, insulin, digoxin
- Previous admissions within last 3 months or length of stay greater than 7 days
- Support-living situation
- Health literacy & language
- Cognitive impairment
- Patient self-health rating
- Fall risk
- Palliative care
- Psych/social-mental health
Summary of Challenges from Expanding Regulatory Requirements, Payer Stipulations and the Current HealthCare Environment

• **Increased regulatory requirements by CMS to provide the following:**
  - Discharge appointments, often with more than one provider
  - Exploration into a patient’s nutritional needs, access to healthy food and preparation abilities
  - Ability to fund long term medications, co-pays, utility bills, etc.
  - Home safety, need for safety devices and ability to fund needed enhancements
  - Transportation beyond the hospital and to include physician, wound care, OP services, etc.
  - Cognitive ability and safety threats to or from their community
Summary of Challenges from Expanding Regulatory Requirements, Payer Stipulations and the Current Healthcare Environment

• Changes to reimbursement structure and restrictive third party payer policies and processes
  – Dissolution of straight Medicaid in favor of multiple managed care products with confusing, inefficient and restrictive processes impacting reimbursement
  – Increased Medicare replacement products that have costly co-pays for post-acute services that the patient is frequently unable to secure
  – Narrow post-acute provider networks that are insufficient to meet the volume of need resulting in triple to quadruple processing time
  – Majority of commercial and managed care products subcontract to third party providers at a capitated rate to manage post-acute services for their members. The fewer services approved, the more money they make
# Top 5 System Delays

**FY2015**

## Top 5 by Total Days

<table>
<thead>
<tr>
<th>Reason</th>
<th>Incidence</th>
<th>Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disch/Placement-Infusion Needs w/hx- IV Drug Abuse</td>
<td>51</td>
<td>981</td>
</tr>
<tr>
<td>Disch/Placement-Inpat Rehab not available</td>
<td>410</td>
<td>990</td>
</tr>
<tr>
<td>Financial/Payor-Precert or preauth delay</td>
<td>533</td>
<td>1401</td>
</tr>
<tr>
<td>Disch/Placement-Family/Patient related delays</td>
<td>558</td>
<td>1654</td>
</tr>
<tr>
<td>Disch/Placement-SNF not available</td>
<td>763</td>
<td>2151</td>
</tr>
</tbody>
</table>
LMHS Payor Mix 
FY2015

- Medicare: 36%
- Medicaid: 6%
- MCAREHMO: 14%
- MCAIDHMO: 15%
- MCaidu: 2%
- UNITED: 3%
- AETNA: 2%
- WORKERS COMP: 0%
- AUTO/LIAB: 1%
- CHAMPUS: 2%
- CHARITY: 3%
- CIGNA: 2%
- COMM/CONT: 2%
- COMM/NONC: 1%
- LMHS EMPL: 2%
Medicare Part A (Hospital Insurance) covers skilled nursing care provided in a skilled nursing facility (SNF) under certain conditions for a limited time. Medicare-covered services include, but aren't limited to:

- Semi-private room (a room you share with other patients)
- Meals
- Skilled nursing care
- Physical and occupational therapy*
- Speech-language pathology services*
- Medical social services
- Medications
- Medical supplies and equipment used in the facility
- Ambulance transportation (when other transportation endangers health) to the nearest supplier of needed services that aren’t available at the SNF
- Dietary counseling

*Medicare covers these services if they're needed to meet your health goal.
Medicare Skilled Nursing Facility Coverage

People with Medicare are covered if they meet all of these conditions:

- You have Part A and have days left in your benefit period.
- You have a qualifying hospital stay.
- Your doctor has decided that you need daily skilled care given by, or under the direct supervision of, skilled nursing or therapy staff. If you're in the SNF for skilled rehabilitation services only, your care is considered daily care even if these therapy services are offered just 5 or 6 days a week, as long as you need and get the therapy services each day they're offered.
- You get these skilled services in a SNF that's certified by Medicare.
Medicare Skilled Nursing Facility Coverage

- You need these skilled services for a medical condition that was either:
  - A hospital-related medical condition.
  - A condition that started while you were getting care in the skilled nursing facility for a hospital-related medical condition.

Your doctor may order observation services to help decide whether you need to be admitted to the hospital as an inpatient or can be discharged. During the time you're getting observation services in the hospital, you're considered an outpatient—you can't count this time towards the 3-day inpatient hospital stay needed for Medicare to cover your SNF stay. An inpatient stay begins on the day you’re formally admitted to a hospital with a doctor’s order. That’s your first inpatient day. The day of discharge doesn’t count as an inpatient day.
Medicare Skilled Nursing Facility Coverage

Your costs in Original Medicare

- You pay:
  - Days 1–20: $0 for each benefit period.
  - Days 21–100: $157.50 coinsurance per day of each benefit period.
  - Days 101 and beyond: all costs

If your break in skilled care lasts more than 30 days, you need a new 3-day hospital stay to qualify for additional SNF care. The new hospital stay doesn’t need to be for the same condition that you were treated for during your previous stay.

If your break in skilled care lasts for at least 60 days in a row, this ends your current benefit period and renews your SNF benefits. This means that the maximum coverage available would be up to 100 days of SNF benefits.
Community Coalition with SNFs, Home Health and ALFs
Priority Areas For Initial Focus

- Reducing ED visits & “all cause“ readmissions
- Increasing consistency and effectiveness of written and electronic communications;
- Increasing efficiency of clinicians in communicating key information with each other;
- Employing root cause analysis and case and record review to identify key issues and barriers to improved communications and outcomes;
- Using established industry best practices to promote initiative efficiency and success;
- Measuring the outcomes of work group initiatives to confirm their impact.
Overview of the INTERACT Quality Improvement Program

- Can help safely reduce hospital transfers by:
  
  1. Preventing conditions from becoming severe enough to require hospitalization through early identification and assessment of changes in resident condition
  2. Managing some conditions in the NH without transfer when this is feasible and safe
  3. Improving advance care planning and the use of palliative care plans when appropriate as an alternative to hospitalization for some residents
### SNF Capabilities List

<table>
<thead>
<tr>
<th>Nursing Home Capabilities List  Oct. 2013</th>
<th>Calusa Harbor</th>
<th>Consulate of N. Ft. Myers</th>
<th>Coral Trace</th>
<th>Citrus Gardens</th>
<th>Cypress Cove</th>
<th>Evans Health Care</th>
<th>Gulf Coast Village</th>
<th>HealthPark Care Center</th>
<th>Heartland</th>
<th>Heritage Park</th>
<th>Life Care of Estero</th>
<th>Page Rehab</th>
<th>Rehab of Cape Coral</th>
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</thead>
<tbody>
<tr>
<td>Primary Care Clinician Services</td>
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<tr>
<td>At least one physician, NP or PA in the facility 3 or more days a week</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>At least one physician, NP or PA in the facility 5 or more days a week</td>
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<td>Diagnostic Testing</td>
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<td>Stat lab tests with turnaround time &lt; 8 hours</td>
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<td>Stat X-rays with turnaround time &lt; 8 hours</td>
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<td>EKG</td>
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<td>Bladder Ultrasound</td>
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<td>Venous Doppler</td>
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<td>Cardiac Echo</td>
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<td>Wound Care</td>
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<tr>
<td>Other physician specialty consults</td>
<td>ortho / neuro</td>
<td>pain / rehab</td>
<td>psychiatry</td>
<td>Derr, vision, dental, audiologist, pneumologist</td>
<td>Derr, int. medicine, Bl</td>
<td>pain</td>
<td>Dental, Derm</td>
<td>Podiatry, oral, neuro</td>
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<td>Social and Psychology Services</td>
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<td>Licensed Social Worker</td>
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<td>Psychological Evaluation and Counseling by a Licensed Clinical Psychologist</td>
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17
## Readmission Rates FY2010 – FY2015

INTERACT Participating Facilities Highlighted

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1</td>
<td>19.1%</td>
<td>17.3%</td>
<td>14.3%</td>
<td>15.5%</td>
<td>17.1%</td>
<td>16.4%</td>
</tr>
<tr>
<td>2</td>
<td>17.2%</td>
<td>23.6%</td>
<td>13.4%</td>
<td>17.2%</td>
<td>18.0%</td>
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Avg. Totals

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18
### Medicare Fee-For-Service Hospital Readmissions from Skilled Nursing Facilities
#### July 1, 2014 - December 31, 2014

