Missouri Quality Award Application Summary

Golden Valley Memorial HEALTHCARE

1600 North Second, Clinton, MO 64735 Telephone Number (660) 885-5511

Table of Contents

Glossary of Terms and Abbreviations

AA	Assistant Administrator
ADA	American Diabetes Association
Adj	Adjusted
AHA	American Hospital Association
AIDET	Acknowledge, Introduce, Duration, Explanation and Thank You
AIDS	Acquired Immune Deficiency Syndrome
AMI	Acute Myocardial Infarction
AONE	American Organization of Nurse Executives
AP	Action Plan
APS	Associated Purchasing Service
AR	Accounts Receivable
ASHHRA	American Society of Healthcare Human Resources Associations
AT	Administrative Team
BC	Birthing Center
BKD	Fiscal advisory firm
Board	Board of Directors
BOE	Behaviors of Excellence
BRHC	Bothwell Regional Health Care
BSC	Balanced Score Card
BSN	Bachelor of Science in Nursing
C	Community
CC	Compliance Committee
CAP	College of American Pathologists
CAUTI	Catheter Associated Urinary Tract Infection
CBL	Computer-based Learning
CCD	Community of Care Document
CCO	Chief Compliance Officer
CDIFF	Clostridium difficile
CDSWS	Care Delivery Support Work System
CEO	Chief Executive Officer
CFO	Chief Financial Officer
CHART	Community Health Assistance Resource Team
CHF	Congestive Heart Failure
CLIA	Clinical Laboratory Improvement Act
CME	Continuing Medical Education
CMP	Complaint Management Process
CMS	Centers for Medicare and Medicaid Services
CNA	Certified Nurse Assistant
COPD	Chronic Obstructive Pulmonary Disease

CPA	Certified Public Accountant
CPOE	Computerized Physician Order Entry
CPR	Cardio Pulmonary Resuscitation
CQI	Continuous Quality Improvement
CRNA	Certified Registered Nurse Anesthetists
CSF	Critical Success Factor
CSS	Customer Service Standards
CT	Computed Tomography
CUSP	Comprehensive Unit Based Safety Program
DCOH	Days Cash on Hand
DO	Doctor of Osteopathy
DoH	Department of Health (State of MO)
E/P	Employer/Payer
EA	Environmental Assessment
EBIDA	Earnings Before Interest Depreciation and Amortization
ED	Emergency Department
EDU	Education Department
EDI	Electronic Orders
EFC	Exceptional Friendly Compassionate
EHR	Electronic Health Record
EIB	Employee Incentive Bonus
ELI	Engage, Listen, and Inform
EMR	Electronic Medical Record
EMRAM	Electronic Medical Record Adoption Model
EMS	Emergency Medical Services
EOC	Environment of Care
EP	Emergency Patient
EPA	Environmental Protection Agency
EPS	Employee Perspective Survey
ER	Emergency Room
ESS	HealthStream Employee Satisfaction Survey
FAP	Financial Assistance Program
FTE	Full Time Employee
GHX	Global Healthcare Exchange
GPO	Group Purchasing Organizations
GPS	Golden Path to Success
GSE	Golden Standard of Excellence
GVMH	Golden Valley Memorial Healthcare
H&P	History and Physical
HAI	Healthcare Acquired Infections

HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HFAP	Health Facility Accreditation Program
HHP	Home Health Patient
HIDI	Hospital Industry Data Institute
HIMSS	Healthcare Information and Management Systems Society
HIPAA	Health Insurance Portability and Accountability Act
HP	High Performance
HPPD	Hours per Patient Day
HR	Human Resources
HS	House Supervisor
ICD	Interdisciplinary Care Delivery
ICDWS	Interdisciplinary Care Delivery Work System
ICT	Interdisciplinary Care Team
ICU	Intensive Care Unit
ID	Identification
IP	Inpatient
IRT	Intelligent Risk Taking
IS	Information System
IT	Information Technology
KAs	Key Actions
KMP	Knowledge Management Process
LDI	Leadership Development Institute
LEM	Leadership Evaluation Manager
LC	Leadership Council
LPN	Licensed Practical Nurse
LT Debt	Long Term Debt
MAHC	Missouri Alliance for Home Care
MCDP	Multi-disciplinary Care Delivery Process
MCT	Multi-disciplinary Care Team
MD	Medical Doctor
MHA	Missouri Hospital Association
MHCIS	Meditech Health Information System
MMM	Monthly Meeting Model
MQA	Missouri Quality Award
MQC	My Quality Commitment
MR	Medical Record
MRI	Magnetic Resonance Imaging
MRS	Medical Revenue Solutions
MSEC	Medical Staff Executive Committee

MSS	Mid-America Service Solutions
MT	Management Team
MVV	Mission, Vision, and Values
NA	Nursing Assistant
NEO	New Employee Orientation
NHSN	National Healthcare Safety Network
NVHA	Novation
OIMA	Organization, Industry, and Market Analysis
OP	Outpatient
ORYX	Set of performance measures
OSHA	Occupational Safety and Health Administration
OSWS	Operations Support Work System
PA	Patient Advocate
PACS	Picture Archival Computer System
PAP	Performance Appraisal Process
PCF	Patients other customers and healthcare
PCM	Patient Call Manager
PCP	Physician's Clinic Patient
PDCA	Plan-Do-Check-Act
PEP	Performance Evaluation Process
PET Scan	Positron Emission Tomography
PHO	Paid Hours Off
PI	Performance Improvement
Pillars	Pillars of Excellence
POC	Plan Of Care
PR	Public Relations
PSA	Primary Service Area
PWC	Price Waterhouse Cooper
QC	Quality Council
QI	Quality Improvement
QM	Quality Management
QSR	Quarterly Status Report
QST	Quality Steering Team
RCT	Rapid Cycle Team
RN	Registered Nurse
ROI	Return On Investment
RVUs	Relative Value Units
SAC	Staff Advisory Committee
SAN	Storage Area Network
SAT	Systems Access Team

SCIP	Surgical Care Improvement Process
SEP	Service Excellence Program
SET	Service Excellence Team
SLHHN	St. Luke's Hospital and Health Network
SMART	Specific, Measurable ,Attainable, Realistic, Timely
SOs	Strategic Objectives
SOC	Standards of Conduct
SPP	Strategic Planning Process
SPT	Strategic Planning Team
SRP	Service Recovery Process
SSA	Secondary Service Area
SSI	Surgical Site Infection
STAR	Suggestions That Achieve Results
STEPS	Strides Taken Everyday Produce Success-employee wellness program
SWOT	Strengths, Weaknesses, Opportunities, Threats
TCP-IP	Transmission Control Protocol-Information Protocol
TJC	The Joint Commission
TSS	Technology Strategy Support
TYYO	Take You and Your Organization to the Next Level
VAP	Ventilator Associated Pneumonia
VHA	A national purchasing alliance
VOC	Voice Of the Customer
WE	Workforce Engagement
WMMC	Western Missouri Medical Center

Preface: Organizational Profile

P.1 Organizational Description

Golden Valley Memorial Healthcare (GVMH) is a not-for-profit healthcare delivery organization consisting of an 84 bed hospital, a home health service, and physician and outpatient clinics located in west central Missouri. State law provides for the formation of public hospital districts across Missouri and GVMH fills that role, therefore, it is a political subdivision of the State of Missouri. Located in Clinton, with physician and outpatient clinics in Warsaw and Windsor, we are a rural and sole community provider and are licensed and accredited as an acute care inpatient, outpatient, home health, and physician clinics facility.

P.1a Organizational Environment

(1) Service Offerings - We provide a wide range of primary health care services, including medical/surgical care; urgent/intensive care; cardiology care; orthopedic care; maternal care; home care services; outpatient services; physician clinics**;** ambulance services; and emergency services. We also provide a wide variety of ancillary and support services including diagnostic services such as CT scan, MRI, nuclear imaging, laboratory, PET scan, ultrasound, radiology, digital mammography, and stereotactic breast biopsy; and specialty services including oncology, pulmonary, urology, cardiology, pain and wound clinics. Our comprehensive health care services also include a pharmacy, nutritional services, diabetes management, and a broad range of educational programs for the hospital staff and the community.

The GVMH model for delivering our patient and family-centered care is a formal **Interdisciplinary Care Delivery Work System (ICDWS),** which is applied in inpatient, outpatient, emergency room, home health, and physician clinic settings. Key ICDWS processes are Scheduling, Admission, Assessment, Planning, Intervention, Discharge, and Follow-up. The ICDWS is used for all patients and produces a plan of care to achieve the best possible clinical outcomes and high patient satisfaction, both of which are driven by the patient requirements shown in Figure OP-4.

GVMH's health care delivery is characterized by strong collaboration among care providers and customization of the plan of care to the individual needs of patients and families. **Interdisciplinary Care Teams (ICTs)** carry out the delivery of health care. These teams typically include the physician, nursing staff, social worker, pharmacists, and representatives from other disciplines required to address the plan of care requirements. ICTs individualize care for each patient by customizing the plan for care and involving the patient and family in the planning process. In this way, patient and family input is obtained, expectations can be shared, and all requirements and preferences may be incorporated into the care plan.

(2) Vision and Mission – Our objective is to achieve our **Golden Standard of Excellence (GSE)**, which we define as the provision of America's finest quality healthcare – exceptional, friendly and compassionate (EFC), and is measured by achievement of at least top quartile performance in comparative data bases. This standard is evident in our **Guiding Principles** - the Vision, Mission, and Value statements, as well as our Core Competencies, shown in Figure OP-1.

MISSION
To provide exceptional health and wellness services with friendliness and compassion.
VISION
To make a positive difference in the health and wellness of each life we touch
VALUES
Quality – GVMH is committed to providing exceptional care and services.
Professionalism – GVMH is a learning organization that maintains a competent, qualified and progressive staff.
Accountability – GVMH respects its responsibility to the community and the cost effective utilization of resources and financial soundness.
Compassion – GVMH is a caring organization, valuing human dignity and quality of life.
Excellence – GVMH is committed to providing an exceptional health care experience.
CORE COMPETENCIES
1-Scope of services and physicians
2-Exceptional, Friendly and Compassionate Service Delivery
3-Technologically Advanced

Figure OP-1 GVMH Guiding Principles

(3) Workforce Profile – A culture of engagement and continuous improvement is the foundation for achievement of the GSE. The workforce understands our standard and the Guiding Principles and carries out their responsibilities accordingly. Our 679 person workforce is segmented into four categories and is comprised of 31 physician providers, 212 nursing staff, 341 management, technical, and administrative staff, and 95 volunteers. Figure OP-2 summarizes our workforce profile - we have no collective bargaining units.

The key elements that are integral to promoting the high level of workforce engagement are shown in Figure OP-3. To produce this understanding and to ensure alignment between organizational and individual objectives, leadership has deployed a **My Quality Commitment (MQC)** process. MQC includes a card that each employee carries listing the mission, vision, values, corporate compliance responsibilities, Pillars of Excellence, Strategic Objectives, department goals, and personal goals for each individual employee. MQC provides all employees a quick and ready reference to the Guiding Principles and line of sight for each employee from their individual responsibilities and goals up to the organization's objectives and goals.

Staff Profile	
Gender	Female: 80.7%; Male: 19.3%
Position	Professional/Paraprofessional = 49.0%; Technical = 14.0%; Service/Support = 32.1%; Management = 4.9%
Tenure	<5 = 43.2%; 5-9 = 27.7%; 10-14 = 6.2%; 15-19 = 7.7; 20+ = 15.2 %
Employment Status	Full Time = 76.0%; Part Time = 24%
Shift	Day = 76.9%; Evening =7.4%; Night = 10.3%; Rotating = 5.4%
Ethnicity	Caucasian = 96.1%; Afro-American = 1.9%; Hispanic = .7%; Other = 1.3%

Figure OP-2 Workforce Profile

Segment	Engagement Elements
Staff	Teamwork and cooperation
	Trust and involvement
	Respect and fairness
	Feedback and accountability
Physicians	Quality patient care
	Staff skill and positive attitude
	Responsiveness to issues or requests
	Support from administration
Volunteers	Useful work that makes a difference
	Feeling of ownership
	Respect
	Effective communication

Figure OP-3 Key Workforce Engagement Elements

(4) Assets – GVMH's physical facilities include the hospital, a physician clinic, a home health building, an outpatient rehabilitation center, and an aquatic wellness center in Clinton, and outpatient and physician clinics and rehabilitation facilities in Windsor and Warsaw. The organization's physical plant and equipment are modernized, with major construction and renovation projects completed over the past several years. These projects included new inpatient and outpatient surgery areas, a new laboratory, birthing center, and specialty clinic and special procedures area, as well as changes and improvements to respiratory therapy, social services, nursing administration, nuclear medicine, ultrasound, and dietary storage. A later addition provided for an in house MRI service; a 3600 square foot centrally located Outpatient Treatment Center to better meet the needs of patients and to bundle services; clinics in Warsaw and Windsor; and a 60,000 square foot extension to the hospital to house the main physician clinic, a facility which also includes leased space to partners providing patient support services. Then, after just one year of operation, we added space to the Warsaw facility due to the significant demand for service. Finally, corridors and public areas throughout the hospital were completely renovated in 2012.

(5) Regulatory Requirements - Health care is a highly regulated industry focusing on patient and employee safety and business process compliance. GVMH is licensed by the State of Missouri and is subject to numerous state agency regulations dealing with hospital and staff licensure. On the federal level, we are subject to regulations of the Centers for Medicare and Medicaid Services (CMS), Occupational Safety and Health Administration (OSHA), Environmental Protection Agency (EPA), and Centers for Disease Control and Prevention. We are accredited by The Joint Commission (TJC) hospital accreditation process, the Clinical Laboratory Improvement Act (CLIA) accreditation process, the Nuclear Regulatory Commission accreditation process, and the College of American Pathologists (CAP) accreditation process. In addition, the U.S. Department of Health and Human Services has developed regulations on patient confidentiality under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that requires compliance. The hospital has also been designated as a Rural Referral Center and the physician clinics as Rural Health Clinics, which positively impacts reimbursements.

P.1b Organizational Relationships

(1) Organizational Structure - GVMH's organizational structure and leadership system promote leadership accountability, collaboration in executing the mission, decision making at the point of service, a focus on the future, and high performance. The system is comprised of a Board of Directors (Board), the Administrative Team (AT), the Medical Staff Executive Committee (MSEC), and a number of other leadership teams all of which are fully integrated and function in a collaborative manner to lead and govern the organization.

The **Board** is a six-member group that provides governance oversight. Members are elected by the citizens of the district, with each serving a six year term and one new member elected each year. It has taxing authority and assures management and fiscal accountability for the organization's actions through meetings and representation on various committees.

The **AT** consists of the CEO, Assistant Administrator/Patient Care Services, Assistant Administrator/Professional Services, Chief Financial Officer, Director of Human Resources, and the Administrator - Physician Clinics. The AT meets weekly and is focused on hospital performance, policy, and improvement priorities.

The **MSEC** is the leadership team of the Medical Staff and is comprised of the Medical Staff Officers, Service Chiefs, the CEO, and the Assistant Administrator/Patient Care Services. It meets monthly to address health care service issues and outcomes, as well as key hospital administrative and operational matters.

The **Leadership Council (LC)** is comprised of the CEO, Administrator - Physician Clinics, and six employed physician leaders. It meets monthly to address physician clinics issues and ensure full integration of the medical staff and administration.

Management Team (MT) is made up of the AT plus all Department Directors. It meets monthly to review progress to

plan, performance improvement initiatives, hospital performance, and also provides for two-way communications between senior leaders and directors.

(2) Patients, Other Customers and Stakeholders - In addition to Clinton, GVMH provides services to all of Henry County and seven surrounding counties. The Primary Service Area (PSA) is within a 25 mile radius of the hospital, and the Secondary Service Area (SSA) is within an additional 25 mile radius. The market area is segmented geographically. Patients are our key customers, with the Community and Employers/Payers categorized as other customers. Key patient segments for data collection and service provision purposes are based on the point of care and are listed in Figure OP-4, which also identifies key customer requirements. The key requirements do not vary across segments.

