Board Informational Report

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As we shared last month this fiscal year is showing for the first time in 3 years lower patient volume in the current fiscal year vs. a prior fiscal year. The causes of this drop in volume year over year are multi-factorial. Only one of these factors is a poor snow fall YTD vs the last 2 fiscal years.

As of my writing of this memo our team has not seen the YTD financial performance beyond October 31, 2017 which was shared with the Board last month. Our team is working very hard with Premier and our new business/accounting software to have a financial update through 12/31/17 by tomorrow 2/16/18 if at all possible. Then our team is targeting catching up two more months to February 28 as of the March Board meeting.

We estimate our Revenues and volumes are below budget by at least 4% YTD, and due to a more unfavorable payor mix this fiscal year YTD, we believe Net Revenues will be more than 4% below budget. Again, we await having actual financial numbers soon.

I have a hypothesis that the growing success of our patient navigation and care coordination programs are delivering on the "value proposition" I've talked about many times. In our region we are striving to reach our goal to improve the health status of our residents and to lower the number of ER visits or IP admits per 1000 population per year for illness matters. There will be future board updates on the tremendous progress of patients being actively managed relative to their healthcare needs in care coordination. This upcoming report will test my shared hypothesis.

Our leadership team is poised and committed to thoughtfully take all actions necessary on the operating and capital aspects of our health system this fiscal year as we make sure we also properly support the quality of patient care we provide which is always our number 1 focus. We will also make sure we are fully supporting our deep and complex investment in a new electronic health record and the two companion business software applications so that these strategic investments operate very quickly in the most optimal manner possible.

Our employees and their important value to our health system are always top of mind and we are currently following through on a long list of employee suggestions made during approximately 18 Town Halls we held in 2017 to narrow the feedback from our employees on the journey to a "second to none" patient care experience or "perfect patient care experience" as it's been called here for many years by giving our staff the opportunity narrow more than 100 suggestions to what are their top 2 or 3 improvement actions we can take to make further improvements in our patient care experience. These findings will be concluded in a few days.

Further on the topic of the importance of our employees, we have scheduled several more employee focus group meetings to look for other areas for improvement in the unselfish team care we provide as we continue to act on summary feedback from a prior Press Ganey employee survey.

Looking to our Physician critical strategy, we are gearing up for the 3rd floor of our medical office building remodel and the buildout of the second floor of the cancer center to commence near the end of this fiscal year! This investment of increased space and remodel of space for serving many more patients is critical for our long term health and to lower the number of days it takes for patients to be seen by many physicians here in our health system.

We have been actively engaging with other healthcare systems in our region, visiting Quincy earlier and also having recent discussions with physician leadership at Renown as we explore additional and new ways we can attempt to be more timely and effective on physician recruitment, exploring some new collaborative methods, versus each health system working in a silo for “one off” physician recruitment. This new strategy would be in addition to the many recruiting firms we have been using to find quality physicians we need to fill specialty gaps here.

Also looking at our Physician critical strategy, continuing to move forward on our Rural Health Clinic (RHC) strategy is of the highest importance to our health system. For the February Board meeting, we are bringing forward staff requests for Board support by resolution for two additional RHC sites within our health system. It is my experienced view that the RHC strategy is the most important strategy for our health system relative to anything we do to improve physician services and patient access here in the health system. When this strategy is fully operationalized, we will have at least 4 Rural Health Clinics in our health system.

Five of our team members including myself visited Adventist Health in the Central CA region of Kings County, two weeks ago, to really observe and learn first-hand what they have learned over more than 20 years of greatly improving healthcare access via rural health clinics. Back in 2004 they had 4 rural health clinics and today they have 36 rural health clinics that provide over 500,000 visits per year just in this local region. Over a wider region of CA they have more than 100 rural health clinics providing over 1,000,000 patient access visits per year. It’s clear that patients value the access to great healthcare these clinics provide.

Strategically as we continue to improve the quality and the transparency of the care we provide the very important educational update at the Board meeting this month on the BETA H.E.A.R.T program is a tremendous improvement for our team as we deal in an improved manner with unexpected outcomes in healthcare.

Also every three years we perform a Community Needs Assessment. This important topic will likely require a lot more time than some initial comments at this month’s Board meeting. We all look forward to learn from this assessment and to also review our past goals and the work of our team from the previous Community Needs Assessment.

From a new federal and state policy suggestion perspective, especially reflecting on the growing shortage of physicians in America, I will recommend that new federal or state policies allow full normal reimbursement for telemedicine physicians or telemedicine mid-levels to treat, see and examine patients who are visiting in a clinic or physician office setting. The core goal

here is that this care setting is a reimbursed visit by Medicare, Medicaid and other insurance companies in the same fair way as if the physician was physically there. This policy change would need to apply to rural health clinics as well. To maintain timely access to healthcare in many rural communities this new type of federal and state policy is critical. If approved, it would allow many patients to stay in their own communities for specialty or primary care vs. driving hundreds of miles to large urban settings for evaluation and management of medical conditions. Kaiser and other managed care health systems already have this right or privilege to use telemedicine in a long list of creative ways.