#### Fort Myers SNF Coalition

<table>
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<tr>
<th></th>
<th>Number of Discharges to SNF</th>
<th>Percentage of All Discharges to SNF</th>
<th>Discharges to SNF with a 30-Day Readmit</th>
<th>Percent of Discharges with a 30-Day Readmit</th>
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<tr>
<td>Fort Myers SNF Coalition</td>
<td>2,878</td>
<td>3.78%</td>
<td>603</td>
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<tr>
<td>State</td>
<td>76,151</td>
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<table>
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<th>Days to Readmission</th>
<th>0 - 7 Days</th>
<th>8 - 14 Days</th>
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<tr>
<td>n</td>
<td>Percent of 30-Day Readmits</td>
<td>n</td>
<td>Percent of 30-Day Readmits</td>
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<td>Fort Myers SNF Coalition</td>
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<td>State</td>
<td>5,560</td>
<td>32.8%</td>
<td>4,438</td>
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</table>

#### 30-Day All-Cause Readmission Rates

- **SNF Group**
- **State**


Report created: August 2015
Questions?
Lee Memorial Health System

“Fall 2015 Leapfrog Safety Scores”

October 2015 Release

Board of Directors Meeting
November 5, 2015
Marcelo Zottolo/ Process Analytics

The disclosure of this document and the contents herein does not constitute a waiver of any and all protections afforded Patient Safety Work Product under the Patient Safety Quality Improvement Act of 2005 and implementing regulations.
Leapfrog Safety Scores will remain the same for 3 hospital with 1 decline in the October publication

Published in April 2015

Cape Coral Hospital
636 Del Prado Blvd
Cape Coral, FL 339902695

Gulf Coast Medical Center
13681 Doctor’s Way
Fort Myers, FL 339124300

Healthpark Medical Center
9981 S. HealthPark Drive
Fort Myers, FL 33908

Lee Memorial Hospital
2776 Cleveland Avenue
Fort Myers, FL 339015855

Published for October 2015

<table>
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<th>Hospital</th>
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<td>B</td>
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<tr>
<td>Gulf Coast Medical Center</td>
<td>B</td>
<td>Spring 2015</td>
</tr>
<tr>
<td>Healthpark Medical Center</td>
<td>B</td>
<td>Spring 2015</td>
</tr>
<tr>
<td>Lee Memorial Hospital</td>
<td>C</td>
<td>Spring 2015</td>
</tr>
</tbody>
</table>
Leapfrog Safety Scores – April 2015 Publication
Fall Leapfrog Safety Scores - October 2015 Publication
Findings

• CCH and GCMC were respectively 0.02 and 0.05 short of getting an A grade this publication

• HPMC and LMH were respectively 0.07 and 0.08 short of getting an B grade this publication

• HPMC Safety Score was borderline B for the previous publication and reduce to a C for this publication due to:
  – Surgical Site Infections for 2014 declined compared to that of 2013
  – A decline in ICU CLABSI SIR performance in CY14 compared to CY13 also contributed.

• Other HPMC indicators improved (Accidental lacerations, Iatrogenic Pneumothorax, etc.) and are better than the National average. However, not enough to offset the grade
## Historical & Current Leapfrog Safety Grades

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Spring 2014</th>
<th>Fall 2014</th>
<th>Spring 2015</th>
<th>Fall 2015</th>
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</thead>
<tbody>
<tr>
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<td>C</td>
<td>B</td>
<td>B</td>
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<tr>
<td>Gulf Coast Medical Center</td>
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<td>B</td>
<td>B</td>
</tr>
<tr>
<td>HealthPark Medical Center</td>
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<td>B</td>
<td>C</td>
</tr>
<tr>
<td>Lee Memorial Hospital</td>
<td>C</td>
<td>C</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>
What would the safety scores be if Leapfrog were to use selected LMHS’ most recent data?

• For this publication, the data used by The Leapfrog Group ranges from mid 2011 to mid 2014
• Data for calendar year 2015 is not included in their analysis. It reflects LMHS’ focused efforts to increase our pace of improvement
• Selected measures include:
  – Catheter – associated urinary tract infections (CAUTI)
  – Central-line associated bloodstream infections (CLABSI)
  – Surgical site infection post colon surgery (SSI)
  – Postoperative pulmonary embolism/deep vein thrombosis (PE/DVT)
  – Postoperative respiratory failure
  – Postoperative wound dehiscence
Safety Scores would improve if more recent data were to be used

<table>
<thead>
<tr>
<th>Facility</th>
<th>Letter Grade</th>
<th>Numeric Score</th>
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<tbody>
<tr>
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<td>HealthPark Medical Center</td>
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<td>Lee Memorial Hospital</td>
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<td>2.8823</td>
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Fall 2015 Score Using CYTD Data Select Measures

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<td>A</td>
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<td>A</td>
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<td>2.9849</td>
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Takeaway:
LMHS most recent data has improved; potentially improving, therefore, Leapfrog safety scores for future publications
Current Improvement work

- Central line bloodstream infections
- Catheter associated urinary tract infections
- Surgical Site Infections
- Perioperative Pulmonary embolus/Deep Vein Thrombosis
- Severe Sepsis and Septic Shock
Questions?

We are Caring People, caring for People.
Data and performance periods used for the October 2015 publication

<table>
<thead>
<tr>
<th>Measure Category</th>
<th>Measure Name</th>
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<th>Reporting Period</th>
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<td>Process/Structural - HIGHER IS BETTER</td>
<td>Computerized Physician Order Entry (CPOE)</td>
<td>2015 Leapfrog Survey</td>
<td>01/01/2014 - 12/31/2014</td>
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<td></td>
<td>ICU Physician Staffing (IPS)</td>
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<td></td>
<td>Safe Practice: Leadership Structures and Systems</td>
<td></td>
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<tr>
<td></td>
<td>Safe Practice: Culture Measurement, Feedback and Intervention</td>
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<td></td>
<td>Safe Practice: Teamwork Training and Skill Building</td>
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<tr>
<td></td>
<td>Safe Practice: Identification and Mitigation of Risks and Hazards</td>
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<td></td>
<td>Safe Practice: Nursing Workforce</td>
<td></td>
<td></td>
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<td></td>
<td>Safe Practice: Medication Reconciliation</td>
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<td>Safe Practice: Hand Hygiene</td>
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<td>Safe Practice: Care of the Ventilated Patient</td>
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<tr>
<td></td>
<td>SCIP-INF-1: Prophylactic antibiotic received within 1 hour prior to surgical site preparation and incision</td>
<td>CMS Hospital Compare</td>
<td>10/01/2013 - 09/30/2014</td>
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<tr>
<td></td>
<td>SCIP-INF-2: Prophylactic antibiotic selection for surgical patients</td>
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<td>SCIP-INF-3: Prophylactic antibiotics discontinued within 24 hours after surgery endtime</td>
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<td>SCIP-INF-9: Urinary catheter removed on postoperative day 1 or 2</td>
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<td>SCIP-VTE-2: Surgery patients who received appropriate venous thromboembolism (VTE) prophylaxis</td>
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<td>Outcome - LOWER IS BETTER</td>
<td>Foreign Object Retained After Surgery</td>
<td>CMSHACs</td>
<td>07/01/2011 - 06/30/2013</td>
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<td></td>
<td>Air Embolism</td>
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<td>Stage III and IV Pressure Ulcers</td>
<td>2015 Leapfrog Survey</td>
<td>01/01/2014 - 12/31/2014</td>
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<td>Falls and Trauma</td>
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<td>PSI 3: Pressure Ulcer Rate</td>
<td>CMSAHRQ PSIs</td>
<td>07/01/2012 - 06/30/2014</td>
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<td>PSI 14:Postoperative Wound Dehiscence</td>
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<td>PSI 15: Accidental Puncture or Laceration</td>
<td>CMSAHRQ PSIs</td>
<td>07/01/2012 - 06/30/2014</td>
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Lee Memorial Health System

Safe Practice
Nursing Work Force Update

Board of Directors Meeting
Donna Giannuzzi, CNO
November 5, 2015
Purpose

Annual Board review of the critical components of the nursing workforce that reinforces patient safeguards including:

- Recruitment – Internship Program
- Tactics and Innovation Recruitment Strategies
- Creative Methods of Nurse Staffing
- Staffing adjustments
- Standardized measures and unit measures for staffing effectiveness
- National Database of Nursing (NDNQI) RN Survey
Internship Program Update
Growing Our Own

The total year-to-date number of interns hired is **335**.

Breakdown by campus and month is indicated below.