Customer Groups	Key Requirements
Patients	
• Inpatients • Outpatients • Emergency patients • Home health patients • Physician clinics patients	• EFC Care • Safety • Easy Access • Prompt Service
Other Customers	
Community	• Service Availability • Fair Cost • Technology
Employers/Payers	• Fair Cost • Accuracy • Timely Response

Figure OP-4 Customer Groups and Requirements

(3) Suppliers and Partners - Partners, collaborators, and suppliers are important to GVMH for four reasons. First, partners are often directly involved in the delivery of services to patients and stakeholders; second, our people devote substantial time and effort working with partners and collaborators to achieve short- or long-term objectives; third, the products and services that we procure can directly impact the quality of care we provide and how effective we are in delivering that care; and fourth, non-labor expenses represent a significant component of our costs. For these reasons, we have established a number of partnerships and collaborative relationships, and identified key suppliers of vital products and services.

Partners – those organizations or individuals that we have a strategic alliance with and have a direct role in patient care or health care delivery services and for which there are reciprocating relationships, or dual requirements.

Collaborators –organizations that we work with to achieve short- or long-term objectives or support initiatives that benefit stakeholder or community groups.

Key Suppliers – group purchasing organizations through whom we purchase supplies or manufacturers we purchase substantial amounts from directly when group purchasing opportunities are not available.

P/C/S	Role	Requirements
Partners		
Referring Physicians	• Provide patients • Deliver Care • Improve and innovate • Manage information	• Admissions • EFC Care • Patient satisfaction • Accurate, timely information
Lifeflight Eagle	• Provide Air Ambulance	• Competency • Communication
CHART	• Community health needs and delivery	• Collaboration • Health and Wellness Programs
Collaborators		
Henry County Health Department	Disease prep	• Competency • Communication • Cooperation
	Volunteer coordination	
	Vaccines	
	Medication distribution	
City of Clinton	Emergency planning and response	
Key Suppliers		
MSS, APS NVHA	Med/surgical supplies	• Product/Service Quality • Timely Delivery • Fill Rate • Billing Accuracy • Stockouts
Owens & Minor	MSS/NVHA Distribution	
AB	Medications	
SYSCO US Foods	Dietary items, food, equipment	
Hospira	IV therapies	

Figure OP-5 Partners, Collaborators and Key Suppliers

Figure OP5 identifies GVMH partners, collaborators, and key suppliers and our key supply chain requirements. Partners, particularly referring physicians, are integrated into many of GVMH's key processes, including strategic planning, support processes, CQI teams, and organizational improvement and innovation efforts. Collaborators and key suppliers are integrated into the GVMH strategic planning process and various improvement and innovation initiatives.

P.2 Organizational Situation

P.2a Competitive Environment

(1) Competitive Position - The PSA includes Henry County, and portions of several surrounding counties that include Benton, St. Clair, Johnson, Cass, and Bates. The population of the PSA is approximately 30,000 people. Approximately 80% of all hospital discharges are patients who reside within

the PSA. The SSA extends further into the surrounding counties as well as portions of Pettis and Hickory Counties. The population of the SSA is also approximately 30,000 people. We provide the only acute care hospital within a 25-mile radius of Clinton, and enjoy the highest market share in the PSA. There are two other hospitals whose market areas overlap with ours and are direct competitors. These include **Western Missouri Medical Center (WMMC)** in Warrensburg and **Bothwell Regional Health Center (BRHC)** in Sedalia.

(2) Competitive Changes - All three of these competing hospitals are in rural markets and do not provide a full range of healthcare services. As a result, market share is negatively impacted by the lack of specific services that are made available, particularly tertiary care services, which are provided primarily by Kansas City area hospitals. In addition, healthcare services formerly provided in inpatient settings are now frequently provided in outpatient settings, thereby having an additional negative impact on inpatient market share. Since a greater share of inpatient requirements is being met by Kansas City area hospitals, we are focusing on outpatient services and are adding services that are needed in the PSA but not currently provided.

(3) Comparative Data - Although **w**e have made a significant effort to identify relevant comparative data sources and collection methods within the health care industry, sharing results between institutions within the industry as a whole is very limited. Limitations also include a data lag of up to two years, data which are often not severity adjusted, data which frequently do not reflect rural hospitals like GVMH, and data reports only for norms or top 25% performance. However, we recognize the importance of comparative data in achieving our GSE and strive to find and use the best comparisons possible. Those we use are listed in Figure OP-6.

Data Type	Source of Data
Patient Satisfaction	HealthStream HCAPHS, MAHC,
Health Care Delivery	CMS, ORYX, OASIS, MHA, HIDI, NHSN, CDC
Financial Performance	HIDI, BKD, NVHA
Workforce Performance	PWC/Saratoga
IT Performance	HIMSS

Figure OP6 Comparative Data Sources

P.2b Strategic Context

We have identified a number of strategic challenges and advantages that are shown in Figure OP-7.

Strategic Advantages
1 - Favorable location.
2 - Primary care base.
3 - Strong staff and variety of service offerings.
4 - Outlying and specialty clinics providing additional access to care.
5 - Strong balance sheet permitting us to take advantage of opportunities.
6 - Advanced medical technology.
7 - Highly collaborative medical community.
Strategic Challenges
1 - Establishing effective strategies related to the implementation of health care reform and changes in reimbursement methodologies. .
2 - Generating growth in market share and volumes; reducing referrals away from GVMH; and preventing competitor thrusts into the GVMH market area.
3 - Ability to continue to recruit physicians in key specialties to provide enhanced services to the market area: Full-time Hospitalists; Internal Medicine; Pediatrics.
4 - Improving emergency department services so patient satisfaction is consistently at a high level.
5 - Providing greater ease of access from Warsaw to Clinton and creating the realization that access is easier than people might think
6 - Overcoming space limitations which prevent expansion of services.
7 - Developing a primary care presence in Osceola and other surrounding communities.

Figure OP-7 Strategic Advantages and Challenges

P.2c Performance Improvement System

A focus on performance excellence and organizational learning is embedded in the GVMH culture and is reinforced through a series of processes designed to help us achieve the Golden Standard of Excellence. The **Golden Path to Success (GPS),** shown in Figure OP-8, is our leadership and performance improvement approach that maintains a widespread focus on improvement and innovation by integrating the **Strategic Planning Process (SPP)** with the **Balanced Scorecard (BSC)**, **Leader Evaluation Manager (LEM),** and **My Quality Commitment (MQC)** processes to communicate and align Strategic Objectives (SOs), Key Actions (KAs), Measures and Goals across the organization and to link them to department and individual actions and performance goals.

The SPP develops SOs and KAs in each of our five **Pillars of Excellence (Pillars)**: **People; Service; Quality; Financial; and Growth**. The **Balanced Scorecard (BSC)** process identifies the measures and goals that align with the SOs and KAs and allows for tracking performance at the organizational level. The **Leader Evaluation Manager (LEM)** process serves to identify measures and goals that are aligned with the SOs, KAs, and BSC measures at the department level and provides for monitoring performance and gauging progress toward implementation of plans achievement of goals. The MQC process identifies commitments on the part of the workforce to achieve goals relative to their job responsibilities that align with the department plans and goals.

The GPS approach includes reviews of performance at the organizational level, the department level, the key process level, and the individual level. Performance at the organization as a whole is monitored through **Quarterly Status Report (QSR)** reviews of BSC performance and status of the KAs. Performance at the department level is monitored through LEM reviews that are held monthly through the **Monthly Meeting Model (MMM)** process. In this process, each member of the AT and all department managers report progress against their LEM goals and key actions in meetings with their reporting official. Likewise, department managers work with their individual staff members to track progress on their actions and goals informally throughout the year and formally on an annual basis as part of the **Performance Appraisal Process (PAP)**.

At the process level, a continuous quality improvement culture has been created to focus on process design, management, improvement, and innovation. Process measures are established and reviewed to ensure that process performance is stable and to identify when process improvements are needed, and innovation initiatives are encouraged. The **CQI Model** is used to guide the workforce in these efforts.

GVMH has also adopted the MQA Criteria for Performance Excellence and assessment methodology as its business model and undergoes an MQA-based assessment annually. This permits an overall evaluation of the approaches used to lead and manage organizational activities and provides feedback that is integrated into the SPP so improvement actions can be developed to positively impact the entire organization. Innovation processes include risk-taking, applying best practices, benchmarking high performing organizations, and the quest for high performance across the Pillars.

This approach focuses GVMH on performance improvement and innovation continuously over the course of the year. On a daily basis, CQI efforts allow process owners and department managers to understand performance of their processes and design improvements and innovations as needed and as opportunities arise. Monthly reviews using LEM updates and financial and quality reports, and quarterly reviews using the BSC permit a focus on broader performance requirements. On an annual basis, the MQA assessments, the SPP, and the MQC/PAP allow an emphasis on longer-term requirements needed to sustain and enhance GVMH's level of excellence and individual performance improvement.

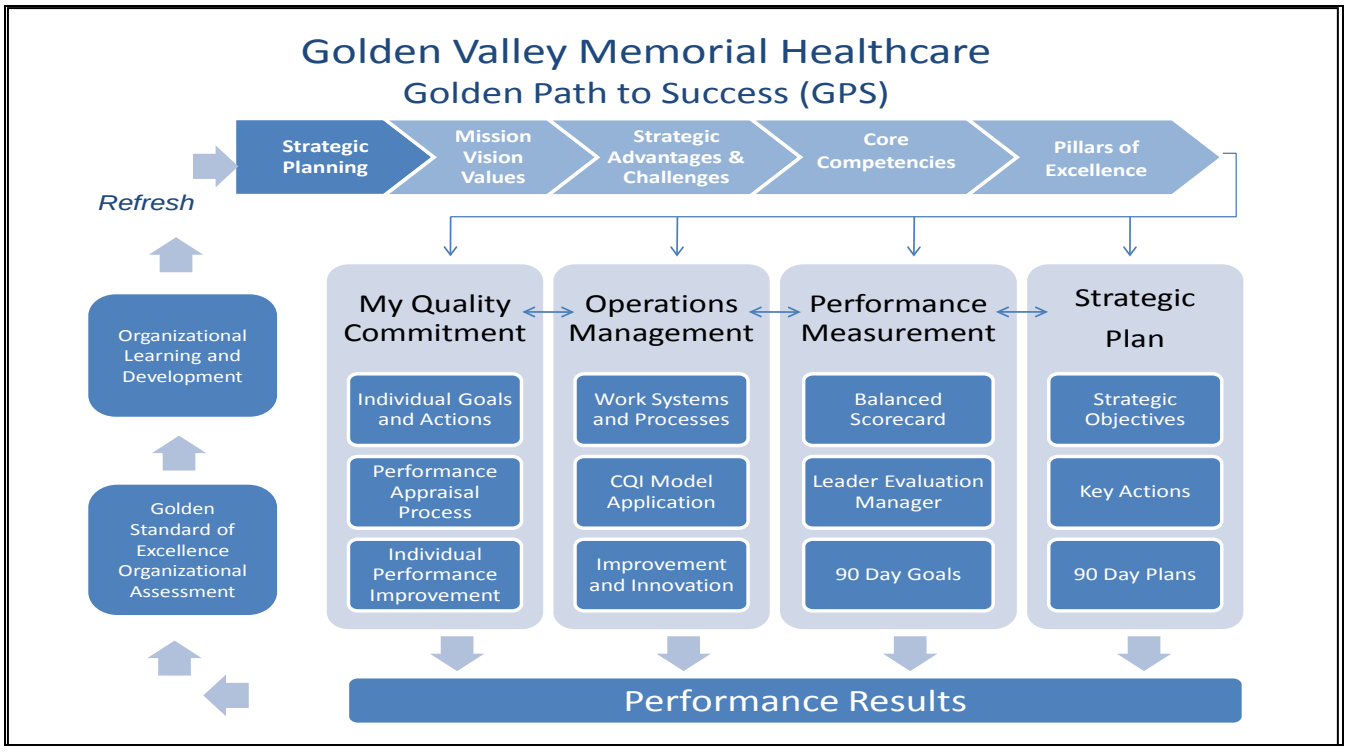


Figure OP-8 Golden Path to Success (GPS)

Category 1 Leadership

1.1 Senior Leadership

1.1a Vision, Values and Mission

(1) Vision and Values - Senior leaders set the organization's Mission, Vision, and Values (MVV) during the analysis step of the SPP. Each fall the Strategic Planning Team (SPT), comprised of the AT, representatives of the MSEC, the physician staff and the Board meet to develop the strategic plan and review the MVV. While these Guiding Principles tend to endure over time they are reviewed at least annually and are adjusted as needed based on changing priorities. During the 2010 strategy development retreat, for example, the mission statement was revised to place greater focus on friendly and compassionate care which had been determined to be drivers of patient engagement.

The **Golden Path to Success (GPS)**, Figure OP-8, is our leadership approach and forms the basis for deployment of the MVV to all leaders, the workforce, partners, key suppliers and customers through the variety of avenues depicted. The Board and the AT review the mission and vision statements each month during Board meetings and the MVV are prominently displayed in our main entrance area as well as in the Patient Information Guide booklets provided to patients. All leaders and staff, including Board Members, Physicians, and Administrators, are introduced to the MVV in orientation.

Leadership instituted the **My Quality Commitment (MQC)** approach and integrated the MVV into the **Performance Appraisal Process (PAP)** to ensure full deployment of these important principles. In this process, each employee is rated annually in seven different areas, one of which is MVV. Employees are scored in relation to their ability to carry out the mission, the extent to which they live the values, and how well they strive to achieve the vision. In this way, the MVV are constantly reinforced and the workforce is mentored on how to improve their performance in these critical areas on a regular basis. We reinforce the MVV by displaying these statements on all meeting agendas and including them on the *GVMH Insider*, and members and patients who participate on teams are introduced to these statements during their orientation to the team activity. Partners, collaborators and key suppliers are introduced to these statements during meetings with staff, and all stakeholders are exposed to the MVV in various publications and communications venues.

To demonstrate their personal commitment to the organization's values and provide further support for the formal deployment tools, senior leaders model the values in their interactions with the workforce, patients, the community, partners, collaborators and suppliers by publicly recognizing employees for their outstanding work (quality and professionalism), sharing of performance information (accountability), and personally pursing the **Golden Standard of Excellence (GSE)** in all that they do (compassion and excellence). To help the workforce understand what the values mean, senior leaders have translated the values into operating priorities. Further, leaders are evaluated on their performance in the same manner as all other staff, which includes the degree to which they live the values. Figure 1.1-2 highlights all methods used to deploy the MVV.

(2) Promoting Legal and Ethical Behavior – Senior leaders demonstrate their commitment to legal and ethical behavior by doing what's right at all times and by personally promoting an environment that fosters, requires, and results in legal and ethical behavior. Methods include **Standards of Conduct (SOC)**; compliance and ethics training; annual assessment as part of the PAP; and open lines of communication for asking questions and sharing concerns. Senior leaders sign, support, model and enforce the SOC, which is our formal policy that outlines requirements and expectations for compliance and ethical behavior, identifies reporting methods, and establishes consequences for failure to meet the standards. Senior leaders invite and encourage frank, two-way communications with all stakeholders through the **Engage, Listen, and Inform (ELI)** system, and have established methods for stakeholders to pass a question, concern, or suspected breach of ethical behavior to senior leaders or our Chief Compliance Officer (CCO), such as our toll-free confidential and anonymous Help Line.

The Board appointed the CCO to ensure that a strong focus is established in this area. In addition, a Compliance Committee (CC) is in place which evaluates the effectiveness of the program and develops a Compliance Plan to put necessary improvements in place to ensure that it is as effective as possible. The CCO ensures that expectations are clear to the workforce, partners, volunteers, suppliers, collaborators, patients and the community, and that the standards are up to date with all legal requirements. The workforce is trained on ethical behavior and compliance during orientation and is provided annual updates to reinforce the standards and maintain competency. "Just in time" training is provided whenever policy or regulatory changes are made. In addition to the SOC, training includes confidentiality, patient rights, and safeguarding the privacy of protected health information. Strict guidelines and policies are in place and procedures are established for dealing with inappropriate behavior. Finally, the workforce is evaluated on their ethical behavior and adherence to the SOC annually as part of the PAP.

(3) Creating a Sustainable Organization - Senior leaders have created an environment for achievement of the mission, improvement of organizational performance, performance leadership, and organizational and personal learning through development and deployment of the GPS. All components of the GPS are focused on mission achievement, particularly the **Pillars of Excellence (Pillars)**, **Strategic Plan**, **Balanced Scorecard (BSC)**, **Leader Evaluation Manager (LEM)**; and the **Individual Goals and Actions**. Similarly, the GPS fosters organizational performance improvement through

development of **Strategic Objectives (SOs)** and **Key Actions (KAs)**, **90 Day Plans and Goals**, **Process Improvement and Innovation**, and **Individual Performance Improvement** activities. Performance leadership is addressed as a result of the **GSE Organizational Assessment**, which includes comparisons to competitors and benchmarks, while organizational and personal learning occur through the BSC and LEM processes, Operations Management activities, MQC process, and the GSE Organizational Assessment, all of which produce Learning and Organizational Development outcomes. To reinforce the need for organizational improvement and successful mission accomplishment, leadership also instituted the **Employee Incentive Bonus (EIB)**. The EIB provides for a bonus payment to all staff if patient satisfaction and financial goals are met. Further, retirement plan contributions increase if organizational performance reaches certain thresholds.

Senior leaders create an environment for innovation and intelligent risk taking, achievement of SOs, and organizational agility by promoting empowerment throughout the organization, providing timely information, and maintaining an organizational structure that is conducive to efficient decision-making at the point of greatest impact. Senior leaders have created an environment that embraces change and all staff are empowered and encouraged to generate improvements and innovations within a structured environment where implementation is authorized when other components of the organization are unaffected. If the impact is more widespread, proposals are brought to the **Quality Steering Team (QST)** for intelligent risk assessment and decision. Similarly, senior leaders have empowered managers to identify goals at the department level to address the SOs and organization-wide KAs. Senior leaders and managers break down annual goals into 90-day goals and action plans to achieve them, and use the **Monthly Meeting Model (MMM)** to evaluate progress and make adjustments where needed. This promotes organizational agility by providing the opportunity for modification on a frequent and scheduled basis.

Senior leaders have also created a workforce culture that promotes a positive experience for patients and stakeholders and fosters strong engagement. Our Guiding Principles focus on quality care and an exceptional health care experience, Service is a Pillar of Excellence and is emphasized to the workforce through the GPS, and the SOs and BSC/LEM measures focus on satisfaction and quality care. Patient satisfaction is a key component of the EIB, and satisfaction data are posted every day throughout the organization. *GVMH in Action* always has an article included about the extraordinary effort we are making to serve patients and customer comments are posted on the intranet each day identifying positive experiences that customers have had with our people. Additionally, senior leaders engaged with the Studer Group in 2011 to build an even stronger focus on patients and stakeholders with such initiatives as AIDET, Patient Call Manager, and Leader Rounding being implemented or enhanced.

	Employees	Volunteers	Physicians	Partners	Suppliers	Collaborator	Patients/
Orientation	*	*	*	*	*		*
Job/Service Description	*	*					
SOC	*	*	*		*		
SPT	*	*	*			*	*
GPS	*	*	*	*	*	*	*
Core Competencies	*		*				
MQC Card	*	*					
BSC/LEM	*	*	*	*	*	*	*
PAP Reviews	*						
Performance Reviews	*	*	*				
Capsulized News	*	*	*				
Meeting Agendas	*		*	*	*		
Intelligent Medicine			*	*	*	*	*
Team Activity	*		*	*	*	*	*
Reward and Recognition	*	*	*			*	*
Town Hall Meetings	*	*	*				
Medical Staff Meetings			*				
Formal Contact				*	*	*	
Patient Information Guide							*
Facility Postings	*	*	*	*	*	*	*
Marketing Materials	*	*	*	*	*	*	*
GVMH Insider	*	*	*	*	*	*	*

Figure 1.1-2 MVV Deployment Methods

Our succession planning approach is multifaceted. The Board manages the succession planning process for the CEO and the CEO for his direct reports. Senior leaders and managers are directly involved through identification of candidates who have the potential for higher levels of responsibility, and by serving as mentors, trainers, and evaluators of those identified. We instituted the **Leadership Development Institute (LDI)** in 2012 to provide a quarterly learning and development opportunity for GVMH senior leaders and department managers, and senior leaders identify and encourage those with potential to attend other learning and development programs and discuss promotion opportunities with them when they arise. We make every effort to hire from within and prepare people for greater responsibility.

Senior leaders create and promote a culture of patient safety by their active participation in and direct oversight of the many methods used to address this critical issue. Three members of the AT sit on the Safety Committee to reinforce this emphasis. In this way, leaders are deeply involved in developing ideas and implementing actions to proactively prevent injuries and hazardous conditions from developing.

Through service on this committee, leaders are also constantly apprised of patient safety status, participate in evaluation of patient safety issues, and direct action needed to resolve those issues. In addition, leadership initiated our involvement in the **Comprehensive Unit Based Safety Program (CUSP)**, a joint program between the Centers for Patient Safety and MHA to teach organizations how to reduce errors and improve outcomes, and commissioned a Patient Safety Culture Survey to identify ways to improve.

1.1b. Communication and Organizational Performance

(1) Communication - Senior leaders communicate with and engage the workforce, patients, and other customers and encourage frank, two-way communications throughout the organization by means of the ELI system, which contains a wide variety of communication methods as shown in Figure 1.1-3. This process begins with new employee orientation when the CEO addresses the new hires. During his presentation the CEO invites and encourages the new employees to bring any issue to his attention at any time. To support this invitation senior leaders have an open door policy to facilitate direct engagement and encourage use of e-mail to make direct contact. In addition to formal communication methods, senior leaders also use informal approaches such as lunches, rounding, celebrations and social interactions to ensure that information is passed to the workforce and that concerns are identified and addressed.

Several methods are used to communicate key decisions to the workforce. If the decision relates to the strategic direction of the organization in the context of strategic planning and budgeting, senior leaders use the systematic strategy deployment component of the SPP to communicate strategies and goals and align department and individual actions. Senior leaders also meet with MT and the workforce to communicate this information and often follow up with e-mail messages and intranet announcements as progress is made. Other decisions made during the course of the year are communicated to the workforce by means of *GVMH in Action*, *GVMH Insider*, the Staff Advisory Committee, and "Town Hall" meetings. Where appropriate, decisions are communicated to the community using the Leadership Blog and through media reporting tools including the website, television, radio, press releases, and news articles. For example, a local radio show called "Speak Out" focuses on GVMH each month to provide information to the community, partners, collaborators, and key suppliers.

Senior leaders take an active role in motivating the workforce by fully engaging with them through **Leader Rounding**, a process which requires leaders at all levels to round with each of their direct reports on a monthly basis as a minimum. In addition, leaders focus on the key factors that drive engagement and satisfaction to develop methods to promote high performance. For example, one of the key factors for the workforce is to have a role in decision-making. Therefore, senior leaders promote delegation of authority and allow decision making at the point of greatest impact on customer satisfaction. CQI teams and individuals are empowered to identify and implement improvement opportunities, and all staff members are empowered to make decisions to resolve complaints on the spot with authority to spend $25 to mitigate customer concern as part of our service recovery process. Various managers empower their staff to make decisions such as scheduling and action planning, and staff members are routinely involved in most other departmental decision-making. In addition, senior leaders strive to afford the workforce ownership in GVMH success through the empowerment initiatives in place and by generating the understanding that everyone's responsibilities lead to our core responsibility of achieving the GSE. All employees understand their contribution to overall organization success because they have "line of sight" from their individual responsibilities to the organization's objectives. The GPS culture has instilled a strong sense of pride throughout GVMH and the vision and values provide a set of expectations that all aspire to realize. Senior leaders are also directly involved in the employee recognition program, presenting or otherwise participating in events where individuals are recognized with the awards. For example, the CEO personally recognizes and makes presentations to the staff in recognition activities such as retirement receptions, the awards banquet, the STEPS award program, Employee of the Month, and the annual CQI "We Love You Teams" and Customer Service celebrations.

(2) Focus on Action – Senior leaders create a focus on action that will achieve our objectives, improve performance, enable innovation and intelligent risk taking, and attain the vision through the GPS. The GPS produces the Pillars, SOs, KAs, key measures, and 90-day plans and goals, all of which are linked together to produce higher levels of performance in pursuit of the GSE. Senior leaders are assigned accountability for SOs and KAs, thereby serving as champions for the SOs developed during the SPP. As such, they play a pivotal role in identifying actions needed to deploy and communicate plans and measure progress. They monitor those actions, which are linked to the objectives, improved performance and the GSE and vision, and ensure that the organization maintains its focus throughout the plan year.

Senior leaders create and balance value for patients, other customers, and stakeholders by use of multiple methods to understand the needs and expectations of these groups through the VOC process described in Item 3.1. During planning, senior leaders evaluate those needs and expectations and identify where requirements of different customers and stakeholders are in variance so consideration can be given to prioritization of all customer and stakeholder needs and expectations based on value. Leaders use multiple data points and their own knowledge and expertise to establish priorities and then to reflect them in their decisions as appropriate.

Method	What	With Whom	Frequency
CEO's E-mail	Request input	Workforce	Weekly
Leadership and Department Meetings*	Values, direction, new initiatives, performance results, decisions, SOC	Team Members	Weekly
Town Hall Meetings*	MVV, performance results, strategic plan, decisions, improvements, best practices, SOC	Workforce	Quarterly
Management Team Meetings*	Values, strategic plan, initiatives, performance results, best practices, learning opportunities, community focus, improvement needs, SOC	Managers	Monthly
Management Team Retreats*	Improvement planning, assessment, leadership skills, succession planning	Managers	Annually
LDI*	Leadership development, service excellence	GVMH Leaders	Quarterly
Service Excellence Rounds*	Service excellence, patient concerns	Patients	Daily
Leader Rounding*	Input to and from staff	Workforce	Daily
Safety Rounds*	Environmental assessment of physical conditions and personnel practices; view and discuss	Workforce and Patients	Monthly
GVMH in Action	Decisions, new initiatives, policies, events, items of interest, announcements	Workforce	Weekly
Staff Advisory Committee*	Input from workforce to CEO, decisions, issues, opportunities for improvement	Committee Members	Monthly
Nursing Roundtable*	Feedback and communication, new initiatives, decisions, professional development, recognition	Nursing Department Staff	Monthly
Intelligent Medicine	Vision, values, direction, new initiatives, performance results, decisions, announcements	Patients, Community, Partners, Collaborators	Semi-annual
Capsulized News	Vision, values, direction, new initiatives, performance results, decisions, announcements	Workforce	Bi-weekly
"Speak Out"	Vision, values, direction, new initiatives, performance results, decisions, announcements	Patients, Community, Partners, Collaborators	Monthly
Website Communications	Values, direction, performance results	Workforce, Patients, Partners, Collaborators	Continuous
Leadership Blog	GVMH updates, current events, healthcare news	Workforce, Patients, Partners, Collaborators, Suppliers, Community	3 Times per Week
E-mail*	New initiatives, decisions, announcements	Workforce, Partners, Collaborators	Continuous
Surveys	Upward communication	Workforce, Patients	Semi-annually
My Quality Commitment*	MVV, SOs, goals, service standards, SEC	Workforce	Annually
One-on-one Discussions*	Direction, expectations, needs and concerns	Workforce, Patients	Spontaneous
PAP Assessments*	Direction, SOs, goals, job requirements, values, SEC, development opportunities	Workforce	Annually
BSC Reports	Performance results, direction	Workforce	Quarterly
Department Reviews*	Performance results, direction	Workforce	Monthly
Partner /Supplier Meetings*	Values, SEC, direction, expectations, performance	Partners, Suppliers	Quarterly or more
Board of Director Meetings*	Values, directions, expectations, public concerns, performance results	Leadership, Community	Monthly
Community Boards & Other Meetings*	Values, direction, public concerns & impacts	Community, Partners, Collaborators	Continuous

Figure 1.1-3 ELI Communication Methods *** Two-way communications (in bold)**

1.2 Governance and Social Responsibilities

1.2a Organizational Governance

(1) Governance System - The Board provides overall governance oversight and assures management accountability through the **Quarterly Status Report (QSR)** process and monthly reviews of quality, safety, patient grievances, human resources and a variety of clinical and business indicators. Board members also serve on a number of GVMH teams including strategic planning, building and grounds, compliance, education, finance, joint conference (Board and medical staff), quality and safety. Through service on these teams, the Board is directly involved in decision-making pertaining to key organization-related issues and has the opportunity to exercise its oversight responsibility from an "in process" perspective.

To assure fiscal accountability, the Board approves the annual budget and reviews financial performance monthly, we conduct internal financial audits monthly, and the Board commissions a third party audit firm, BKD, to conduct a

financial management audit annually. Audit reports are reviewed in depth and improvement action is directed when warranted by the audit results and/or recommendations from the auditor. To ensure the effectiveness of audits we reconcile the results of the monthly audits with the annual audit to identify the number of journal entries required, which indicate that an error occurred and an adjustment had to be made. The fewer entries, the more effective our internal audits have been. Additionally, our CMS Cost Report is used to verify the effectiveness of the annual BKD audit.

As a public entity, the actions of the Board are totally transparent, and Board members are elected in accordance with Missouri statutes. As a result, they are totally independent. To further protect stakeholder interests, the Board discloses conflicts of interest, meeting minutes are publicly reported in the newspaper and e-mailed to the workforce, and the Board reviews and approves the strategic plan. The Board also conducts an annual review of the CEO, receives input from the CEO on performance of the leadership team, and reviews the feedback from the GSE Organizational Assessment to better understand the overall effectiveness of the leadership team.

To effectively achieve succession planning for senior leaders the Board has adopted a formal **Succession Planning and Leadership Development Profiles** process. This process includes identification of each of the key senior leadership positions in the organization, the needed competencies associated with each one, and specific strategies to ensure the appropriate transition of leadership in the event of a temporary or permanent vacancy in any of these positions. Leadership Development Profiles are created for each position which detail the Key Competencies required, Developmental Objectives, a Developmental Plan, a potential internal successor, and potential external candidates. The profiles are reviewed and updated annually and are intended to guide, not constrain, management and Board decisions. The Board is responsible for appointment of the CEO, while the CEO is responsible for appointment of his or her direct reports.

(2) Performance Evaluation - The Board evaluates the CEO's performance annually using a tool that assesses the CEO in the following areas: Adaptability, Administrative Ability, Communications, Decision-Making Ability, Initiative, Innovativeness, Interpersonal Skills, Interpersonal Relations, Ability to Plan and Organize, Problem Solving Skills, Ability to Supervise, Time Management, Relationship to Department Managers, Relationship with Physicians, Knowledge, and Overall Effectiveness as Chief Executive Officer. Senior leaders are evaluated by the CEO using the PAP in the same manner other employees are evaluated but with an emphasis on leadership skills and responsibilities. He provides each direct report feedback and ensures creation of a personal development plan. All leaders are evaluated relative to achievement of their LEM goals monthly to ensure that they are consistently focused on the Pillars and SOs. Input from employees is also gathered to identify opportunities for leadership improvement. The Leader Rounding process and the staff satisfaction survey address leadership and supervisory effectiveness, which provides leaders additional insight on their performance. Senior leaders use the feedback to improve leadership and management effectiveness, including communication, teamwork, and supervisory skills. Although market survey data are the basis for determining executive compensation, senior leader performance evaluations are used to determine salary adjustments each year and LEM outcomes drive bonus payments.

The Board and members of the Medical Staff are also reviewed on a regular basis. The Board conducts an annual self-assessment, which includes an appraisal of all teams with Board representation. The tool used to accomplish this review is an assessment completed by each individual board member relating their perception of the strengths and weaknesses of the Board and the teams and suggested ways to improve. The results are tabulated and reviewed by the Board and improvement actions are identified and implemented. Evaluation of the medical staff is performed through the credentialing process, HealthStream patient satisfaction results, and staff surveys.