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<thead>
<tr>
<th>Date of Internship</th>
<th>Lee Memorial Hospital</th>
<th>Gulf Coast Medical Center</th>
<th>Cape Coral Hospital</th>
<th>HealthPark Medical Center</th>
<th>Golisano Children's Hospital of SW Florida</th>
<th>The Rehabilitation Hospital</th>
<th>Running Total</th>
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## Projected number of Nurse Residents expected to transition to Independent practice FY 16

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<td>6</td>
<td>2</td>
<td>6</td>
<td></td>
<td>215</td>
</tr>
</tbody>
</table>
Recruitment

- 335 Nurse Residents hired in fiscal year 2015.
- 39% of nurses hired had a BSN – 61% Associate Degree
- Florida Southwest College is the major provider of new graduates followed by Florida Gulf Coast University.
Tactics and Innovative Strategies for Retention

• Tactics
  o Per Diem pool
  o Benefitted pool
  o Float pool
  o Internal seasonal staff
  o Traveler program
  o Preceptors/Clinical Coaches
  o Internships

• Innovative Strategies
  o Flexible scheduling
  o New technology for self-scheduling
  o Tuition reimbursement
  o Professional education
  o Certification recognition
Creative Methods of LMHS Nurse Staffing Resource Program

- Annual Long-Term Nurse Staffing Process
- Seasonal Nurse Staffing Process
- 4 Week Nurse Staffing Process
- Covering Daily Nurse Staffing Needs
Creative Methods of Nurse Staffing Resource Program – Annual Long-Term Staffing Process

**Annual Hours Per Patient Day (HPPD)/Full Time Equivalent (FTE) Calculation Process**

- Projected unit HPPD for next fiscal year benchmarked against Labor Management Institute and NDNQI
- Annual FTEs required for units calculated based on average daily census and HPPD
- Seasonal staff requirements calculated and annual FTEs identified

**Seasonal Staffing Process**

- Number of available seasonal employees is compared to seasonal FTE need by unit
- Contract agency travelers hired to supplement FTE need above seasonal staffing component
Nursing Travelers

Acquisition of Southwest Regional and Gulf Coast Hospitals

Estimate
Creative Methods of Nurse Staffing Resource Program – 4 Week Staffing Process

**Census Point Forecasting**
- Five weeks before start of scheduling period, census for each hospital unit is forecasted using statistical analysis
- Number of staff required to support forecasted census is identified and published in productivity/scheduling system

**Balanced Schedule Process – One Staff Units**
- Unit leadership builds a 4 week schedule based on identified staff needs
- Schedules should be balanced

**Balanced Schedule Process – Web Scheduler Units**
- Employees self-schedule through online application based on identified staff needs
- Rules-based application empowers staff to contribute to achieving a balanced schedule
- Unit leadership finalizes balanced schedule

**Balanced Schedule Process – PRN Scheduling**
- Difference between number of shifts required for schedule and number of shifts picked up by unit staff is calculated
- Difference in shifts offered to internal staffing pool staff to fill
Creative Methods of Nurse Staffing Resource Program – 4 Week Staffing Process

4 Week Staffing Process

- Units with a 4 week staffing need (FMLA, LOA, multiple vacations or vacancies) can request a staffing direct placement
- Filled by volunteers from internal staffing pool
- Schedules must be balanced before 4 week staffing request is approved
Creative Methods of Nurse Staffing Resource Program – Daily Nurse Staffing Needs

**Census Point Forecasting**

**Balanced Schedule Process – 4 Week Staffing process**

**Daily Staffing Needs**
- Any staffing need not filled by 4 week staffing process is reported to centralized staffing office
  - By shift, on day of need
- Interactive allocation tool based on productivity allows centralized staffing office to identify areas of greatest need in health system on a shift by shift basis
- Centralized staffing office can allocate internal staffing pool employees (and unit staff, if possible) to areas of greatest need on a shift by shift basis
Standardized Measures – Staffing Effectiveness

- Daily Reports/Weekly/Monthly Reports
  - Productive hours
  - FTE’s actual vs. projected need
  - Overtime percentage
  - Salary cost
  - Total paid salaries

- Compare internally and externally with the National Database of Nursing Quality Indicators
  - Nursing hours per patient day
  - Falls
  - Hospital acquired pressure ulcers
  - RN, LPN and CNA turnover
  - Ventilator associated pneumonia
  - Central line associated blood stream infections
  - Catheter associated urinary tract infections
  - Nurse Satisfaction Survey
Quality Results

• Culture of Patient Safety - The following three hospital based composites improved by 8 points or better since 2012.
  -Handoffs and Transitions
  -Teamwork across Units
  -Nonpunitive Response to Error
Nurse Satisfaction Survey-2015

• **Staff Perceptions of Professional Practice Environment Survey**
  • Measures: autonomy, control over practice, clinician-physician relationships, communication, teamwork, conflict management, internal work motivation, cultural sensitivity

• **NDNQI Nurse Survey with Practice Environment Scale Subscales**
  • Nurse Participation in Hospital Affairs
  • Nursing Foundations for Quality of Care
  • Nurse Manager Ability, Leadership, and Support of Nurses
  • Staffing and Resource Adequacy
  • Collegial Nurse-Physician Relations
## PCS Mean Scores on Professional Practice Environment Characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>HPMC</th>
<th>LMH</th>
<th>GC</th>
<th>CCH</th>
<th>LMHS</th>
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<tr>
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<td>2.90</td>
<td>3.02</td>
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<td>2.95</td>
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<tr>
<td>Nursing Participation in Hospital Affairs</td>
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<td>2.84</td>
<td>2.99</td>
<td>2.86</td>
<td>2.91</td>
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<tr>
<td>Nursing Foundations for Quality of Care</td>
<td>3.14</td>
<td>3.10</td>
<td>3.17</td>
<td>3.11</td>
<td>3.13</td>
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<td>Ability, Leadership, and Support of Nurses</td>
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<td>2.95</td>
<td>3.15</td>
<td>3.03</td>
<td>3.04</td>
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<td>Staffing and Resource Adequacy</td>
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<td>2.61</td>
<td>2.78</td>
<td>2.74</td>
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<td>2.90</td>
<td>2.99</td>
<td>2.99</td>
<td>2.80</td>
<td>2.92</td>
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</table>

*If the number of units is less than five, comparison data are suppressed to maintain confidentiality. For additional information, please refer to NDNQI reference documents.*

Questions?
DATE OF THE NEXT
REGULARLY SCHEDULED
MEETING

QUALITY/ SAFETY
FULL BOARD MEETING

Thursday, February 25, 2016
at 1:00p.m.

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

Lee Memorial Health System
FULL BOARD OF DIRECTORS MEETING
Thursday, November 5, 2015

BOARD CHAIRMAN:
Sanford Cohen, M.D.
Admissions: Up 5.8% from budget / Up 3.5% from PY

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Actual</th>
<th>Prior Yr</th>
<th>Var Bud</th>
<th>Var PY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>14,347</td>
<td>15,284</td>
<td>14,657</td>
<td>6.5%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1,572</td>
<td>1,553</td>
<td>1,609</td>
<td>-1.2%</td>
<td>-3.5%</td>
</tr>
</tbody>
</table>
Patient Days – FY 2015

Patient Days: Up 9.1% from budget / Up 6.4% from PY

- Budget: 65,015
- Actual: 70,949
- Prior Year: 66,686

ALOS: Up 3.2% from budget / Up 2.8% from PY

- Budget: 4.08
- Actual: 4.21
- Prior Year: 4.10
Net Revenue: $204,612,551 – Up 1.1% from budget
Up 1.6% from PY

Net Rev. per Adj. Admit: $7,427 – $66 less than budget
$17 less than PY

Payer Mix

Budget

- Medicaid, 12.5%
- HMO/PPO, 20.4%
- Self Pay / Charity, 6.6%
- Other, 5.1%

Actual

- Medicare, 55.4%
- Medicaid, 12.4%
- HMO/PPO, 20.7%
- Self Pay / Charity, 6.2%
- Other, 5.5%
Salary Expense – FY 2015

**Staffing:**

- Salaries and Benefits: $85,437,165
  - $399K less than budget
- FTEs: 1,314
  - 1 more than budget
- FTEs per AOB: 4.13
  - 0.22 less than budget
Supply Expense – FY 2015

Supply Expense per Adj Admit: $1,353

- Down 1.5% from budget
- Up 3.4% from PY
Profitability – FY 2015

EBITDA: $70.97 million, $8.3 million more than budget

EBITDA %: 33.2% vs. Budget of 30.6%

Gain From Operations: $58.2 million, $7.6 million more than budget

Operating Margin: 27.2% vs. Budget of 24.7%
Patient Experience: 4Q FY 2015

- HCAHPS Overall Rating was 67.8%
  - Up 2.4 points over the previous quarter (65.4% vs 67.8%)
  - FY 2015 Goal – 70.9%

- ED-CAHPS T&R (Adult) Overall Rating was 54.9%
  - Down 1.0 point over the previous quarter (55.9% vs 54.9%)
  - FY 2015 Goal – 63.6%

- ED T&R (Peds) Overall Rating was 63.1%
  - Up 13.5 points over the previous quarter (49.6% vs 63.1%)
  - FY 2015 Goal – 66.7%
**Challenges**

1. Surgical volumes lower than previous year due to loss of some surgery retirement.

2. Opening all 291 beds for FY 16 Season – first time in CCH history (38 years)

**Opportunities**

1. Relocation of Cardiac Decision Unit to 3 North incorporation of Heart Failure, Heart Failure Program at Cape as well as other cardiac services for a total of 39 beds.
   - Heart Failure – Medical Director, Dr. Cross
   - Heart Failure Coordinator, Kelly Richardson
   - Goal is to decrease LOS and readmissions to identify and increase awareness for referrals to Cardiac Rehab & Care Transition Program.


3. Additional vascular and orthopedic surgeons starting at CCH.
People

Recognition:
Quarterly Recognition Winners
- Jenny Drew - Outstanding Support
- Jeannie Cade - Outstanding Clinical Support
- Sharon Rothwell - Outstanding Patient Care Services
- Carol Anderson - Outstanding Volunteer
- Dr. Martinez - Outstanding Physician/Physician Extender

Connectivity
- Over 1,711 staff have participated in this onsite facility update, sharing system-wide goals and site specific expectations.
- CCH met and exceeded Employee Engagement Index for the past 3 years
CCH Advance
- Theme - “Inspire and recognize excellence” by sharing how we intentionally drive our business outcomes through the lens of an optimal healing environment using lean our management system. This will, in turn, support our system mission, vision and values.

- 3 Takeaways
  - Know and post your “aspirational” goals (e.g., based on top state or national performance).
  - Know and post your current performance levels and focus on “continuous improvement.”
  - Utilize the “house” as a way to showcase and share your own department story.

Clinical Integration
- 1st Phase of Pathway to Discovery is complete. Ribbon Cutting scheduled for November 4, 2015 at 7:30am.
New Birth @ HP

Three?! I don't look a day over two!
Admissions - YTD September 30, 2015

Admissions: Up 8.4% from budget/Up 4.6% from PY

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Actual</th>
<th>Prior Yr</th>
<th>Var Bud</th>
<th>Var PY</th>
</tr>
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<tbody>
<tr>
<td>Adult</td>
<td>19,457</td>
<td>21,186</td>
<td>20,332</td>
<td>8.9%</td>
<td>4.2%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>1,797</td>
<td>1,854</td>
<td>1,701</td>
<td>3.2%</td>
<td>9.0%</td>
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</tbody>
</table>
Patient Days - YTD September 30, 2015

Patient Days: Up 16.5% to Budget/Up 12.2% from PY

- Budget: 92,035
- Actual: 107,192
- Prior Year: 95,577

ALOS: Up 7.4% from budget/Up 7.3% from PY

- Budget: 4.33
- Actual: 4.65
- Prior Year: 4.34
Short Stays: Down 8.6% to Budget/ Up 5.7% from PY
Statistics - YTD September 30, 2015

- **ED Visits**
  - Budget: 64,495
  - Actual: 64,095
  - Prior Year: 66,879

- **Surgeries**
  - Budget: 10,143
  - Actual: 10,026
  - Prior Year: 10,615

- **Kidney Transplants**
  - Budget: 64
  - Actual: 56
  - Prior Year: 47

- **Deliveries**
  - Budget: 1,584
  - Actual: 1,602
  - Prior Year: 1,731
Revenue - YTD September 30, 2015

Net Revenue: $326,827,000 – Up 10.7% from Budget/Up 8.2% from PY
Net Rev. per Adj. Admit: $9,927 - $340 more than budget
$373 more than PY

Payer Mix

Budget

Medicare 59.1%
HMO/PPO 18.5%
Medicaid 11.6%
Self Pay / Charity 5.6%
Other 5.2%

Actual

Medicare 59.6%
HMO/PPO 19.2%
Medicaid 11.2%
Self Pay / Charity 4.7%
Other 5.3%
**Staffing**: Salaries and Benefits: **$5,031,000 over budget**

FTEs: 1,788 – **77 over budget**

FTEs per AOB – **4.37** vs. Budget 4.73
Supply Expense per Adj Admit: $2,389 Actual vs. $2,242 Budget
Up 6.6% from Budget
Up 13.9% from PY
Profitability - YTD September 30, 2015

EBDITA: $108.0 million, $14.8 million more than budget
EBDITA %: 33.0% vs. Budget of 31.6%
Gain From Operations: $69.7 million, $12.2 million more than budget/$2.6 million more than PY
Operating Margin %: 21.3% vs. Budget of 19.5%
Key Challenges and Opportunities

Challenges
1. Overcapacity
2. Staff burnout

Opportunities
1. GCMC Expansion process begun – Listening tour and design process
2. Parking Garage
3. 7 new licensed beds open in December
4. Seasonal planning
5. ED Schedulers in place
6. Transfer process is streamlined
7. Potential MOB purchase
Admissions - YTD September 30, 2015

Admissions: Up 7.9% from Budget/Up 6.3% from PY

<table>
<thead>
<tr>
<th>Department</th>
<th>Budget</th>
<th>Actual</th>
<th>Prior Yr</th>
<th>Var Bud</th>
<th>Var PY</th>
</tr>
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<tbody>
<tr>
<td>Adult</td>
<td>13,991</td>
<td>14,855</td>
<td>14,129</td>
<td>6.2%</td>
<td>5.1%</td>
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<tr>
<td>Obstetrics</td>
<td>3,671</td>
<td>4,451</td>
<td>3,961</td>
<td>21.2%</td>
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<tr>
<td>Pediatrics</td>
<td>4,397</td>
<td>4,412</td>
<td>4,275</td>
<td>0.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>NICU</td>
<td>710</td>
<td>843</td>
<td>741</td>
<td>18.7%</td>
<td>13.8%</td>
</tr>
</tbody>
</table>
Patient Days - YTD September 30, 2015

**Patient Days:** Up 7.2% from Budget/Up 6.0% from PY

- Budget: 103,751
- Actual: 111,194
- Prior Year: 104,919

**ALOS:** Down 0.6% from Budget/Down 0.3% from PY

- Budget: 4.56
- Actual: 4.53
- Prior Year: 4.54
Short Stays: Up 15.7% over Budget/Up 32.0% from PY

- Short Stays
  - Budget: 7,955
  - Actual: 9,207
  - Prior Year: 6,976
Revenue - YTD September 30, 2015

**Net Revenue:** $381,542,000—**Up 12.3% from Budget/Up 11.8% from PY**

**Net Rev. per Adj. Admit:** $10,116 - **$31 less than Budget**  
**$83 more than PY**

### Payer Mix

**Budget**
- Medicare: 45.54%
- Medicaid: 24.45%
- HMO/PPO: 20.78%
- Self Pay / Charity: 4.49%
- Other: 4.74%

**Actual**
- Medicare: 46.21%
- Medicaid: 23.76%
- HMO/PPO: 21.36%
- Self Pay / Charity: 3.86%
- Other: 4.81%
**Staffing**: Salaries and Benefits: **$3,939,118 over Budget**

FTEs: 1,963 – **76 more than Budget**

FTEs per AOB – **4.37** vs. Budget 4.60
Supply Expense per Adj Admit: $2,132 Actual vs. $2,142 Budget
Down 0.5% from Budget
Up 3.4% over PY
Profitability - YTD September 30, 2015

EBDITA: $142,921 million; $29,205,000 more than Budget
EBDITA %: 37.5% vs. Budget of 33.5%

Gain From Operations: $129,105 million; $29,630,000 more than Budget/$23,324,000 million more than PY
Operating Margin %: 33.8% vs. Budget of 29.3%
RX Games – 261 employees raised $50,263.00. HPMC staff members have raised the most money three years in a row.

3rd Quarter Star Awards
- Star Non-Clinician: Deb LaSalle
- Star Physician: Elie J. Checo Heinsen, MD
- Star Leader: Kayla Kozi, NMTCB

“Healthpark has Talent” debuted on September 3, 2015. Fifteen talented employees participated in an evening “Where Stars are Born.” The following three Top Talented staff members will compete in the System-wide Talent Show on November 19, 2015.

- Sandi Falk, RN from Surgical Services took 1st Place singing “I Dreamed a Dream” from Les Miserables.
- Elise Snyder, RN from Information Systems grabbed the 2nd place singing "Con Los Años Que Me Quedan."
- Shawna Storozuk, RN from Pediatrics was named the 3rd place winner dancing a Ukraine Folk Dance.
Doc Coggins Winners from HPMC include:

- Callie Zintz, RN Pediatrics
- Marcy Burchfield, RN Operating Room
Construction

• The Atrium Courtyard has been updated with new furniture, lighting, and renovated public restrooms.
• The open house for the Endoscopy Suites and the “Boca Grande” conference room will be early December 2015.
• First floor observation unit beds (1A/1B meeting rooms) are under construction and on schedule as a patient care area and expected to be ready mid December.
Key Challenges and Opportunities

**Challenges:**
- Managing significant inpatient volumes
- Volume increases over the summer necessitated the postponement of major renovations of the Surgical Progressive Care Unit.
- Recruiting adequate resources to staff the system Emergency Departments and patient care units.
Opportunities:

• OB Hospitalist program is providing 24/7 in-house obstetricians to support the Regional Perinatal Intensive Care Center high-risk obstetrical patients.