1.2b Legal and Ethical Behavior

(1) Legal Behavior, Regulatory Behavior, and Accreditation - We have determined that the key potential adverse impacts on society and public concerns that we need to anticipate are substandard care, nuclear medicine waste, bio-hazardous waste, and medication disposal. This is based on our expertise as well as information obtained from numerous community "listening posts" that include our partnership with CHART, which is focused on community health and wellness activities; our community perception survey process; community education activities; health fairs; support groups; customer service procedures; community participation on GVMH teams; open houses; the GVMH Insider; and the Customer Service Hotline. In addition, Board members obtain input from constituents in their Districts pertaining to our operations and bring them to Board meetings for discussions. The information obtained from these methods is aggregated and analyzed in the SPP and discussed at AT and MT meetings throughout the year to determine emerging needs or concerns, to identify actions that can be taken to mitigate concerns and to determine how the community can be better served. We have proactively addressed hazardous waste disposal, for example, by eliminating the potential for radioactive leaks in our nuclear medicine department by adopting "unit dosing" whereby we purchase nuclear pharmaceuticals instead of producing them on site. Similarly, we have addressed potential supply-chain management issues by participating in group purchasing organizations to reduce the cost of supplies as well as ensuring their availability, and ensured that the most energy efficient products have been used

in our remodeling plans which produced a $50K one-time rebate from our electric company.

To ensure a senior leader focus on compliance, the CCO is a member of the AT, and there is Board representation on the CC. The CCO chairs the CC, which meets monthly and is comprised of representatives from high-risk areas within the organization. The CC provides guidelines on how to conduct business with an attitude of honesty, integrity and diligence, and promotes legal and ethical conduct in all business aspects in order to prevent wrongdoing whether by intent, mistake or inadvertent behavior. The Compliance Plan is reviewed and modified annually by the CC and specifies the responsibilities of the CCO and CC, workforce responsibilities in reporting noncompliance, monitoring and reporting procedures, and investigative procedures. Auditing and monitoring is a way of life for GVMH and we use a third party compliance auditor, **Medical Revenue Solutions (MRS)**, to conduct an elective monthly audit in high risk areas that are proactively identified in an annual work plan. In addition, external agencies conduct non-elective compliance audits totaling more than 50 per year.

We take into consideration regulatory, legal and accreditation requirements and strive to surpass these requirements when establishing our health care and operational performance expectations. These standards and regulations come directly from several controlling and accrediting bodies. The CC is responsible to monitor the regulatory environment and identify when changing requirements are emerging. Information is also solicited from the Missouri and American Hospital Associations, and our legal advisers, Lathrop and Gage, to help identify and interpret legal and regulatory requirements and identify when changes are made. In addition, information on malpractice and licensure background for members of the hospital's medical staff is received from the National Practitioner Data Bank, and all staff and vendors are checked against the federal exclusion list monthly. Risk management focuses on the incident reporting process. This process produces a report for incidents involving potential risks, such as medication errors, needle sticks and other healthcare-related injuries, and proactive development of improvement actions. All incidences are reported to the Safety Committee, with needle sticks also being reported to the Infection Control Committee. Medication errors are reported to the Pharmacy and Therapeutics Committee quarterly and an annual summary is formulated, and patient falls are also closely monitored.

(2) Ethical Behavior - We promote and ensure ethical and responsible practices and conduct from a business and patient care perspective through our Statement of Ethical Values, Statement of Ethical Commitments, SOC, and the work of the Compliance and Ethics Committees. The statements are all contained in the Compliance Plan and the CC serves to formulate policies and procedures which are reviewed and updated periodically, provide education about ethical practices, and provide a forum in which physicians, other care givers, patients and/or families may seek a consultation to discuss the ethical issues involved in the care of the patient. The standards specify what constitutes ethical behavior, and auditing, monitoring, and response procedures are detailed in the Compliance Plan. The Social Services Director convenes a meeting of the Ethics Committee on an as-needed basis to review specific cases and assist with difficult ethical decisions.

1.2c Societal Responsibilities and Support of Key Communities

(1) Societal Well-Being - We are an integral part of Henry County and the Clinton Community, not only as provider of health care but also as a good citizen who cares for the overall well-being of the local citizenry. As a result, we focus on environmental, social, economic and community health needs during the SPP annually and in AT and MT meetings throughout the year using data from CHART, the Community Health Needs Assessment, focus groups, and senior leader and staff engagement with the community on boards, teams, and in informal settings. From an environmental standpoint, we provide public transportation to our facilities to both enhance access and reduce fuel consumption and our nuclear regulatory activities, advanced nuclear medicine capability, and nuclear regulatory compliance are all well developed. We also have partnered with the community in starting a "green" initiative and a member of the AT is serving on the committee to move this concept forward. We also took the lead to pull community groups together to address bioterrorism preparedness and other health-related emergencies. In this regard we have been designated as a site to house the area mobile response unit and our ambulance service provides first responder support to any emergency. Community plans to deal with such situations are in place due to our vigilance and concern. We also provide training on environmental protection, hazardous material containment, and decontamination for contact with hazardous materials.

From a social standpoint we provide care to all persons in need regardless of their ability to pay and have developed and maintained a **Financial Assistance Program (FAP)** that is patterned after the Hill-Burton criteria and results in substantial contributions annually. We are bringing additional physicians to the area to boost health care service offerings, and provide public transportation as mentioned earlier. Economically, we are among the largest employers in the region with a $27M payroll and recognize our responsibility to maintain a large staff to ensure we continue the significant economic impact that we provide. We also recognize how important a health care facility with a wide scope of services is to retaining businesses and attracting new businesses to the community and leverage our core competency of Scope of Services and Physicians in this regard.

(2) Community Support – Our key communities are those where we have a physical presence – Clinton, Warsaw, and Windsor. Our relationship with CHART has been an integral

part of our development of long-term strategies related to community health and support and identification of more immediate short-term needs. We proactively promote health and wellness throughout the community and made a large donation to build a new Community Center in Clinton that houses a wellness center and an aquatic center, and provide access to a Wellness Coordinator and a fitness trainer. We also have developed a wellness center in Windsor and are heavily focused on community health and wellness education, offering a wide range of support. Since we have a high rate of incidence of diabetes we have established a Diabetes Education Center to support the community at large and conduct an annual diabetes walk fundraiser to support those inflicted with this disease. We also play a significant role in the Greater Clinton Area Chamber of Commerce with a member of the AT serving as past President on the board. We encourage employees to volunteer to support community initiatives and goals have been set as part of the PAP. We also conduct other programs including a Speaker's Bureau, CPR and Safe Sitter classes for youth, the Christmas Cheer Basket Event, staffing the Clinton Free Health Clinic, serving as a clinical site providing learning opportunities for students, and the Zeta Gilvin Healthcare Scholarship Program for community members pursuing a health care career. Figure 1.2-1 summarizes our leadership processes, measures, and goals.

Area	Processes	Measures	Goals
Communications	Leadership Blog	# Views per Post	125
	Leader Rounds	# Rounds	250
Legal, Regulatory, Ethical	Compliance	Licensure # Violations Coding Accuracy	100% Zero 100%
	Financial Management	# Internal Audits Journal Entries	12 ≤ 3
Risk Management	Patient Safety	Medication Errors Infection Rate Falls Incident Rate	< 150 <.1 4.0 < .1
	Emergency Prep	Assessment Results	90%
Accreditation	Accreditation	% Accredited	100%
Community Health and Support	FAP	$ Used to Assist	3.9M
	Community Ed	# of Events	700
	Clinical Site	# of Students	150
	Transportation	# Rides	1500
	Diabetes Walk	$ Raised	17K
	Financial Support	$ Contributed	20K

Figure 1.2-1 Leadership Processes, Measures, and Goals

Category 2 Strategic Planning

2.1 Strategy Development

2.1a Strategy Development Process

(1) Strategic Planning Process – We conduct our strategic planning using the **Strategic Planning Process (SPP)** shown in Figure 2.1-1, which depicts the four major phases: **Analysis**, which takes place from April – October culminating with a strategic planning retreat; **Development**, which takes place from October through February beginning with the retreat; **Deployment**, which takes place from November through March; and **Review**, which takes place throughout the plan year. The plan is ready for implementation on April 1st of each year, which is the start of our fiscal year. The key process steps within each phase are also shown. The **Strategic Planning Team (SPT)** implements the process and also evaluates its effectiveness and makes improvements. Key participants on the SPT are the Board, AT, Medical Staff leaders, and the MT, which collectively gather and review extensive data from the staff, physicians, patients, community, partners, collaborators and key suppliers, and makes the key planning decisions.

Our long-term planning horizon is three years, which is addressed by our SOs, while our short-term planning horizon is one year, which is generally addressed by the KAs. We develop a three year long-term strategy with SOs that can reach out that far, and a short-term plan made up of KAs and department actions generally covering a one-year timeframe with built-in agility to stretch out further as needed and to rapidly respond to opportunities and challenges that arise within the one-year planning horizon. The SPP addresses these time horizons by looking out over a three year period in our **Environmental Assessment (EA)** to help us understand what the challenges and opportunities will be over that period, thereby giving us the necessary information to produce SOs to address them, and KAs and department actions that begin immediately upon plan implementation to move toward achievement of the SOs. In addition, the process is cyclical, producing an updated plan each year that builds on the prior year's plan to ensure continuity of purpose, and it is dynamic in that can be modified throughout the plan year as new issues emerge or progress takes place.

The SPP addresses the need for organizational agility and operational flexibility due to the cyclical and dynamic nature of the process. The Board and AT set the one-year and three-year planning horizons to balance GVMH's need to focus on the future and remain agile in a dynamic healthcare environment and in market conditions which frequently change. Tracking progress to plan frequently and making just-in-time decisions and modifications provides us the ability to be agile in response to changing needs and flexible in how we respond to maximize our effectiveness and enhance our competitiveness in the marketplace. Monthly progress to plan reviews are held though the **Monthly Meeting Model (MMM)** during which leaders meet with their direct reports to assess progress toward achievement of their goals and completion of their planned actions. The Board and AT also conduct regular reviews of plan progress to identify where adjustments and modifications need to be made.

The Analysis phase of the SPP begins with data gathering to

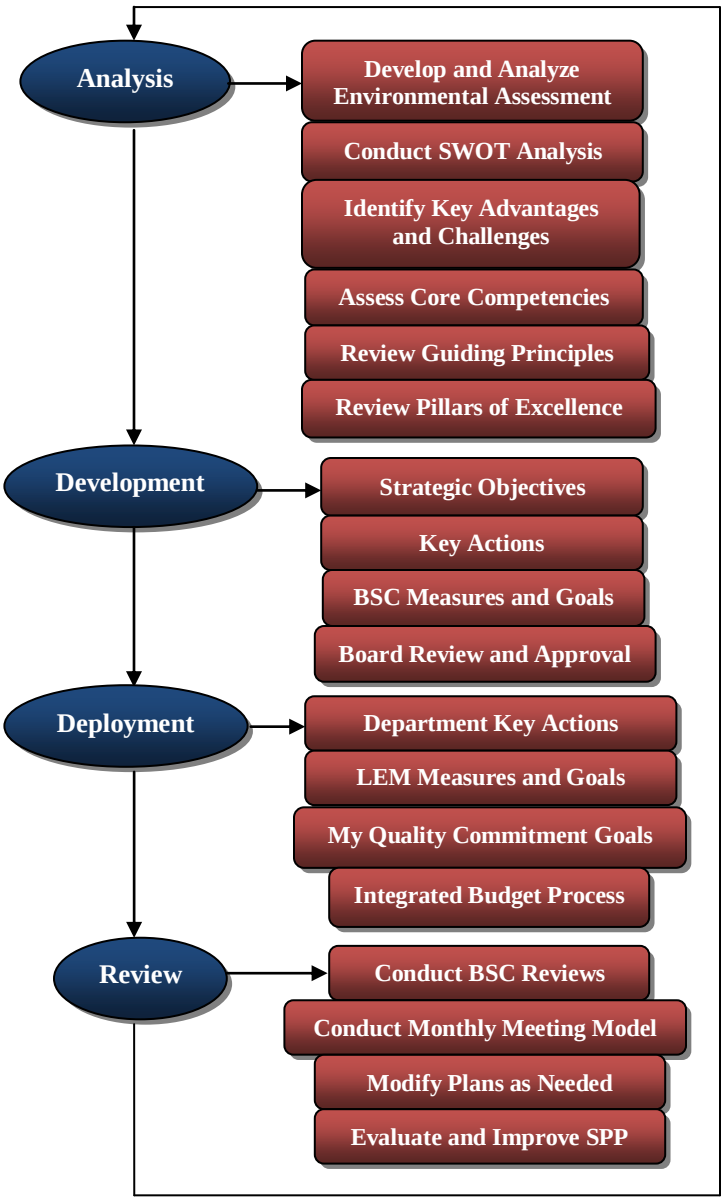


Figure 2.1-1 Strategic Planning Process

support the EA that includes both external and internal factors that have a bearing on strategy development. Data are collected using the BSC process, the LEM process, the VOC process, the Engage, Listen and Inform (ELI) system, the physician satisfaction and performance processes, compliance monitoring, reviews with partners, supplier discussions with MSS and VHA, and progress reports with collaborators. The EA provides an evaluation of the community we serve in both primary and secondary service areas including projected total population growth and trends, projected total population by age with a focus on those over age 65, medium household income as compared to the state and nation, distribution of state and nation, and employment projections as compared to household income within Henry County as compared to the state and nation. In addition, the competitive environment in the community is analyzed to identify market share trends, physician admission trends, and a forecast of service opportunities and physician manpower needs by specialty for the future. From an internal performance perspective, the EA provides an analysis of utilization trends over the past four years, length of stay and payer mix trends, financial performance data, patient satisfaction and engagement data, staff satisfaction and engagement data, Joint Commission Priority Focus Point data, and progress implementing information technology upgrades.

Once the EA is complete, the SPT participates in a two-day planning retreat that is facilitated by a third-party professional to develop the plan. The first day of the retreat includes representation from the Board and the medical staff, and the entire AT, and is focused on long-term needs. First on the agenda is a thorough examination of the material contained in the EA. From the information presented, the SPT is able to gauge shifts in our market and project community healthcare service needs, changing patient preferences, competitor activity, technology opportunities, and emerging regulatory requirements. Once the SPT completes this work, it embarks on a SWOT analysis using brainstorming and multi-voting techniques to identify our most significant strengths, weaknesses, opportunities and threats. Using the information obtained from the EA and the SWOT analysis, the SPT then breaks into two sub-teams, one to identify key strategic challenges and one to identify key strategic advantages. Each sub-team completes an analysis and then presents a proposal to the other team, discussion ensues, then consensus is achieved.

(2) Innovation – We create an environment that supports innovation by emphasizing both the internal and external challenges that we face and the need for priority action against those challenges and focusing on breakthrough change during strategic planning; promoting empowerment throughout the organization; and reviews of our progress frequently so that we have many opportunities to discuss where significant improvement is needed. As explained above, we identify key strategic opportunities during the SWOT Analysis at the planning retreat, and then decide which of these are determined to be intelligent risks in a subsequent team analysis to identify key strategic advantages and challenges. Those strategic opportunities that are to be pursued are classified as strategic advantages or challenges, which are later translated into SOs or KAs and subsequent implementation. Our strategic opportunities include:

1) Expansion of services and addition of physician manpower to support pediatrics and internal medicine;
2) Expand services in the surrounding communities;
3) Enhance marketing to create a positive community perception by sharing positive performance information and competitive advantages; and
4) Leverage quality initiatives and technology better.

(3) Strategy Considerations – We collect and analyze relevant data and develop information on key planning elements as follows.

Strategic Challenges and Advantages – As explained above, the EA process produces the necessary data collection and analysis to provide the basic information to determine our challenges and advantages. We deem these elements as critical to long-term sustainability and strive to ensure that each is addressed in our SOs and/or KAs.

Risks to Sustainability and Blind Spots – Risks are assessed during the sub-team activities as discussion takes place as to which challenges and advantages should be identified and which should not. Later, as SOs and KAs are developed, we cross check those plan components back against the challenges and advantages to ensure that all have been addressed. Similarly, a discussion takes place to ascertain risks associated with our ability to successfully achieve our objectives as well as the risks associated with not choosing objectives that may have been proposed. The focus here is to consider contingencies and identify potential blind spots that could materialize if some issues are not addressed in the plan. As the plan nears completion, a final discussion is held to confirm that there is confidence in our ability to execute the plan from a time and resource perspective, and to verify that the challenges and advantages have been satisfactorily addressed by the SOs and/or KAs.