• Phase 2 of the surgery expansion will provide needed pre-operative and post anesthesia care beds by February 2016.
HPMC

• HPMC inpatient achieved 81.0%. This score placed HPMC in 86th percentile on “overall rate this facility.”
Admissions: Up 12.2% from Budget/Up 7.9% from PY

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Actual</th>
<th>Prior Yr</th>
<th>Var Bud</th>
<th>Var PY</th>
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<tr>
<td>Adult</td>
<td>14,196</td>
<td>15,928</td>
<td>14,758</td>
<td>12.2%</td>
<td>7.9%</td>
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</table>
Patient Days - YTD September 30, 2015

Patient Days: **Up 14.3% from Budget/Up 8.7% from PY**

- Budget: 66,643
- Actual: 78,487
- Prior Year: 72,234

ALOS: **Up 1.9% from Budget/Up 0.7% from PY**

- Budget: 4.84
- Actual: 4.93
- Prior Year: 4.89
Short Stays: Up 27.3% from Budget/Up 31.5% from PY

- Budget: 5,790
- Actual: 7,373
- Prior Year: 5,606
Revenue - YTD September 30, 2015

Net Revenue: $261,297,836 – Up 7.7% from Budget/Up 8.3% from PY
Net Rev. per Adj. Admit: $11,088 - $310 less than Budget
$50 more than PY

Payer Mix

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>Budget</th>
<th>Actual</th>
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<tbody>
<tr>
<td>Medicare</td>
<td>46.7%</td>
<td>47.1%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>13.3%</td>
<td>13.5%</td>
</tr>
<tr>
<td>HMO/PPO</td>
<td>16.3%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Self Pay / Charity</td>
<td>9.5%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Commercial</td>
<td>4.1%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Other</td>
<td>10.1%</td>
<td></td>
</tr>
</tbody>
</table>
Total FTEs: 1,418 – 94 more than Budget

OT and Contract FTEs: Up 58.3% from Budget/Up 34.8% from PY

FTEs per AOB: 4.46 vs. Budget 4.69
Supply Expense - YTD September 30, 2015

Supply Expense per Adj Admit: $2,714 Actual vs. $2,658 Budget
Up 2.1% from Budget
UP 6.0% from PY
EBDITA: $91.3 million, $7.4 million more than Budget

EBDITA %: 33.3% vs. Budget of 33.65%

Gain From Operations: $81.1 million, $8.1 million more than Budget/$15.2 million more than PY

Operating Margin %: 29.6% vs. Budget of 29.3%
Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

- LMH IP Adult Overall
- NRC 50th Percentile
- NRC 90th Percentile
LMH Service, Safety and Quality

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LMH IP Adult Overall</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Positive Score</td>
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<td>68.8%</td>
<td>61.1%</td>
<td>65.1%</td>
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<tr>
<td>n-Size</td>
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<td>174</td>
<td>128</td>
<td>113</td>
<td>149</td>
<td>91</td>
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<tr>
<td><strong>NRC 50th Percentile</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Positive Score</td>
<td>71.4%</td>
<td>71.4%</td>
<td>71.5%</td>
<td>71.5%</td>
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<td>571,693</td>
<td>571,693</td>
<td>571,693</td>
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<tr>
<td><strong>NRC 90th Percentile</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive Score</td>
<td>82.4%</td>
<td>82.4%</td>
<td>82.2%</td>
<td>82.2%</td>
<td>82.2%</td>
<td>82.2%</td>
</tr>
<tr>
<td>n-Size</td>
<td>545,029</td>
<td>545,029</td>
<td>571,693</td>
<td>571,693</td>
<td>571,693</td>
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</tbody>
</table>
## LMH Service, Safety and Quality

### Correlated to: HCAHPS: Rate hospital

<table>
<thead>
<tr>
<th>Question</th>
<th>Positive Score (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCAHPS: Did everything to help your pain</td>
<td>70.8%</td>
</tr>
<tr>
<td>HCAHPS: Treated w/courtesy/respect by Nurses</td>
<td>82.3%</td>
</tr>
<tr>
<td>HCAHPS: Nurses listened carefully to you</td>
<td>69.3%</td>
</tr>
<tr>
<td>HCAHPS: Staff took preferences into account</td>
<td>69.3%</td>
</tr>
<tr>
<td>HCAHPS: Nurses explained things understandably</td>
<td>70.0%</td>
</tr>
<tr>
<td>HCAHPS: Pain well controlled during stay</td>
<td>54.4%</td>
</tr>
<tr>
<td>HCAHPS: Got help as soon as wanted</td>
<td>54.7%</td>
</tr>
<tr>
<td>HCAHPS: Help going to bathroom as soon as wanted</td>
<td>60.7%</td>
</tr>
<tr>
<td>HCAHPS: Understood managing of health</td>
<td>45.3%</td>
</tr>
<tr>
<td>HCAHPS: Drs listened carefully to you</td>
<td>69.9%</td>
</tr>
</tbody>
</table>

**Units:** LMH IP Adult Overall

*From September 21, 2014 to September 20, 2015*
LMH Service, Safety and Quality

- Advance the Culture of Caring:
  - Focus on correlations: Good to great!
    - Care Transitions
    - Communication
OPERATIONS REPORT
4th Quarter 2015

Golisano Children’s Hospital of Southwest Florida

Kathy Bridge-Liles, CAO
## Admissions – 4th Quarter 2015

### Admissions: Up 2.7% from Budget / Up 4.9% from PY

<table>
<thead>
<tr>
<th></th>
<th>Budget</th>
<th>Actual</th>
<th>Prior Yr</th>
<th>Var Bud</th>
<th>Var PY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics</td>
<td>4,397</td>
<td>4,412</td>
<td>4,275</td>
<td>0.3%</td>
<td>3.2%</td>
</tr>
<tr>
<td>NICU</td>
<td>710</td>
<td>843</td>
<td>741</td>
<td>18.7%</td>
<td>13.8%</td>
</tr>
<tr>
<td>SCN</td>
<td>184</td>
<td>179</td>
<td>164</td>
<td>-2.7%</td>
<td>9.1%</td>
</tr>
</tbody>
</table>
Patient Days – 4th Quarter 2015

Patient Days: Flat to Budget / Up 2.6% from PY

- Budget: 31,553
- Actual: 31,546
- Prior Year: 30,736

ALOS: Down 2.6% from Budget / Down 2.2% from PY

- Budget: 5.96
- Actual: 5.81
- Prior Year: 5.93
Short Stay Days 4th Quarter 2015

Short Stay Days: Up 91.6% from Budget/Up 71.5% from PY

- Budget: 641
- Actual: 1,228
- Prior Year: 716

Bar chart showing the comparison of budget, actual, and prior year short stay days.
Ed Visits +2,792 and ED Admits +428 from Prior Year
Staffing*:  
Salaries and Benefits: **$531.5 thousand under fixed budget**  
FTEs: **333 vs. fixed budget of 348**  
FTEs per AOB: **3.59 vs. fixed budget 3.82**

*This does not include ancillary departments*
Supply Expense per Adj Admit*: $343 Actual vs. $373 Fixed Budget
Down 8.1% from Budget
Down 3.9% to PY

Medical Gases and Anesthetics are the top two expenses with a favorable variance to budget

*This does not include ancillary departments
Quality

Pediatric Asthma Core Measures

- CAC 1 100% Reliever ordered and administered
- CAC 2 100% Systemic corticosteroid ordered and administered
- CAC 3 96.7% Written Home Management Plan of Care at discharge
GCHSWF Year End HCAHPS Results

- Peds Top Box: 81.8% - Meets
- NICU Top Box: 84.8% - EXCEEDS!!
Key Opportunities

- Golisano Pediatric Urgent Care Facility and sub specialty offices in Naples. **Construction in progress**

- **Advance – Culture of Caring** – 5 full day sessions completed for over 150 Golisano staff in order to lay the ground work for a cultural transformation to the new facility.

- PWC- have received the working draft of the Golisano Children’s Hospital Strategy Assessment and are currently in the preliminary review phase with our Strategy and Planning Department

- Working with Jesse Bender, MD, FAAP, CHSE, Staff Neonatologist, Women & Infants' Hospital, Co-Director of CNE Simulation Program, Assistant Professor of Pediatrics, Warren Alpert Medical School at Brown University
Enhanced Simulation to Identify Latent Safety Hazards in Your NICU

Jesse Bender MD, CHSE
Pending publication, 2015
Heart and Vascular Institute
LMHS Board Update

Richard A Chazal, MD, FACC
Medical Director
November 5, 2015
HVI: A Review of...