Ability to Execute the Plan - during these deliberations, the SPT is required to give consideration to workload and resource requirements to ensure that the scope of work and level of effort is manageable so that the plan can be executed effectively. As budgets are developed there is a continual assessment of the financial and personnel resources needed to support the plan, and if resources become a limiting factor, priorities are established so that the most critical plan elements are retained and there is assurance that they can be resourced.

(4) Work Systems and Core Competencies – Three key work systems form the basis for all of our operations: Interdisciplinary Care Delivery; Care Delivery Support; and Operations Support, as indicated in Figure 6.1-2. We make decisions on our work systems during the SPP. During the Analysis phase we review EA data pertaining to emerging market requirements, organizational capability relative to key customer needs, and organizational performance, and consider how they impact our work systems to determine what adjustments must be made. We also evaluate our core competencies to ensure alignment with our work systems and determine the need for new and improved competencies that must be developed to support work system improvement and innovation, and also what opportunities we have to make work system adjustments based on core competency strengths that we already possess. Based on the challenges and advantages that have been identified, the SPT assesses our core competencies (Figure OP-1) to affirm those that have been identified before, determine if any actions are required to strengthen existing competencies, and identify any new competencies that may be required to deal with the challenges that are on the horizon.

We strive to maximize the use of internal resources in our work systems in order to increase the likelihood that all requirements and objectives will be better understood and enhance the likelihood that they will be met. However, there are situations where core competencies are not available internally or financial considerations suggest the use of external resources. These decisions are made either during strategic planning or at other times during the year in various leadership team settings based on new issues or opportunities that might arise. When the option of using external resources is proposed, a cost-benefit analysis is conducted. This includes a determination of anticipated effectiveness of outsourcing as compared to internal operations, determination of the cost to outsource as compared to internal costs, a judgment of supplier core competencies, and their capability to align with our Guiding Principles and meet all of our requirements. The results of the cost-benefit analysis are reviewed and discussed, and then a collaborative decision is made. Areas in which we make use of external resources include referring physicians, emergency room physicians, speech pathology, PET scanning, patient care equipment repair, and laundry services.

Determination of future core competencies is made during the "Assess Core Competencies" step of the SPP. The SPT makes determinations about core competency needs to address future challenges and opportunities, as well as the competencies needed to succeed in each of the Pillars. If they judge that there is a gap between what we currently possess and what is needed in the future, actions are taken to develop SOs and/or KAs to address that gap.

2.1b Strategic Objectives

(1) Key Strategic Objectives – Our SOs, most important goals, the timetable for achieving them, and key changes planned are shown in Figure 2.1-2. SOs are created in the Development phase of the SPP. The SPT breaks into five sub-teams, one for each of the Pillars, which work to establish the three-year SOs for their Pillar. To begin this effort, the teams assess the Key Strategic Advantages and Challenges and determine the linkage to their Pillar. The teams are then responsible to define candidate SOs that will address the key strategic challenges, build on key strategic advantages, and project the level of performance needed to move GVMH closer to realization of the GSE. Once all of the sub-teams have completed their work, each presents recommendations to the other teams, discussion ensues, and consensus on the SOs is achieved.

(2) Strategic Objective Considerations – Figure 2.1-3 demonstrates which SOs address the Strategic Challenges,

Pillar	Strategic Objective	Key Goals & Timeframe	Changes Planned
People	1 Achieve high staff engagement and satisfaction at the 75th percentile rank or higher as measured by HealthStream.	Staff Satisfaction - maintain top quartile percentile rank	Enhanced learning and development in focused areas
	2 Produce and maintain staff performance excellence.	Staff Retention – maintain at 85% or higher	Focus on and assure individual accountability
Service	3Achieve patient satisfaction for all patient segments at the 75th percentile rank or higher by the end of FY 2014 as measured by HealthStream.	Patient Satisfaction – achieve and maintain top quartile percentile rank from 2014 to 2016	Fully implement the Studer initiatives
	4 Be the provider of choice in the region for available services and maintain dominant market share in the primary service area for inpatients, outpatients and emergency patients.	Outpatient and Clinical Services Market Share – maintain at 90%	Expand scope of services
			Develop telemedicine capabilities
			Expand walk-in clinics
			Increase MRI operating hours
Quality	5 Improve Core Measure performance to obtain maximum reimbursement.	Core Measure Performance – achieve 100% by 2016	Identify core measure patients early in process
	6 Assure quality care delivery through consistent, timely, appropriate, accurate, evidence-based, and safe practices.	Quality Index – maintain at 3.0 thru 2016	Implement evidence based order sets
Financial	7 Maintain strong financial performance in key operations and liquidity measures.	Operating Margin – achieve 3.5% in 2014	Increase use of GPOs
			Implement ICD-10
	8 Meet all requirements of the Health Care Reform Act to achieve maximum financial reimbursement in FY 2014, 2015, 2016.	Achieve Meaningful Use payments in 2014-2016	Implement Meditech version 5.6.6
Growth	9 Expand primary care services.	Maintain 3% growth in OP visits and 2.5% growth in Clinics RVUs thru 2016	Add internal medicine and pediatric physicians
			Expand the service area
	10 Initiate facility development needed to support an expansion of services.	Secure project funding in 2014	Update Master Plan for Clinton campus

Figure 2.1-2 Strategic Objectives, Goals, Changes Planned

leverage the Core Competencies, Strategic Advantages, and Strategic Opportunities, and balance the short- and longer-term horizons and the needs of all stakeholders. The numbers in the figure identify the specific challenge, competency, advantage, and opportunity that align with a particular SO (see Figure 2.1-2 for SO numbers; Figure OP-1 for Core Competencies numbers; Figure OP-7 for challenges and advantages numbers; pp. 8-9 for opportunities numbers).

2.2 Strategy Implementation

2.2a Action Plan Development and Deployment

(1) Action Plan Development – The SPT develops the KAs to support achievement of the SOs right after they complete work on the SOs. Once again, the group is divided into five sub-teams, one for each Pillar, and is tasked to identify appropriate KAs to support each of the SOs within their respective Pillars. When the teams have completed their work they present their recommendations to one another, discussion ensues, and consensus is achieved on the KAs for each of the SOs. The KAs and their relationship to the SOs are shown in Figure 2.2-1.

(2) Action Plan Implementation - Once the SPT retreat is complete, the KAs are assigned to individuals or teams (KA "Champions") for follow through and long-term accountability, a target completion date is established, the draft plan is coordinated with the AT, MSEC, and MT, modifications are made as necessary, and the plan is reviewed with the Board for initial approval. At that point the plan is presented to the workforce by the CEO and the MT develops supporting KAs. Each manager is required to identify SMART (Specific, Measurable, Attainable, Realistic, Timely) Goals for his or her department, along with action plans, a statement of purpose, and measures aligned with the Pillars, SOs and top level KAs. These are documented on their LEM evaluation forms and coordinated with their AT leader to ensure alignment and integration with the strategic plan.

Deployment of action plans to the individual level of the organization is accomplished through the MQC process. Each individual staff member works with his or her manager to identify their personal "commitment", or set of individual

SOs	1	2	3	4	5	6	7	8	9	10
# - Strategic Challenges			4	2,4, 5	1	4		1	2,3, 7	6
# - Core Competencies	3	3	3	1	1	2	1,2	2	1	1,2
# - Strategic Advantages	3	3	3	1,2, 4,5	6,7	7	2	6	1,2, 4, 5	5
# - Strategic Opportunities	4	4	1	1,2, 3	4	4	4	4	1,2, 3	1
ST/LT Horizon	S L	S L	S	S L	S	S L	S L	S L	S L	S
Stakeholder Needs	*	*	*	*	*	*	*	*	*	*

Figure 2.1-3 Strategic Objective Considerations

goals, to support their department goals. They then complete a MQC card that lists their personal goals that they carry with them at all times. The card links the individual goals with department goals and the SOs. This process provides staff members a clear indication of how their work impacts organization outcomes. Plans are deployed to partners, collaborators and key suppliers through direct contact as appropriate when they are involved in or impacted by any of the plans. The leadership of the Medical Staff educates physicians, members of the AT work directly with partners and collaborators, and materials management personnel provide plan information to our key suppliers. KA Champions are responsible to oversee the work to develop and implement the KA they are assigned, and also to ensure sustainability of the outcomes of their plans. This is accomplished through development of Pillar of Excellence Worksheets, establishment of measures and goals, tracking progress and performance, reporting to senior leaders, and review of effectiveness once the implementation has been complete.

(3) Resource Allocation - Staffing and financial resources to assure the capability of carrying out the KAs are incorporated into the annual operating budget for the fiscal year. To ensure this happens, the SPP is integrated with the budget process as indicated in Figure 2.1-1. In the November/December timeframe the Finance Department projects what the financial status will be at the end of the fiscal year and sends a report to all departments with those projections and a request for submission of the follow-on year's budget allocation request. Managers review the projections and formulate their operating and capital funding requirements to support their mission-related activities and the plans that are emerging from the planning process. Managers identify resource requirements as they develop their planning worksheets and submit budget requests to support their plans along with appropriate rationale, and their budget requests are given full consideration and a high priority for funding according to importance and risk. Finance receives the requests and conducts a series of discussions with the departments to clarify and prioritize their requests, and works with the AT member responsible for that area to establish a better understanding of needs, risks, and priorities. From these discussions the budget is formulated and is presented to the Finance Committee of the Board and ultimately the full Board for approval. Integration of planning and budgeting ensures that each department understands and requests the needed resources to support execution of the plan, and that the budget process gives high priority to strategy-related requests.

(4) Workforce Plans - Key workforce plans to support the SOs and KAs and their impacts on the workforce are shown in Figure 2.2-2.

(5) Performance Measures – Key measures to track the performance and effectiveness of the KAs are shown in Figure 2.2-3. These measures are designed to reflect progress relative to the SOs, and KAs and are tracked through the LEM and BSC processes. An important component in achieving the SOs and KAs is establishment of LEM measures which align the CEO's measures with those of all senior leaders and managers. This is the second activity in the Deployment step of the SPP, which requires the selection of department measures and goals. As indicated previously, every manager completes LEM evaluation forms that establish measures, SMART goals and actions which relate to each of the Pillars, SOs and the KAs. Measures are established as part of this process, which provide an understanding and assessment of department specific progress towards accomplishing their goals and completing their actions. Each month, departments assess and report progress toward achieving goals through the MMM and develop or modify action plans for improvement.

(6) Action Plan Modification – We modify department action plans through the MMM process when it becomes necessary to change direction. In addition, KAs may be modified through the frequent progress to plan reviews with the Board and Administrative and Medical Staff leadership teams, which provide the opportunity for discussion and mid-course corrections depending on progress and changes in the environment. Every ninety days, the QSR is published which documents the progress made on each KA. This information is distributed to the MT and medical leadership and discussed by each group. Based on these discussions, actions may be taken to modify the existing plans. In addition, the AT presents the QSR to the Board and this document is reviewed in detail at a Board meeting. Based on the information presented, plans may be modified.

2.2b Performance Projection

We calculate projected performance in the measures and goals based on the impact we expect the strategic plan to have and compare those projections to past performance and relevant benchmarks whenever possible. When performance is not at the desired level or further improvement is warranted, new or modified strategies and plans are created through the SPP annually or modification to existing plans is made during the progress to plan reviews. Performance projections reflect the

SO	Key Actions
1	1.1 Promote staff engagement with a commitment to providing exceptional care and services. 1.2 Maintain an ongoing commitment to multiple avenues of communication. 1.3 Promote the work environment benefits of positive attitudes.
2	2.1 Enhance learning and development programs; evaluate, select and implement additional opportunities 2.2 Strengthen processes related to promoting/assuring a focus on individual accountability.
3	3.1 Develop, implement and hardwire methods for improved communications with patients and families 3.2 Enhance the customer experience.
4	4.1 Improve services to increase customer engagement.
5	5.1 Increase CPOE utilization. 5.2 Improve standardized documentation. 5.3 Implement medication reconciliation process/system. 5.4 Implement processes/protocols to identify patients early in the care process that will fall into a core measure category. 5.5 Strengthen core measure compliance monitoring/accountability.
6	6.1 Promote improved physician documentation using templates and voice recognition. 6.2 Implement evidence based order sets. 6.3 Improve patient education material provided to all patient types. 6.4 Provide a single patient portal for all patient types. 6.5 Promote increased standardization of documentation. 6.6 Maintain organization-wide emphasis on safety.
7	**7.**1 Increase the percentage spent through Group Purchasing Organizations. **7.**2 Be prepared to implement ICD-10 in accordance with required deadlines. 7.3 Maintain the ability to qualify for less than 50 beds designation. 7.4 Achieve operating performance and liquidity goals.
8	8.1 Complete requirements to receive stage 1 year 2 Meaningful Use funds in FY 2014. 8.2 Implement Meditech version 5.6.6 and the Meaningful Use stage 2 certified version of Med 3000. 8.3 Ensure a sound understanding of the decisions made to implement the health care reform act, determine impact and develop actions to address all requirements and maximize reimbursements.
9	9.1 Recruit internal medicine and pediatric physicians. 9.2 Identify and prioritize zip codes for establishing primary care presence in selected communities. 9.3 Develop a primary care expansion timeline to include locations, facilities and scope of service.
10	10.1 Update and/or validate the facility Master Plan for the Clinton campus. 10.2 Complete a financial feasibility analysis of the scope and size of needed expansion. 10.3 Develop and finalize construction plans. 10.4 Secure funding and initiate construction.

Figure 2.2-1 Key Actions

expected improvement that will occur as a result of implementation of the KAs. The overall intent is to produce a level of performance in each area to allow us to achieve the GSE. Figure 2.2-3 displays our projected performance and associated comparisons.

3 Customer Focus

3.1 Voice of the Customer

3.1a Listening to Patients and Other Customers

(1) Listening to Current Patients and Other Customers - We listen to, interact with, and observe patients and other customers to obtain actionable information through the Voice of the Customer (VOC) process, which is comprised of the data gathering methods shown in Figure 3.1-1. Listening methods are designated "L", interaction methods "I" and observation methods "O", and they vary by customer segment as shown in the figure.

Measure	2012	2014	2016	Comp
People				
Staff Satisfaction % Rank	79.0	75	75	50
Service				
IP Satisfaction % Rank	62.5	75	75	50
OP Satisfaction % Rank	55.8	75	75	50
ER Satisfaction % Rank	45.3	75	75	50
Quality				
Quality Index	3.8	3.0	3.0	N/A
Core Measure Performance	96.7	98.0	100	100
Financial				
Operating Margin %	5.8	3.5	3.0	2.5
Growth				
OP Visits % Growth	9.6	3.0	3.0	1.0
Clinics RVUs % Growth	2.0	2.5	2.5	1.0

Figure 2.2-3 Performance Projections and Comparison

SO	Workforce Action Plans	Workforce Impact
1	• Conduct management training in defined areas • Achieve 100% participation in MQC • Further engage leadership and staff • Promote the work environment benefits of positive attitudes	Strengthened engagement and satisfaction
2	• Enhance learning and development programs • Strengthen processes related to promoting and assuring a focus on accountability	Greater opportunity for learning and development and acceptance of accountability
3	• Develop, implement and hardwire methods for improved communications with patients/families • Enhance the customer service experience	Increased ability to engage with patients and families
5	• Provide learning opportunities on methods to enhance compliance with core measure requirements	Higher core measure compliance scores
6	• Continue focus on use of timely, appropriate, accurate, evidence-based and safe practices	Enhanced quality of care
9	• Recruit and hire staff to provide for expansion of services	Provide broader range of services to a greater population base

Figure 2.2-2 Key Workforce Plans

Social media and web-based technologies have become an important method of communicating with our patients and other customers and we use these methods to both send out or post information and seek input. We focus on Facebook and have identified a proactive approach to increase our fans by reviewing the Facebook "reach" and "engagement" data to determine what information our fans are interested in and then tailor our posts to meet that interest. As a result of this initiative we have increased our fan base by 40% in 2012. Our media/web-based technology effort includes: our Facebook page with 477 followers where users can provide us comments; interactive website with a feedback link; our Leadership Blog where readers can comment or be surveyed; an e-newsletter sent to nearly 400 subscribers monthly with an option to provide a response; and we utilize *GVMH Insider* for our staff to communicate with our patients and physicians, access organizational and community information, and obtain information about "giving back" to the community through volunteerism and fundraising. Our most popular page internally is the home page which displays announcements, census, patient satisfaction scores and other results data, new employees, meeting minute links, and much more.