- “The Gap”
- MACRA: How changes in Federal laws and regulation will affect physicians (and how this applies to HVI)
- Review of HVI vision, governance, timeline, phases
- HVI Metrics 2015, 2016
- Chest Pain Center Review
- Non Metric Initiatives/Activity
- Challenges
- Next Steps
**THE CURVE**

1. **First Curve**
   - Fee-for-Service
   - Quality Not Rewarded
   - Pay for Volume
   - Fragmented Care
   - Acute Hospital Focus
   - Stand Alone Providers Thrive

2. **Second Curve**
   - Value Payment
   - Continuity of Care Required
   - System of Care
   - Providers at Risk for Payment
   - IT Centric
   - Physician Alignment

**STRADDLE**

- Revenue Drops
- Minimal Reward for Quality
- Volume Decreases

**PERFORMANCE**

**TIME**
## Overview

<table>
<thead>
<tr>
<th>Pre-MACRA</th>
<th>Post-MACRA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 21% payment cut in 2015, continued uncertainty</td>
<td></td>
</tr>
<tr>
<td>• Separate quality reporting programs with penalties</td>
<td></td>
</tr>
<tr>
<td>• Some regulatory flexibility for alternative payment model participation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Eliminates SGR; implements stable payment increases</td>
</tr>
<tr>
<td></td>
<td>• Streamlined quality reporting program with penalties and bonuses</td>
</tr>
<tr>
<td></td>
<td>• Incentives for alternative payment model participation</td>
</tr>
</tbody>
</table>
Annual Payment Updates

Mid 2015-2019
- 0.5% annual payment update

2020-2025
- 0% annual payment update
- Introduction of Merit-Based Incentive Payment System

2026 and After
- 0.75%: Alternative Payment Model participants
- 0.25%: All other professionals

Averts a 21% payment cut in 2015 and future uncertainty
Merit-Based Incentive Payment System

- Quality (PQRS)
- Meaningful Use (EHR Incentive)
- Resource Use (Value Modifier)
- Clinical Practice Improvement

- Individual program penalties continue through 2018
- MIPS begins in 2019 for physicians and most mid-level clinicians
- Eligible professionals scored against benchmark based on prior year’s performance
- Low-volume providers and some APM participants may be exempt from MIPS requirements
MIPS Composite, Year 1

- Meaningful Use requirements
- Meaningful Use weight may be adjusted down to 15 percent if 75% or more EPs are meaningful users

- Expanded Practice Access
- Population Management
- Care Coordination
- Beneficiary Engagement
- Patient Safety
- Practice Assessment (ex. MOC)
- Patient-Centered Medical Home or specialty APM

- PQRS measures
- eCQMs
- QCDR measures
- Risk-adjusted outcome measures

- Value-Based Modifier measures
- Risk-adjusted outcome measures
- Part D drug cost (if feasible)
### MIPS Payment Adjustments

<table>
<thead>
<tr>
<th></th>
<th>Low Performance</th>
<th>Benchmark</th>
<th>High Performance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Negative Adjustment</td>
<td>Neutral Adjustment</td>
<td>Positive Adjustment</td>
</tr>
<tr>
<td>PQRS+VM+EHR Incentive Penalties (combined)</td>
<td>-4.5%</td>
<td>-6.0%</td>
<td>-9.0%</td>
</tr>
<tr>
<td>MIPS Bonus/Penalty (max)</td>
<td>-4.5%</td>
<td>-6.0%</td>
<td>-9.0%</td>
</tr>
</tbody>
</table>

* May be increased by up to 3 times to incentivize performance

$500$ mil funding for bonuses allocated through 2024
Alternative Payment Model

2019 and 2020

- ≥ 25% of total Medicare revenue

2021 and 2022

- ≥ 50% of total Medicare revenue
- ≥ 50% of total revenue, Medicare and all-payer combined

2023 and Beyond

- ≥ 75% of total Medicare revenue
- ≥ 75% of total revenue, Medicare and all-payer combined

- 2019-2024: 5% bonus
- CMS/CMMI models (except Healthcare Innovation Awards)
- Other eligible models
  - Requires CEHRT
  - Payment based on quality measures
  - Financial risk or a Patient Centered Medical Home
- APM participants meeting threshold are MIPS-exempt
Measure Development Plan & Funding

- **By Jan 2016**
  - HHS Secretary and stakeholders must develop and publish a **draft plan** for MIPS and APM measure development

- **By Mar 2016**
  - Close of **public comment period**

- **By May 2016**
  - **Final plan** published on HHS website

- **May 2017 & beyond**
  - **Annual progress report**, including a listing of each measure developed or in development

- **$15 mil each fiscal year 2015 to 2019**
- Prioritize measure gaps
  - outcome, patient experience, care coordination, and appropriate use measures
- Incorporation of private payer and delivery system measures
- Coordination across stakeholders
- Utilization of clinical best practices and practice guidelines
HVI VISION STATEMENT

The Lee Memorial Heart and Vascular Institute will provide the highest quality cardiac and vascular care in a cost-effective manner.
Governance

• HVI Board
  – 4 from System Administration
  – 4 CV physicians, elected by HVI members

• HVI Medical Director

• HVI Administrative Director
HVI Board

- Erick Burton, MD
- Robert Cross, MD
- Michael Rubin, MD
- Steven Priest, MD
- Cindy, Brown, RN
- Donna Giannuzzi, RN
- Kevin Newingham
- Scott Nygaard, MD
HVI Leadership/Employees

• Richard Chazal, MD, FACC: Medical Director
• Michael Montgomery, FACHE: Service Line Director
HVI Leadership

• Richard Chazal, MD, FACC: Medical Director
• Michael Montgomery, FACHE: Service Line Director
• David Bailey, MD, FACC: Cath Lab Director
• Anita Arnold, DO, FACC: Non-Invasive Director
HVI Timeline

- Fall 2011: Concept work
- January 2012: HVI Board begins work
- September 2012: Contractual launch
- September 2012: HPH CHF unit
- October 2012: HPH Chest Pain Center
- October 2012-now: Metrics and non metrics work
- October 4-5, 2013: HVI Strategic Plan Retreat
- April, 2015: Mike Montgomery-first full time HVI
- August 21-22, 2015: HVI Strategic Plan Retreat
HVI Phases

• Phase I: Quality Metrics with target goals and physician incentives (engagement, culture).
• Phase II: Service Line Process focusing on improved quality and efficiency; expanded use of clinical evidence based guidelines.
• Phase III: Evolution of CV care culture; expanded quality initiatives, research, publication, expansion to include full continuum of care.
HVI Metric Initiatives
November 1, 2014 - September 30, 2015

- Replicate the chest pain center at Lee Memorial Hospital
- Develop a rapid diuresis program for Congestive Heart Failure Patients
- D2B within 90 minutes – system
- Increase the use of the radial artery for access (HPMC/GCMC/CCH)
- Improve the Cath Lab first case on-time starts in each Cath Lab (scheduled time equivalent to lidocaine injection time)
- Expand Cardiac Stress Testing Services
- Improvement performance for patients WITHOUT Acute Coronary Syndrome: proportion of evaluated PCI procedures that were appropriate by the last quarter of reporting available (NCDR).
HVI Metric Initiatives
October 1, 2015 – September 30, 2016

- Percentage of D2B Within 90 Minutes (non-transfer cases)
- Composite Discharge Medications in Eligible PCI Patients: Percentage of patients with PCI procedure who receive prescription for all medications for which they are eligible for upon discharge (Aspirin, P2Y12 inhibitor, Statin)
- PCI In Hospital Risk Adjusted Mortality Rate (STEMI Patients)
- Routine Echo Studies Interpreted within 24 hours: Cohort by group
- Improvement AUC: Proportion of Evaluated PCI Procedures Appropriate (patients w/o ACS)
- Composite: Discharge Medications in eligible ICD Patients: (ACE/ARB and beta blockers) by 4th quarter of the year.
- Expand Cardiac Stress Testing Services
Replicate Chest Pain Center

- HPMC: October 2012
- CCH: January 2014
- GCMC: February 2014
- LMH: September 2015
Chest Pain Centers (CPC):
Goals

• Improved patient care
• Improved physician efficiency
• Improved ER and facility management
Case Study:
Lee Memorial Health System
Heart and Vascular Institute

• Guideline driven
• Physician directed
• Facilitated by Advanced Care Team Members (ACP’s)
CDU: Chest Pain Center

• Protocol driven approach
• Dedicated units
• Staffed with two (2) mid level providers at each campus
• Dedicated RN’s, Tech’s, and UC
Outcomes: Length of Stay

Assigned to CPC

"Usual care"