Our listening methods vary based upon the stage of our customer's relationship with us in the following ways: methods focused on the community and former, potential and competitor patients are designed to build a relationship with those who are not currently patients but could become one in the future; methods focused on current patients are designed to build relationships and generate loyalty beginning when a patient engages with us for treatment and continuing until we cease providing care and the patient is no longer classified as a current customer. Care delivery, rounding and Patient Advocate occur during the period that care is being provided; patient call-backs and satisfaction surveys occur immediately after treatment has been completed and patient monitoring is still in progress. For the community, involvement by GVMH leaders and staff, our health education services, our engagement with CHART, and the health fairs focus on times when we are directly engaged with members of the community and are attempting to forge strong relationships, while all other methods pertain to the community in general. For employers/payers, meetings and reviews are held with those we are directly engaged with, while other methods provide relationship building opportunities that may result in a future engagement.

We seek immediate and actionable feedback on the quality of service provided to patients through our patient satisfaction survey processes and have engaged with **HealthStream** to obtain data pertaining to inpatients, outpatients, and emergency patients. As a process improvement, we changed providers from Press Ganey to HealthStream in 2011 to obtain more actionable and meaningful data. HealthStream calls patients rather than sending a paper survey and will continue making calls until a preselected quota determined by GVMH is achieved, so the desired number of respondents is always realized. Conversations are recorded, questions are preset, and are the same for all patient segments. In addition, an alert system is included so that we are notified immediately if a call results in identification of an issue that requires immediate attention, thereby allowing us to be more responsive to patient needs. The survey consists of 27 questions with responses covering a 10-point scale. We provide contact information each Tuesday for inpatients that have been discharged 5-11 days prior and outpatients and emergency patients who have been seen from one to eight days prior. Data are collected daily and results are segmented by treatment area to permit more detailed analysis.

In addition to the satisfaction survey, the **Patient Call Manager (PCM)** process is designed to obtain immediate and actionable feedback from patients after treatment is complete. Calls are made to all inpatients and selected outpatients and emergency patients starting the day after service is complete with the objective of determining if the experience they had with GVMH met all of their expectations and, if not, what issues emerged. Data from these calls are documented, provided to managers and staff for action, then aggregated and analyzed. CQI Teams are formed to deal with issues and generate improvements or innovations to address findings. Additionally, we gather information on patient satisfaction and engagement through Leader Rounding, Service Excellence Rounding, and periodic focus groups.

Home Health and Physician Clinics surveys gauge patient satisfaction in these specialty areas. Home Health participates in the Deyta-HCAHPS surveys for home health patients and the Missouri Alliance for Home Care (MAHC) survey process. For home health, patient contact information is transmitted to Deyta which sends out the HCAHPS surveys, compiles results and provides those to us online. For home care patients we mail the surveys to all those discharged with a self-addressed, stamped envelope. When the completed surveys are received, we compile the results and submit them quarterly to MAHC which provides comparison data relative to other providers in Missouri. Every discharged patient is surveyed within five days using a nine question survey with a five-point Likert Scale, and the results are evaluated on a continuous basis to improve services. Physician Clinics survey all patients using an 8-question survey with a five-point scale. Patients are surveyed one week per quarter, in accordance with Rural Health requirements. The data are then aggregated and analyzed to improve services.

The community's needs, expectations, and level of satisfaction are evaluated during the SPP through the methods described in Item 1.2. These methods not only provide us with information regarding satisfaction with GVMH, but also the community's perception of us relative to our competitors, as well as services the community thinks should be added. We complete a **Community Health Needs Assessment** every three years and have developed a new community perception survey process that was implemented in 2012. In addition, we were selected to participate in a four hospital Rural Community Needs Assessment pilot project by MHA that was also implemented last year. An innovation to our approach to community listening, a link on the *GVMH Insider*, also enables staff members to provide input that they hear from customers as they interact with them in a variety of environments. These data are aggregated and stored in a database for use in improvement planning.

VOC data from employers and payers are developed through managed care contracts and gathered during frequent face-to-face meetings. Managed care contracts provide a clear

Method	Customer	Frequency
GVMH Initiated		
Care Delivery (I/L/O)	IP,OP,EP.HHP,PCP	Daily
Service Excellence Rounds (I/O)	IP	Daily
Satisfaction Surveys (I/L))	IP,OP,EP,HHP,PCP	Weekly
Patient Call Manager (I/L)	IP,OP,EP,HHP,PCP	Daily
Focus Groups (I/L)	Former, potential, competitor patients	Periodically
CQI Teams (I/L)	Former, potential, competitor patients	Periodically
Community Surveys (L)	C, E/P	Periodically
Health Fairs (I/L/O)	C, E/P	Periodically
Managed Care Contracts (I/L)	E/P	Ongoing
Community Involvement by Leaders/Staff (I/L/O)	C	Daily
MHA Networking (L)	IP,OP,EP	Periodically
Environmental Assessment (L)	All	Ongoing
Meetings and Reviews (I/L/O)	C, E/P	Monthly
Customer Initiated		
Patient Advocate (I/L/O)	IP	Daily
Social Media, Letters, Phone calls, E-mails (L)	All	Daily
Complaint Management (I/L/O)	All	Daily
Customer Care Cards (L)	All	Daily
Customer Service Hotline (I/L)	All	Daily
Community Health Education/Svcs (I/L/O)	C	Monthly
CHART (I/L/O)	C	Monthly
Board Constituents (I/L/O)	C	Monthly
External Website Link (L)	All	Daily
GVMH Insider Link (L)	All	Daily

Figure 3.1-1 Voice of the Customer Methods
IP = Inpatient; OP = Outpatient; EP = Emergency Pt; HHP=Home Health Pt; PCP = Physician's Clinic Pt; C=Community; E/P=Employer/Payer

understanding of customer expectations and contract negotiations serve as a vehicle for discussing expectations and establishing priorities. Contracts are reviewed annually and renegotiated as needed. Our utilization review process allows us to keep close contact with our payers and make changes as needed. We meet regularly with Blue Cross Blue Shield and attend frequent Medicare/Medicaid training sessions to obtain stakeholder input. We also look closely at payment rejections to determine the cause in an effort to decrease further

rejections, and our primary indication of meeting payer needs is the timeliness of payment of claims.

Information gathered through all of the above forms of data collection is compiled and analyzed during the SPP to determine the relative importance and the need for new health care services or service features. The results are also shared with managers to allow for work process improvements when the data indicate that opportunities exist. For example, through community participation in our Warsaw market and listening to community leaders, a decision was made to change the timeline for adding cardiac rehab services in a community that previously did not have access to those services. These services were added two days per week and the volumes grew faster than anticipated so service was increased to three days per week to meet the patient demand. Relationships are now being formed with the patients that allow the cardiac rehab staff to offer additional physician clinic service information to patients who do not have a local physician.

(2) Listening to Potential Patients and Other Customers - The methods shown in Figure 3.1-1 highlight how we obtain information from potential patients and other customers. We consider the "Community" other customer group to be comprised of largely potential patients.

3.1b Determination of Patient and Other Customer Satisfaction and Engagement

(1) Satisfaction and Engagement - Processes used to determine patient and other customer satisfaction and engagement begin with an analysis of quantitative and qualitative information from the various listening methods listed in Figure 3.1-1. HealthStream patient surveys are the primary source of satisfaction and engagement information. Data are segmented by customer group and treatment area. Sampling follows a methodology protocol in all customer segments as well as treatment areas to provide a stratified representation for each group. Reports include top box scores and percentile rank, and are trended by question, patient category, treatment area, and national and regional percentile ranking and are analyzed and integrated into the BSC and LEM processes. Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), a national survey required by the Centers for Medicare & Medicaid Services (CMS), also provides us actionable feedback on the results data received from HealthStream. These data and those generated through the Home Health survey process described above are presented to the QST which then prioritizes them. Correlation coefficient and priority index are two of the primary data analysis methods used to determine priorities. The resulting information is used throughout GVMH to drive improvement, in the SPP for long range planning, and also by managers and teams to determine areas for work process improvement and innovation. Satisfaction information is also cascaded throughout the organization from AT to QST to managers and then to all staff. Results are also posted on the GVMH Insider. Managers receive the results that apply to their department for their own analysis and these are recorded and used to identify action plans for improvement.

(2) Satisfaction Relative to Competitors - We obtain objective information relative to our competitors and other organizations through analysis of the HealthStream results, which include comparative performance to peer group hospitals as well as all hospitals that participate in the process. HealthStreams provides us percentile rankings for its hospitals with respect to each of these comparative groups. HCAPHS also provides comparative data and Home health obtains comparative data from MAHC as indicated above.

(3) Dissatisfaction - Patient dissatisfaction is determined by the satisfaction survey results, PCM input, aggregation of complaint and grievance data, direct input during rounding or other patient interactions, and through the listening methods for the community, employers and payers as described above. These data are also integrated into our planning and improvement/innovation processes as appropriate.

3.2 Customer Engagement

3.2a Service Offerings and Patient and Stakeholder Support

(1) Service Offerings - We determine patient, other customer, and market requirements for health care service offerings through the Community Health Needs Assessment and other VOC inputs and listening methods shown in Figure 3.1-1 and the environmental factors developed to support the SPP. Through these mechanisms, input is captured from the community, patients, employers and payers, physicians and the workforce. Data are input into the environmental scan and service requirements are defined during the SPP where inputs are analyzed, a SWOT analysis is completed, strategic opportunities are defined, and strategies, including new or modified healthcare services or service lines, are identified.

We then validate the viability of the new or modified service offering through the **Business Planning Process** (Figure 3.2-1) where an assessment of resource and implementation requirements is completed. The viability of the new or enhanced service is researched based on market conditions, competitor offerings, and market potential. Once it is determined that the new or modified health care service offering is needed and viable, an individual is assigned responsibility or a team is formed to determine how to bring the service on and manage its implementation. Once implemented, the service is evaluated for effectiveness and improved as required. This same approach is used to identify innovations and service offerings to attract new customers and expand relationships with existing customers.

(2) Patient and Other Customer Support – We have established multiple access mechanisms to enable patients and other customers to seek information and support, obtain

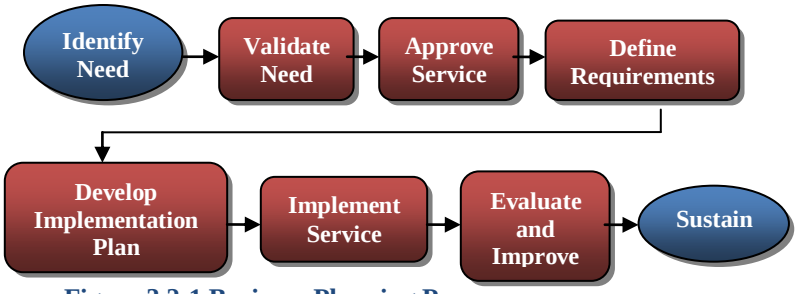


Figure 3.2-1 Business Planning Process

services, and provide feedback as summarized in Figure 3.2-2. Collectively, these address all patients and other customers although some are tailored to specific patient segments or other customer groups. For example, the patient advocate deals only with inpatients, while the meetings and reviews are fundamentally designed for employers and payers. The various methods are communicated to patients and other customers through direct contact, newsletters, brochures, community announcements, ads, the website, and information provided to patients at check-in or admission. Key support requirements are determined based upon analysis of feedback from customers, analysis of data gathered during development of the EA, and analysis of information gathered from the various community listening posts. The QST reviews all patient and other customer-related data and seeks to identify patient and other customer support requirements as well as opportunities for improvement and innovation. Through this method we have determined that easy access and prompt service are key support requirements as indicated in Figure OP-4. As a result, we have placed a significant emphasis on improvement and innovation in these areas. For example, we have purchased a 128 slice CT scanner, one of only ten of its kind in the country at the time of its purchase, which allows us to do more interventional radiology and reduces the time to complete the scan. In addition, we recently evaluated the patient access process resulting in establishment of an offsite rehab facility in Clinton. Outpatient departments developed and deployed a direct admission process and we added a walk-in clinic service in Clinton.

Seeking Information	Obtaining Services	Providing Feedback
Workforce (in person, by phone, letter, e-mail, etc.)	High technology hospital facility	Workforce (in person, by phone, letter, e-mail, etc.)
Newsletters, ads, press releases	Community health offerings	Service Excellence Rounds
GVMH Insider	Referring Physicians	Patient Advocate
Patient Advocate	Multiple clinics	Patient Call Manager
Customer Service Hotline	Emergency responders	Satisfaction surveys
Service Excellence Rounds	Payers	Customer Care Cards
Meetings and reviews	Charity care	Meetings and reviews
Facebook page	Outreach efforts	Facebook page

Figure 3.2-2 Key Service Support Mechanisms

To ensure that all staff members understand how to meet and exceed patient and other customer requirements, including those of their fellow staff members, and provide exceptional service during contact, we developed and deployed the **Behaviors of Excellence (BOE)** shown in Figure 3.2-3. There are four major categories of the Behaviors, each containing a set of excellence areas that vary in number totaling 10. Within each of those areas, specific behaviors are identified that guide the workforce on the how to act totaling 54. For example, among the 10 behaviors under Conduct/Attitude is "I display a positive attitude at all times"; under "Managing Up is "I do not embarrass or criticize co-workers in the presence of others; under Commitment to Customers is "I commit to excellent service and ask customers to tell me how I can meet their expectations"; and under Communication is "I use AIDET in all communications". All staff are trained on the BOE and these are reinforced in the MQC process.

Major Category	Excellence Area	# Behaviors
Professionalism	Conduct/Attitude	10
	Image	3
	Professional Development	3
Commitment to GVMH Team	Commitment to Co-Workers	7
	Managing Up	4
	Sense of Ownership	7
	Mentoring	4
Commitment to Customers and Community	Commitment to Customers	6
	Commitment to Community	2
Communication	Communication	8

Figure 3.2-3 Behaviors of Excellence

3) Patient and Other Customer Segmentation – We identify and determine which customers and market segments to pursue for current and future healthcare services through the Analysis and Development phases of the SPP. Patients are segmented based on the location of care - inpatients, outpatients, emergency patients, home health patients, and physician clinics patients – and also by the type of care being provided. The community is segmented geographically by PSA and SSA.

The Analysis step of the SPP provides the necessary visibility as to emerging patient, other customer, and market needs, and the Development step produces a determination as to changes in patient segmentation and service offerings. Included in the Analysis step is a review of the existing patient mix and the potential patient mix in the market area, including patients of competitors. This information is used to identify changes in service offerings to capitalize on the potential the market offers. Patient segmentation involves a review of the data

associated with the EA developed to support the SPP and data produced by the VOC. In assessing this information we seek to determine if segmentation should be altered based on the following considerations:

1) do special needs exist for a certain group of patients that are significantly different than the entire group;
2) do satisfaction results and analysis indicate different key requirements for a certain group of patients; and
3) do services provided differ sufficiently to warrant establishment of a separate segment.

Market segmentation also involves a review of EA data, which provides an assessment of our PSA as well as the surrounding counties, movement of patients within the market, an assessment of the competition, and identification of new health care needs that may be emerging within the community. Based on this information, senior leaders determine if the existing market strategy is still valid, if an adjustment to that strategy is needed to improve health care and operational outcomes, and if the market should be segmented differently for data collection and tracking purposes. As part of this process, we evaluate information pertaining to community health care needs obtained through a variety of means. These include networking within the communities served and formal participation by senior leaders in local business and civic groups and community wide coalitions, as well as input from members of the Board based upon information received from their constituencies. Data from these sources are considered during the process to help determine how to target the market and determine the need for new or improved services.

3.2.b Building Relationships with Patients and Other Customers

(1) Relationship Management – We market, build, and manage relationships to acquire patients and other customers and build market share by establishing relationships with our physician partners and the communities which we serve. Physicians often recommend or decide where the patient will go for service, so it is important that we build strong relationships with as many referring physicians as possible. To do this we have followed a strategy of integrating physicians into the GVMH employee base, improving communications with all physicians, and we have implemented a number of relationship building initiatives such as: "Meet and Greet" events between new physicians and all managers; a new physician orientation program; and affording greater visibility to physicians in marketing activities. Further, we have expanded specialty care services and enhanced care delivery equipment to allow physicians the opportunity to practice in a "leading edge" environment. We are also highly committed to medical education, with medical students and interns working in a variety of specialties to gain practical experience. We strive to have the finest medical technology available, a highly responsive nursing staff, and state-of-the-art IT systems to provide physicians top quality support and easy access.

A strong perception of our service quality in the communities we serve is an important factor in the decision-making process people go through in selection of their health care provider. Therefore, we build relationships in the communities in an effort to create the most positive image possible. Extensive community outreach and educational activities are in place, including the Diabetes Support Group, free cancer screenings the Cancer Support Group, medical tent at "Olde Glory Days", ambulance and EMS staff at sporting events, "Joint Camp" for individuals needing joint replacement and considering us, "Great Beginnings" birthing camp, Speaker's Bureau, and "Lunch & Learn" wellness program. We also have many community health and support initiatives underway, senior leaders are heavily involved in key community leadership groups and we use a variety of marketing approaches to put forth a strong message. By establishing a positive, valued presence in its communities, GVMH gains a great deal of visibility that serves to attract patients.

We retain patients and other customers, meet their requirements, exceed their expectations and increase their engagement with us through three primary initiatives:

1) **Interdisciplinary Care Delivery Work System (ICDWS)** - engages the patient/family in development of the care plan and customizes it to patient needs;
2) **Service Excellence Program (SEP)**- engages leadership with patients, creates a strong focus on customer service, and promotes exceeding customer expectations;
3) **Patient Call Manager (PCM)** - follows up with patients to ensure their needs were met, see if any concerns exist, and prompts immediate response when the need arises.

The patient care plan is an evidence-based approach to standardize the care provided for various illnesses. The **ICDWS** permits the care plan to be customized based on the specific needs of the patient to ensure that the care provided will be the absolute best possible to meet and exceed the patient's needs as explained in Area 6.1b (2). This approach gets the patient and family engaged at the outset and continues throughout their period of service.

SEP includes a variety of specially designed service features including the following. Managers conduct **Service Excellence Rounds** throughout the hospital on a scheduled basis and proactively seek patient input as to the quality of service delivery, satisfaction, concerns and other matters. These leaders model service excellence and demonstrate to all caregivers the need for detailed attention to patient needs. Caregivers follow this lead with hourly rounding for inpatients to foster relationships, enhance care and exhibit a strong patient focus at all times. **AIDET** is an acronym that stands for Acknowledge, Introduce, Duration, Explanation, and Thank You and represents a very powerful way to communicate with patients who are typically nervous, anxious, and feeling vulnerable; this approach reduces patient anxiety, increases patient compliance,

improves clinical outcomes, and increases patient satisfaction. All staff use the AIDET approach at all times. **Behaviors of Excellence** provides guidelines and establishes consistency in the way all staff treat patients and one another as explained earlier; the **Gold Coupon Program** provides for recognition of employees who provide exceptional service to patients and other customers; **Easy Access** focuses on finding ways to make it easier for patients and other customers to access our services and has produced improvements in making contact, scheduling, transportation services, and admission; and the **Very Good Care** initiative requires nurses to query inpatients as to three ways they could exceed their expectations. This information is then documented on the white board in the patient's room so that all are reminded of what needs to be done to exceed patient expectations throughout their stay. The **Patient Advocate (PA)** visits patients periodically throughout their stay and serves as a liaison between the patient and the hospital. Patients are made aware of the PA upon admission, and this is reinforced upon the PA's initial visit with the patient. The PA responds to concerns, investigates issues, gathers data, and follows through with appropriate personnel to see to it that all of the patient's needs are met and expectations are exceeded. **PCM** seeks to engage with patients after they complete their service experience with us in an effort to understand if there are any unresolved issues, continue to build a strong relationship, and exceed their expectations as explained in Area 3.1a(1).

In addition to these methods, relationship building with outpatients also emphasizes Easy Access initiatives that include transportation services, direct admission, secret shoppers to identify access issues, and extended service hours, among others. To build relationships with Home Health patients, we provide easy access to services, generous scheduling opportunities, an efficient registration process, reminder phone calls, registration by phone, and facilities in Warsaw and Windsor. Relationship building methods are summarized in Figure 3.2-4.

Customer	Relationship Building Methods
Inpatients	ICDWS
	SEP
	PCM
	Computer access in all patient rooms
	Room service
Outpatients ER Patients Home Health Patients PC Patients	ICDWS
	SEP
	Easy Access Initiative
	Transportation Services
	Direct Admission
Physicians	Leading edge technology
	Integration
Community	Strong presence
	Board representation
	Community outreach activities
	Pre-patient orientation classes
Employers /Payers	Timely and accurate service
	Contract negotiations
	Phone calls and meetings

Figure 3.2-4 Relationship Building Methods

(2) Complaint Management –We manage customer complaints through the **Service Recovery Process (SRP)** shown in Figure 3.2-5**.** We welcome input from customers and view complaints as opportunities for improvement. Issues are categorized as grievances or complaints and may be received in person, through the website, via the Customer Service Hotline, in writing, via phone call, survey or e-mail. Grievances occur whenever a complaint cannot be resolved on the spot or when it is provided in writing. Regardless of the categorization or method of receipt, the entire workforce is empowered and expected to resolve issues immediately if at all possible. If an employee is unable to resolve an issue, he or she forwards it to the appropriate manager for action to ensure prompt resolution.

Managers are required to initiate investigation of grievances and complaints upon receipt and to communicate information back to the customer in an expeditious fashion. A "Complaint Tracking Form" is completed for all grievances and complaints and provided to QM for aggregation, analysis and tracking. All complaints received are entered into a database designed to compile the information according to the type of complaint, date and time received, demographic information, and resolution. This information is used to trend grievances and complaints for patterns and promptness of response. These data are used to help understand patient requirements and drivers of satisfaction and engagement, and to determine opportunities for improvement in work processes. In an effort to be proactive and customer-focused, patients are educated on use of the hotline upon admission, through informational flyers in the admitting and outpatient departments, and through the placement of instructions at each patient's bedside. They are also given a copy of the "Patient's Bill of Rights and Responsibilities" upon admission and are invited to contact the appropriate manager if they have any concerns at any time. Managers provide their contact information to the patient to facilitate access.

To help recover patient and other customer confidence and enhance satisfaction and engagement the SRP provides the entire workforce the authority to authorize an expenditure of up to $25.00 on the person providing the input. For example, the employee might purchase food in the cafeteria or a gift in the gift shop to help ease the customer's concern. The workforce is trained on the SRP during orientation and they are reinforced by managers routinely. The SRP is evaluated on a regular basis in an effort to ensure its effectiveness. Recently, the process was improved to include a QST review of complaint data in an effort to create greater understanding of issues and focus on improvement actions.

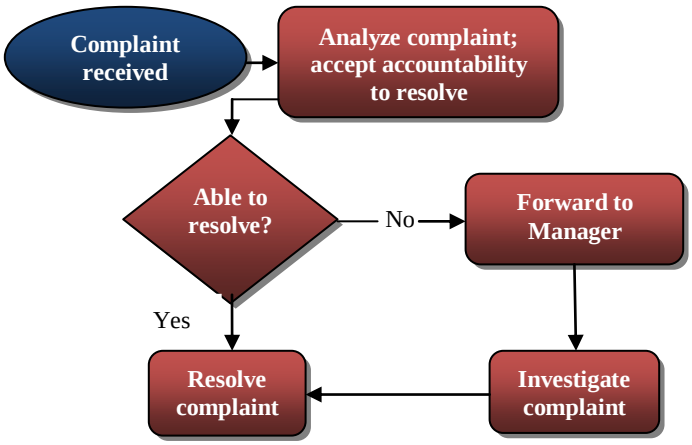


Figure 3.2-5 Service Recovery Process

Category 4 Measurement, Analysis, and Knowledge Management

4.1 Measurement, Analysis, and Improvement of Organizational Performance

4.1a Performance Measurement

(1) Performance Measures – The GPS assures that measurement of organizational performance plays a key role in the achievement of our strategic objectives and forms the basis for ensuring effective process performance in daily operations. Measurement system requirements to track overall organizational performance are driven by the SPP, LEM and BSC processes and measurement system requirements to track daily operations are driven by the CQI Model.

We select daily operations measures to track work process performance as processes are designed, and modified, as necessary, when process improvement and innovation occurs. The third step of the CQI Model, **Analyze Process**, has as one of its objectives the design of a control system for the process to prevent problems from occurring. Included in the **Key Activities** of this step is development of a measurement system and the **Checkpoints** for this step require that the measurement and control system is specific enough to pinpoint potential future problems. The **Output** of this step is a control system with measurable indicators. When process measures are selected, data collection methods to support them are identified and collection procedures are established. These measures are used to make judgments about the effectiveness of daily operations and work processes and include both outcome and in-process measures. This permits staff members to continuously monitor performance and identify improvement actions and innovations needed to ensure the consistent delivery of high quality services to customers. Process level measures are aligned with LEM measures during department measurement selection which allows managers to ensure that the work being accomplished and the measurement system are aligned with the Pillars, SOs and KAs. Hence, measures always reflect People, Service, Quality, Financial, and Growth performance and are aligned with the objectives and plans that have been established at all levels.

We select measures to track progress in achieving SOs and KAs through the BSC and LEM processes. The BSC measures are selected annually during the **Development** and **Deployment** steps of the SPP to align directly with the Pillars of Excellence, SOs and KAs. The measures and goals that are selected for the BSC are then established and placed on the CEO's **LEM Annual Evaluation Form** and these become the primary basis for his evaluation. LEM measures and goals are weighted by importance and a five point scale is created with the goal level being set at the center, or "3" point. The higher levels (4 and 5) reflect stretch goals, and the lower levels (1 and 2) reflect performance below expectations. To ensure alignment, the CEO's LEM also contains a set of **"Common Goals"** which apply to applicable leaders throughout the organization and these are specified on the CEO's LEM. He then meets individually with his direct reports and collaboratively creates their LEM Annual Evaluation Form, ensuring that the appropriate "Common Goals" and associated measures are included for each position. The CEO's direct reports then follow that same process with their direct reports so that aligned measures and goals cascade down to all department managers and are documented on each one's LEM Annual Evaluation Form. Data are integrated across departments through creation of indices or are aggregated to reflect performance at higher levels. For example, patient satisfaction results for individual departments are reflected on the LEM forms for multiple managers and then are aggregated to produce the overall patient satisfaction score for GVMH which is reflected on the CEO's LEM.

Once the measures and goals are set, the CEO, direct reports, and managers create their 90-Day Plans detailing the specific action steps to be taken to achieve the goals that have been established in the measured areas. All plans are aligned with the Pillars of Excellence, the SOs and the KAs contained in the strategic plan. Measures at all levels are tracked monthly and LEMs are updated and reviewed in one-on-one meetings between leaders and direct reports through the **Monthly Meeting Model (MMM)** process. The MMM is a structured meeting designed to evaluate progress toward goals, review the 90-day plans, identify needs, respond to "tough" questions, and allow decisions on plan modifications when necessary.

The BSC serves as a reporting mechanism for the Board and provides a visual depiction of performance which is posted throughout the organization and on the GVMH Insider. A BSC is created to reflect overall organization performance, which reflects the CEO's LEM performance, and a BSC is also created for each department to reflect that department manager's LEM performance. Both the organization level and the department level BSC is posted in each department so every member of the staff can see where performance is at any

given time. Each BSC identifies five levels of performance - the current year goal (color coded green), stretch goals one and two years out (color coded blue), performance below the current year goal (color coded yellow), and performance well below the current year goal (color coded red). In addition, the BSC shows actual performance for the quarter being reviewed and scoring and weighting factors to permit calculation of an overall score for all measures integrated and aggregated together. The BSC is updated and reviewed at various levels on a quarterly basis as shown in Figure 4.1-1.

In addition, managers ensure that the measures and goals are deployed to each staff member through the **MQC Process**. Every staff member has personal goals established that link to the department goals in the measures that are appropriate for that individual, and they are listed on his or her MQC goal card. In addition, each manager establishes and monitors various quality control and/or performance improvement measures that may not be related to specific SOs and KAs but are otherwise required for optimal department operations, regulatory compliance and/or improvement initiatives.

(2) Comparative Data - We use comparative data and information in three ways: competitive/strategic information to support planning; comparative data to determine our relative performance and help set future goals at both strategic and operational levels; and benchmarking to help understand how to improve processes and create innovations. Needs and priorities for competitive/strategic information are driven by the SPP and are incorporated into the EA. Those data are used to help formulate Strategic Challenges, Core Competency needs and SOs each year. Comparative data to determine our relative performance are selected based upon the importance of the measure, the availability of the data, and the relevance of the data. Generally, if a measure is selected for the BSC it automatically becomes a candidate for comparative data collection, but comparative data selection is not limited to BSC measures. These comparisons are used for setting goals and identification of KAs needed to achieve GSE level performance. Figure OP6 summarizes the sources used for results comparisons. If external comparative data are not available, we use internal historic data to perform trend analysis and set goals to drive performance improvement and identify opportunities for innovation.

Benchmark data are stressed for process evaluation and are collected from external sources using the following criteria: peer groups, best in class, and/or standards of practice. We use site visits, phone contact, and electronic mail to request and collect the data. The workforce maintains knowledge of competitive positions, seeks better practices, and identifies improvements and innovations based on what they have learned from others.

(3) Patient and Other Customer Data – Information is provided in Item 3.1 to describe VOC data sources and methods that are used to gather patient- and other customer-related data and information. The VOC data collected are used both by the SPT in strategic planning and by the workforce to improve customer service and patient outcomes throughout the year. The SPT reviews and analyzes patient and stakeholder data contained in the EA, BSC and other performance review data that are presented for analysis during planning. Those data are assessed and integrated into the decision-making process as the plan is developed. Most patient and stakeholder data are provided to the workforce on a continuous basis during the year as they become available and are reviewed by various leadership teams. The employees receive data pertinent to their patient or other customer group as appropriate and act on it by making changes in their customer service processes, creating a CQI team to develop an improvement or innovation, or modifying action plans already in place.

Some VOC data are incorporated into the measurement system, such as the results from our patient satisfaction surveys. These results are tracked on the BSC and presented to the Board, AT, MT and all staff, and also on the LEMs of those who impact patient satisfaction. Since the survey results are segmented by department, they are included with departmental performance measures. Departments get comparisons of services to the entire HealthStream data base and correlation coefficients are calculated to give relative importance to the questions and responses. Aggregated data are shared with departments and staff, and priority indexes are used to set goals and establish improvement priorities. We also track complaints and aggregate those data to identify more prevalent issues that might be driving dissatisfaction and respond by developing improvement actions to address high priority issues.

(4) Measurement Agility - To ensure the ability to respond quickly to rapid or unexpected change, the performance measurement system is not only evaluated annually for changes to BSC and LEM measures, but every month the LEM measures are reviewed to determine the performance in the measured areas as compared to goal and to determine if modifications to the measurement system are needed based upon changes in plans or new information that becomes available. Process performance measures are also reviewed on a regular basis using the CQI Model. Changes are made as warranted when a new measure is needed or an old measure no longer adds value.

4.1b Performance Analysis and Review

Our performance review approach is summarized in Figure 4.1-1. The AT prepares the **Quarterly Status Report (QSR)** for the Board that shows the progress being made on the KAs contained within the strategic plan. The QSR includes the BSC measures as well as additional indicators of progress such as KA measures. The AT, QST, and MT review the BSC with formal BSC reviews being held in QST sessions. All

patient and customer surveys, measured financial indicators, AP measures, in-process performance indicators, health care outcome data, benchmark results, and CQI team data are also reviewed. All data are analyzed and trended so that they are presented to the review teams in an easy to understand fashion. The QC is responsible for reviewing CQI team outcomes and evaluating the quality control and measures of individual departments. Each CQI team and manager reports the status of their improvement efforts on a periodic basis, showing the data collected internally and comparative data from outside sources. The QC evaluates the information presented and provides guidance to help team leaders and managers set goals that are in line with plan objectives and the changing health care environment.