Pre CPC
Post CPC

0 10 20 30 40
Patient Days
Saved by Chest Pain Centers

• FY 2014
  • HPMC: 293 (Oct-Sept)
  • GCHC: 200 (Feb-Sept)
  • CCH: 203 (Jan-Sept)
• Total: 696

• FY 2015
  • HPMC: 301
  • GCMC: 434
  • CCH: 665
  • LMH: 30 (Sept 21-30)
• Total: 1430
Outcomes: Readmission or Death

- 30 day readmission: 2%
- 30 day death: 0%
Patient Centered Care
The Patient Perspective

- Old Paradigm:
  - ER doc: “CP; we’ll get you evaluated”
  - Hospitalist: “We’ll get you seen by cardiology”
  - Cardiologist (the next day!): “We’ll get a test”
  - Hungry, scared, disjointed care
  - “Does anyone know what they are doing?”
Patient Centered Care: The *Real* Goal
The Patient Perspective

• New Paradigm:
  – ER doc: “CP; we’ll get you evaluated by our team”
  – ACP: “Here’s what is going to happen; we’ll get this figured out in the next 18 hours!”
  – Cardiologist (the same day!): “Our ACP has told me about you; let’s proceed to diagnosis”
  – “There is a plan”
  – “These people are pros”
“Non-Metric” Initiatives I

- CHF program: dedicated units, coordinators, rounding teams
- Pulmonary CTA
- A2 study
- CME
- CCH PCI evaluation (twice)
- Atrial Fibrillation program evaluation
“Non-Metric” Initiatives II

- PAC’s workgroup
- Cath lab layout workgroup
- SmartCare
- Health Outcomes Science
- CVSL Director selection
- CCH Chest Pain and CHF accreditation
“Non-Metric” Initiatives III

- Faculty, ACC Summit on CV Care 2013, 2014, 2015
- STEMI call valuation
- Evaluation of TAVR reimbursement
- Grand-Aides
- Cath lab equipment evaluation
- Evaluation renal denervation, remote PA monitoring...
What’s Worked

- Non-metric initiatives
- Cath lab layout
- Chest Pain Centers
- CHF programs
- Radial cath expansion
- Evaluation of programs
Where are the metric challenges?

- D2B
- NCDR metrics
- First case start times
Challenges/Obstacles

• Alignment
• Incentives
• Commitment (time, resources)
Next Steps

- Immediate work on data support: consultant, IT
- Working with IT for system wide data solution for CV
- Focus on clean data input, leading to better metrics, and process improvement
- Continued tactical support for System in aiding patients, physicians
- Administration working with HVI leadership to map strategy/reach
DATE: November 5, 2015  LEGAL SERVICE REVIEW? YES___ NO___

SUBJECT: FY 2015 May through August Compliance Report

REQUESTOR & TITLE: Catherine Kahle, VP Legal Services & Corporate Responsibility

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 Compliance Program Board Policy 10.47C requires updates summarizing compliance activities.

SPECIFIC PROPOSED MOTION:
Acceptance of the Compliance Report for period May 2015 – August 2015

This request supports the following Strategic Initiative(s):
______________________________

PROS TO RECOMMENDATION

CONS TO RECOMMENDATION

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

This report highlights the Compliance Department activities for the period May-August 2015. There were no significant compliance issues or concerns that needed to be brought specifically to the attention of the LMHS Board. The compliance activities encompass the seven elements of a compliance program as contained in the guidelines issued by the Department of Health and Human Services, Office of Inspector General.
Compliance Report

Reporting Period: May 1, 2015 – August 31, 2015

1. Compliance Oversight and Management

   Continued Compliance Participation in System Committees including:
   - Case Management/Compliance/Business Operations Meetings
   - System Audit Meetings
   - System Quality Meetings
   - ICD-10 Advisory Meetings
   - Utilization Management Meetings
   - Documentation Quality Improvement Workgroup Meetings

2. Written Compliance Guidance

   Policies and Procedures (Reviewed/Revised)
   - No Updates

3. Compliance Education and Training

   - Initial Compliance training continues to be provided weekly to new employees, quarterly to Lee Physician Group physicians, and twice a month to new physicians and mid-level practitioners on the Medical Staff. Training includes LMHS Standards of Conduct, Compliance Department functions, Fraud, Waste, and Abuse, Incident-to Billing, Split/Shared Billing, Medical Necessity, and the Compliance Hotline.
   - New Annual Compliance training for all LMHS employees is being developed to ensure and sustain our commitment and efforts to prevent, detect, and address Compliance issues.
   - Presentations were given to the Board of Directors, the COG, and LPG Management.
   - The Compliance Team continues to participate in ongoing education for regulatory updates.
4. **Compliance Communication**
   
   - A total of 40 issues came to the Compliance Department during this quarter.
   - The graph below shows the rate for the categories of reported incidents from May 2015 through August 2015 at all four facilities. The top four categories are: Business/Policy and Process Integrity, Inquiry, HR, Diversity, and Workplace Respect, and Privacy & Security.

![Graph showing compliance issues](image)

<table>
<thead>
<tr>
<th><strong>ALLEGATION CLASS - CHART DATA</strong></th>
<th><strong>Frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality of Care &amp; Patient Rights</td>
<td>2</td>
</tr>
<tr>
<td>Privacy &amp; Security</td>
<td>5</td>
</tr>
<tr>
<td>Misuse, Misappropriation of Corporate Assets</td>
<td>2</td>
</tr>
<tr>
<td>Legacy Case – Follow-up</td>
<td>2</td>
</tr>
<tr>
<td>Inquiry</td>
<td>7</td>
</tr>
<tr>
<td>HR, Diversity and Workplace Respect</td>
<td>7</td>
</tr>
<tr>
<td>Environment, Health and Safety</td>
<td>2</td>
</tr>
<tr>
<td>Business/Policy and Process Integrity</td>
<td>9</td>
</tr>
<tr>
<td>Accounting, Auditing and Financial Reporting/Concerns</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>40</strong></td>
</tr>
</tbody>
</table>

All cases have been investigated and resolved. Anticipatory guidance is provided to LMHS departments on a continual basis.
5. **Compliance Enforcement**
   - Excluded Party Search System (EPSS) – The Compliance department oversees the screening of all newly hired employees to be certain they are eligible for participation in Federal health care programs. The screening is performed by our vendor, the Compliance Resource Center with LMHS Compliance oversight. The CRC also performs monthly screenings of employees, physicians, allied health professionals, vendors, contractors, and non-staff physicians to ensure that none were under exclusion by the Federal government.
   - For this reporting period, the CRC screened monthly an average of:
     - New Hires: 292
     - Medical Staff/Allied Health Staff: 1,863
     - Vendors: 4,113
     - Non-Staff Physicians: 4,540
     - Current Employees: 11,771

6. **Compliance Auditing and Monitoring**
   - Three risk areas were assessed during these quarters. Opportunities for improvement were identified in two areas. Educational recommendations were provided to department Directors to facilitate process improvement efforts.
   - Ongoing collaboration with Health Information Management, Central Business Office, Revenue Integrity, Utilization Management, Decision Support, Home Health, HealthPark Care Center, and Lee Professional Billing

7. **Process Improvements**
   - In process of implementing an electronic Conflict of Interest tracking system (see below)

---

**Conflict of Interest**

**Corporate Protection**

- Customized Questionnaires & Attestations
- Comprehensive Reports
- Year-to-Year Response Disclosure Comparison
- In Progress, Not Started, Pending, Review Pending, Approved, Approved w/Conditions and Updated Pending
- Automated Status Tracking
- Automated Processing of No Conflicts to Approved
OLD BUSINESS

A. Policy10.53 C Electronic Tablets (Approve)
DATE: 11/5/15  LEGAL SERVICE REVIEW? YES  X  NO

SUBJECT: Governing Board Policies

REQUESTOR & TITLE: Jessica Carter Peer, Governance Chair

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 Board of Directors reviewed Board Policy 10.53B on 10/22/2015.

SPECIFIC PROPOSED MOTION:

Motion to adopt the recommended action, to revise Board policy Electronic Tablets for Board Members, Board Community Representatives and Physician Leadership council (PLC) Consultants to the Board 10.53C, as presented.

PROS TO RECOMMENDATION
None identified

CONS TO RECOMMENDATION
None identified

LIST AND EXPLAIN ALTERNATIVES CONSIDERED

None

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

None

OPERATIONAL IMPLICATIONS  (including FTEs, facility needs, etc.)

None

SUMMARY

The Board’s Governance Chairman recommends the Board adopt the recommended action as presented, in line with the periodic review cycle.
Once this policy is printed, it is not considered a controlled document.
Please review the most current electronic version of this policy posted at www.leememorial.org/boardofdirectors.

LEE MEMORIAL HEALTH SYSTEM BOARD OF DIRECTORS

POLICY MANUAL

no. 10.53B53C

supersedes no. 10.53B

--------------------------------------------------------------------------------------------------------------------------------------
category: General Operations
title: Electronic Tablets for Board Members, Board Community Consultants & Physician Leadership Council (PLC) Consultants to the Board

--------------------------------------------------------------------------------------------------------------------------------------
original adoption: 9/8/2011 review date: 4/22/1511/5/15
revision date: 3/28/13 10/22/15 11/5/15

--------------------------------------------------------------------------------------------------------------------------------------
PURPOSE:

To provide for the issuance to and use of electronic tablet devices by the Board of Directors, Board Community Consultants & Physician Leadership Council (PLC) Consultants to the Board.

--------------------------------------------------------------------------------------------------------------------------------------
POLICY:

In order to provide the Board of Directors, Board Community Consultants and Physician Leadership Council (PLC) Consultants to the Board (collectively, the “Users”) with cost efficient, timely, thorough, convenient, and updated information for matters related to the Health System, including without limitation, the Board agenda packets, meeting materials, and emails, it is in the best interest of the Health System to issue each Board Member, Board Community Consultant and Physician Leadership Council (PLC) Consultant to the Board an electronic tablet device. The electronic tablet shall be the property of the Health System and is to be used only by the User and primarily for Health System business.

The Users shall be responsible for obtaining all material necessary to prepare for and attend Health System meetings through the electronic tablets or the Health System website. Paper packets will not be available to Users during Health System meetings.

--------------------------------------------------------------------------------------------------------------------------------------
PROCEDURE:

1. Upon User’s execution of the Receipt and Acknowledgement of Responsibility form, the User shall be issued an electronic tablet that will support the required needs for Health System business, identified by serial and model number. The electronic tablet will have at least 16GB of internal storage capacity, Wi-Fi connection capabilities, and cellular connection capabilities. The Health System may shall provide a 2 GB data plan for cellular connection of the electronic tablets (the “Standard Plan”), if not having such a plan causes undue delay in downloading board business. The User shall be responsible for any usage costs or fees that exceed the Standard Plan. The Standard
Plan does not allow for international cellular connections. This is specifically turned off. When out of the country, use the Wi-Fi connection.
2. The electronic tablet shall be password protected and in the event it is lost or stolen, the User must immediately report the same to the Board Office and Help Desk so that the electronic tablet can be disabled remotely. The tablet will not only be disabled (locked via iCloud), a remote wipe (removal of all data on the tablet) will be performed. If the tablet is offline, the data will be erased the next time it’s online.

3. Each User shall use due care to maintain his or her electronic tablet in good condition and protect it from loss or theft. The Health System shall provide each User with a standard electronic tablet cover. If the electronic tablet is lost, stolen or damaged, the User must reimburse the Health System for the full cost of a new/refurbished electronic tablet within thirty days. If the device fails without fault of the User the device will be replaced by the Health System with an equivalent device.

4. The Health System may install applications on the electronic tablets and may require the Users to establish certain accounts to access System information or applications. The Health System may provide technological support and training to the Users with respect to their use of the electronic tablets for System business. The Users are requested to reference the user manual and contact the Board Office with questions regarding the use of the tablet for System business.

5. The electronic tablets are to be used primarily for Health System business. The information and correspondence related to Health System business contained, viewed, sent or received on or through the electronic tablet may be subject to the public records law and the Users should refer to Policy 10.49. The Users may use the electronic tablet for personal use, however, the Users shall use discretion and shall not download applications or view websites that may be inappropriate or in violation of any Health System policy related to computers, electronic tablets or similar technology. Furthermore, the User shall not allow personal use and applications to interfere with or hinder the use of the electronic tablet for official Health System business. The User shall be responsible for any costs incurred by or through the use of the electronic tablet for any application, hardware, software, service plan, data plan, or other options not provided by the Health System in conjunction with Health System business.

6. Given the constant change in technology and the life span of electronic tablet devices, as long as a Director has served a minimum of two consecutive years on the Board, at the end of his or her last term or upon resignation from the Board, the electronic tablet shall become the personal property of the Director. If a Board Member resigns prior to serving two years or is removed from the Board for any reason, the Board Member shall immediately return his/her electronic tablet to the Board Office.

7. Board Community Consultants and Physician Leadership Council (PLC) Consultants to the Board shall return the electronic tablet to the Board Office on or before the last day of his or her final term.
Electronic Tablet
Receipt and Acknowledgement of Responsibility Form

Name of User: ______________________________

Electronic Tablet distributed to:  (check one)

○ Board Member
○ Board Community Consultant
○ Physician Leadership Council (PLC) Consultant to the Board

Name of Equipment: __________________________

Serial Number: ______________________________

Model Number: ______________________________

I (please print) _____________________________ agree to receipt of an electronic tablet on this date __________.

I agree to ALL terms and conditions as stated in Board policy 10.53A.

Signed___________________               Date ____________
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The Users shall be responsible for obtaining all material necessary to prepare for and attend Health System meetings through the electronic tablets or the Health System website. Paper packets will not be available to Users during Health System meetings.

PROCEDURE:

1. Upon User’s execution of the Receipt and Acknowledgement of Responsibility form, the User shall be issued an electronic tablet that will support the required needs for Health System business, identified by serial and model number. The electronic tablet will have a minimum of 16GB of internal storage capacity and Wi-Fi connection capabilities. The Health System may provide a 2 GB data plan for cellular connection of the electronic tablets (the “Standard Plan”), if not having such a plan causes undue delay in downloading board business. The User shall be responsible for any usage costs or fees that exceed the Standard Plan. The Standard Plan does not allow for international cellular connections. This is specifically turned off. When out of the country, use the Wi-Fi connection.
2. The electronic tablet shall be password protected and in the event it is lost or stolen, the User must immediately report the same to the Board Office and Help Desk so that the electronic tablet can be disabled remotely. The tablet will not only be disabled (locked via iCloud), a remote wipe (removal of all data on the tablet) will be performed. If the tablet is offline, the data will be erased the next time it’s online.

3. Each User shall use due care to maintain his or her electronic tablet in good condition and protect it from loss or theft. The Health System shall provide each User with a standard electronic tablet cover. If the electronic tablet is lost, stolen or damaged, the User must reimburse the Health System for the full cost of a new/refurbished electronic tablet within thirty days. If the device fails without fault of the User the device will be replaced by the Health System with an equivalent device.

4. The Health System may install applications on the electronic tablets and may require the Users to establish certain accounts to access System information or applications. The Health System may provide technological support and training to the Users with respect to their use of the electronic tablets for System business. The Users are requested to reference the user manual and contact the Board Office with questions regarding the use of the tablet for System business.

5. The electronic tablets are to be used primarily for Health System business. The information and correspondence related to Health System business contained, viewed, sent or received on or through the electronic tablet may be subject to the public records law and the Users should refer to Policy 10.49. The Users may use the electronic tablet for personal use, however, the Users shall use discretion and shall not download applications or view websites that may be inappropriate or in violation of any Health System policy related to computers, electronic tablets or similar technology. Furthermore, the User shall not allow personal use and applications to interfere with or hinder the use of the electronic tablet for official Health System business. The User shall be responsible for any costs incurred by or through the use of the electronic tablet for any application, hardware, software, service plan, data plan, or other options not provided by the Health System in conjunction with Health System business.

6. Given the constant change in technology and the life span of electronic tablet devices, as long as a Director has served a minimum of two consecutive years on the Board, at the end of his or her last term or upon resignation from the Board, the electronic tablet shall become the personal property of the Director. If a Board Member resigns prior to serving two years or is removed from the Board for any reason, the Board Member shall immediately return his/her electronic tablet to the Board Office.

7. Board Community Consultants and Physician Leadership Council (PLC) Consultants to the Board shall return the electronic tablet to the Board Office on or before the last day of his or her final term.
Electronic Tablet
Receipt and Acknowledgement of Responsibility Form

Name of User: ______________________________

Electronic Tablet distributed to: (check one)

○ Board Member
○ Board Community Consultant
○ Physician Leadership Council (PLC)
  Consultant to the Board

Name of Equipment: _________________________
Serial Number: ______________________________
Model Number: ______________________________

I (please print) ____________________________ agree to receipt of an electronic tablet on this date __________.
I agree to ALL terms and conditions as stated in Board policy 10.53A.

Signed___________________               Date ____________
NEW BUSINESS
LEE MEMORIAL HEALTH SYSTEM
BOARD OF DIRECTORS

BOARD OF DIRECTORS’ REPORTS
DATE OF THE NEXT REGULARLY SCHEDULED MEETING:

FINANCE BOARD & FULL BOARD OF DIRECTORS MEETINGS

Thursday, November 19, 2015 1:00pm

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