Team	Freq	Performance Reviewed
Board	Quarterly	GVMH performance (QSR/BSC)
AT	Varies	Selected KA status (weekly); LEM and 90 day plan performance (monthly); QSR and BSC (quarterly)
MSEC	Monthly	Health care delivery results
MT	Monthly	LEM and 90 day plan performance
SPT	Annually	GVMH performance (QSR/BSC)
QST	Varies	CQI team performance, improvements, innovations (monthly); QSR and BSC (quarterly)
QC	Monthly	Department performance; CQI team performance, improvements, innovations; Multidisciplinary Chart Review

Figure 4.1-1 Performance Review Structure

We perform a wide variety of performance analyses at the organization level as well as the department and process levels. As previously indicated, BSC analysis allows for color coding of performance and also includes comparison of performance to plan goals, with more detailed trending of performance and comparison to past performance and benchmarks included in both BSC and other leadership reviews. Analysis to support the LEM process includes comparison to goal and trending. To support department and process level analysis, staff members are trained on basic analysis tools during their CQI orientation. These include creating trend charts; comparisons to past performance, goals, and benchmarks; aggregating data; and Pareto and histogram diagramming. The HealthStream gap and correlation coefficient analyses are also used by departments and staff that serve patients. We also use analysis tools to support the review of financial data. The budget is integrated with the financial statements to allow a monthly comparison of actual and budgeted operating results. The AT and the Board regularly compare our financial indicators to the averages of local competitors, peer hospitals in Missouri, and national standards. In addition, our CPA firm prepares analyses of emerging financial trends within the healthcare industry and reports their opinion of our position as part of their annual presentation of audited financial statements to the Board.

4.1c. Performance Improvement

(1) Best Practices – During BSC reviews, when performance measures are exceeding goal (color coded blue for BSC) high performance is indicated so information is brought forward to identify why the extraordinary results have occurred. Often, the reason will be the implementation of an improvement or innovation. When this occurs, QST and QC validate the action as a best practice or that the action contains valuable lessons learned that should be shared. Similarly, when CQI team outcomes result in creation of what is viewed to be a best practice or contain valuable lessons learned QST and QC will validate and then make a decision to bring the information to the MT for a detailed presentation to all managers who then take the information to their work centers for possible application to individual work processes. The LEM and MMM processes also produce information on best practices in a fashion similar to that of the BSC reviews. The quarterly LDI includes a best practice sharing session each time it is held and the annual Skills Fair is also used as a forum to share best practices with the workforce.

(2) Future performance – Performance projections are developed during strategic planning and are based on three factors: current performance, which is determined through the review process and the findings from those reviews; the anticipated impact of the SOs and KAs that have been identified as the strategic plan is developed; and benchmark data which we use to identify the GSE level of performance we are striving to achieve. A gap analysis is conducted to identify the gains that need to be made in order for current performance to rise to the level of GSE performance and to suggest actions that need to be taken. Discussions during plan development and plan deployment produce KAs to close those gaps, and once identified, the KAs are assessed to determine the pace and the level of impact they will have. Once that is accomplished, the projections are agreed upon and become our goals for future years. As reviews are held if projected gains are not being made plans may be modified to allow us to get back on track, new plans created to generate the gains that need to be made or projections may be adjusted if it is determined that it is not possible to reach the performance levels originally identified.

(3) Continuous Improvement and Innovation - Review findings are translated into improvement and innovation priorities in the following manner. During BSC and LEM reviews, measures performing below the goal require explanation and identification of an improvement, innovation or other corrective action. This permits a focus of the review to be directed toward priority areas in need of improvement, and allows for understanding of poor performance, changing needs, or new challenges that may be emerging. Appropriate CQI teams may be chartered or individual departments may develop new or modified plans to address the issue.

It will be noted that one of the BSC measures is in the form of an index with a goal of three. This index is comprised of a number of measures that are being tracked at the department level within the Quality Pillar. Each of those measures has a goal and a score is calculated to indicate performance against that goal. An average of those scores is then computed, which makes up the score for the index. An index score of three indicates that the measures contained within the index are performing at the goal levels in the aggregate. A score above three demonstrates performance higher than the goal, and below three lower than the goal. During reviews, detailed performance information is presented for those measures within the index that are below goal to allow for a determination of improvement actions. Projected performance for the index will always be at the three level as that indicates goal achievement; however, the goals for the component measures are typically increased each year to reflect the quest for improved performance so the index actually requires a higher level of performance.

The deployment of performance review findings and actions taken is accomplished at QC meetings where the information from the various review methods is shared on a regular basis. QC meeting minutes are subsequently posted on the intranet to permit all staff to gain insight as to performance and newly established improvement priorities. Information is provided directly to partners, collaborators, and key suppliers on an as needed basis by process owners and managers. Once data has been analyzed, any areas for improvement are identified and routed to either the QST, the AT, or QM. If it appears the process problem can be quickly corrected, a RCT will be convened, consisting of representatives from departments involved in the process. If a formal team is needed, a petition is presented to the QST. A form is completed listing the reasons for the team, who should be involved, and what the implications are for improving patient care and satisfaction.

4.2 Knowledge Management, Information and Information Technology

4.2a Organizational Knowledge

(1) Organizational Knowledge - We employ a **Knowledge Management Process (KMP)** consisting of four steps: identify knowledge assets; collect the key knowledge possessed by knowledge assets; store key knowledge; and transfer key knowledge to those who have a need for it. The key knowledge that we collect and transfer includes knowledge needed to accomplish work; to make improvements, replicate best practices and create innovations; to address changing needs and directions; and to develop the strategic plan. In support of this process, there are multiple methods used to manage the knowledge. Data collected from various systems reside in a relational data base that is available for ad-hoc reporting to address operational issues, for planning, and to serve as a general knowledge resource for the organization. Additionally, employees possessing current authorization can create various reports directly from these systems. For example, managers can pull reports from the LEM, they can pull reports as often as needed from HealthStream to track progress to goal for patient satisfaction, and look at real time data from Patient Care Manager. In addition, nursing unit managers are able to pull reports to determine the efficacy of hourly rounding as it relates to patient needs being met versus them needing to use their call light to summon help. Formal and informal mechanisms encourage and support the exchange of knowledge at all levels of the organization and we have identified the knowledge types and assets and implemented the knowledge collection and transfer methods as shown in Figure 4.2-1.

(2) Organizational Learning – we embed learning in the way we operate (referred to as "hardwiring") through a series of actions. First we provide structured training to those who are expected to hardwire processes and methods in the way they do their work to ensure that learning occurs. Second, we make use of our skills lab to provide scenario training so staff members can run practical exercises and apply procedures in a setting that closely simulates the real world to reinforce what they have learned by practicing the techniques. Third, managers are normally involved in the learning and are responsible to follow up and observe their staff to ensure the new practices are being put into place and sustained. For example, when we put the Very Good Care initiative in place, nurses were expected to document the three means by which patient expectations could be exceeded on a white board in the patient's room. Nurse managers then observed that the practice was being accomplished as they conducted their patient rounds and documented their findings to track if the behavior change was occurring. When we verified that the requirement was being accomplished 100% of the time we concluded that the procedure was hardwired.

4.2b Data, Information, and Information Technology

(1) Data and Information Properties - The accuracy, integrity, reliability, timeliness, security and confidentiality of organization data, information and knowledge are critical to attaining the IT strategic objectives and are dependent on both the effectiveness of staff and the data management systems. Staff effectiveness is ensured through a detailed hiring and recruiting process, the performance evaluation process, and various learning and development initiatives. These establish performance expectations and boundaries and focus on the need for integrity, reliability, accuracy and confidentiality of data, information and knowledge. Similarly, data management systems are selected, developed and maintained to maximize these properties. As technology systems are selected, hardware and software sources are screened. Specifications are defined through the development of definitions, identification of needed data elements, and user requirements. This structure provides for integrity, reliability and accuracy of the data elements. Training is also provided to end-users to access/use data and reports. This training brings security, integrity, confidentiality and accuracy to the organizational knowledge

Objective	Knowledge Management Methods
Collect and Transfer Workforce Knowledge	Work process documentation
	Management Team, department, unit meetings
	Leader Rounding
	Town Hall meetings
	Leader Development Institute
	Suggestions to committees/councils/teams
	Staff Satisfaction Survey and focus groups
	E-mail
	Bulletin boards/GVMH Insider
	Hospital input sessions
	Staff reports/suggestions to manager
	Team to Team sharing
	Team reporting
	Presentation of team learning or design
Transfer Knowledge from & to Patients and Other Customers	Admissions process
	Patient Advocate
	Staff interaction with patient
	Patient Satisfaction Survey
	Patient Call Manager
	Patient Bill of Rights
	Brochures
	Patient Hourly Rounding
	Grievance and Complaint Management Process
Transfer Knowledge from & to Suppliers, Partners, Collaborators	Negotiations, written agreements, and contracts
	Meetings and phone conversations
	Training
	Feedback and post-mortem sessions
	E-mail
	Website
Share and Implement Best Practices	Leader Development Institute
	Skills Fair
	Research and benchmarking
	Member input to teams and committees
	Website
Knowledge for Innovation and Strategic Planning	Environmental Assessment process
	Leader Evaluation Manager process
	Voice of the Customer process
	Quality Steering Committee process

Figure 4.2-1 Knowledge Management Methods

base. Lastly, the output is validated using data validity checks and statistical analysis to assure reliability and integrity of the reports. The approaches used are summarized in Figure 4.2-2.

(2) Data and Information Availability – GVMH has a full complement of Information System (IS) Applications and IT infrastructure in place. The MEDITECH Healthcare Information System (MHCIS) supports the majority of our information systems and enhances our ability to provide meaningful, real-time data and information to the workforce, customers, partners, collaborators, and suppliers. This integrated system provides easy, end-user access to the information they need to effectively perform their responsibilities. The MHCIS provides online clinical, financial, and research information all

Factor	Method to Ensure
Accuracy	Training
	Audit reports
	Data field validation
	Input masks
	Error reporting
	Complaint data
	Vendor monitoring
	Relational database cross checking
Integrity and reliability	User authentication
	Training
	Audit reports
	Data validation functions
	Comparison to standards
	Hardware and software monitoring
Timeliness	Computer access and availability
	Policies
	Reports
	Work orders
	Training
	Help desk
	Network monitoring
	Hardware recycle policies
Security and confidentiality	User authentication
	Usage policies
	Data encryption
	Access log monitoring
	Virus protection
	Spyware identification
	Firewall
	File permissions
	Data redundancy

Figure 4.2-2 Approaches to Address Data and Information Properties

of which is available to the workforce who require access to this type of information as displayed in Figure 4.2-3. The workforce gains access to these data and information through multiple servers and computers connected to a high speed Transmission Control Protocol – Internet Protocol (TCP-IP) network.

In addition to a full complement of financial systems, MHCIS clinical systems include:

- Electronic Medical Record (EMR) with the add on Scanning and Archiving module;
- Nursing Documentation, Order Entry – Results;
- Radiology Information System;
- Laboratory Information System;
- Integrated Therapy System;
- Operating Room Management;
- Data repository and quality management systems

- Computerized Physician Order Entry (CPOE) and Patient Scheduling; Electronic Medication Administration Record and Bedside Medication Verification Systems;
- Integrated Patient Education System (Truven);
- Patient Discharge Instructions with Dr. First integrated medication reconciliation process;
- Vital sign monitor interface to Patient Care, ER and OR;
- Physician documentation system;
- Mobile bar coded lab system
- Vocera wireless voice communication; and
- Integrated access to UpToDate

In addition, the **Picture Archiving Communications System (PACS)** is deployed and allows medical images to be interfaced to the electronic medical record and is available for physician viewing. A secure network allows physicians to access the system from external locations. We also use a Dictaphone PC based dictation system which is interfaced to the Meditech Electronic Medical Record, KRONOS Time and Attendance, Quadramed Medical Records Encoder, Delta home services system, and Emdeon Insurance Verification. Further, we perform electronic exchange of purchase orders via the GHX and MSS systems and have an electronic patient appointment reminder system to assure that patients make their scheduled appointment or can reschedule if needed. When callers into the hospital are placed on hold, we play recordings that educate the caller on our new and on-going hospital services. We have also installed the 'Meaningful Use' Stage 2 Certified version of the Meditech System – 5.6.6. We have also acquired the Meditech Continuity of Care Document (CCD), Data Repository and Laboratory, Immunizations and Syndromic Surveillance interfaces. We have met the requirements of Stage 1 Meaningful Use and have attested and been accepted for compliance. We are meeting one half of the Stage 2 requirements and have acquired the required patient education system that will be interfaced to the Meditech EMR. Additional improvements we are actively working on include the required Stage 2 patient portal.

The clinics utilize the MedEvolve Practice Management System. We have acquired and implemented the 'Meaningful Use' certified version of the MED3000 – I.C. Chart Clinical System version 6.4. The EHR system is live in all our sites; Windsor, Warsaw and Clinton. We have met all requirements of Stage 1 Meaningful Use Year 2. As part of our efforts to enhance patient care and meet meaningful use, we have interfaced our Meditech system, patient admissions and results to the clinic system so both systems will contain a complete patient history. All PACS images are also available in the clinic EHR. We are also automating clinic ancillary orders to interface to the Meditech system to enhance physician CPOE. We will utilize the MED3000 CCD to interface patient medication history to our Meditech EMR for medication reconciliation.

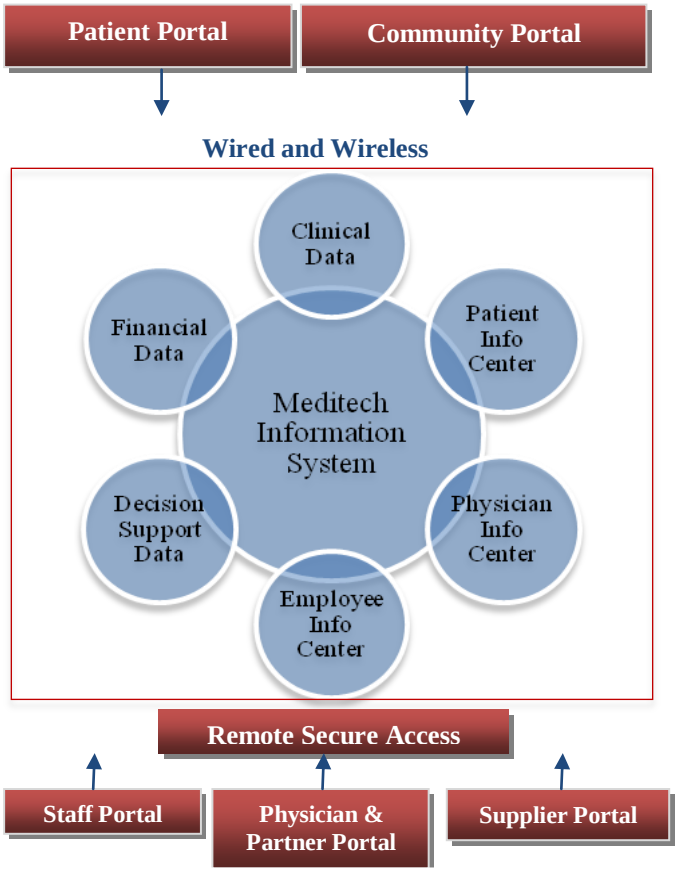


Figure 4.2-3 Data and Information Availability

Through the GVMH Insider, the workforce has access to a variety of information resources, including the latest hospital financial statements and performance reports, all committee meeting minutes, online staff education, maintenance work orders, employment opportunities, and e-mail. The Insider provides for timely deployment of information and all staff members are provided an e-mail address to enhance accessibility to information. The intranet and e-mail are addressed during new employee orientation and highlighted throughout the year so the workforce gains an understanding as to how to use the system. The hospital also provides a public Internet website: http://www.gvmh.org that offers potential and current customer's health related information, new baby photographs, job availability, general hospital information, and a link to provide a simplified method to submit information to the hospital.

(3) Hardware and Software Properties - We ensure hardware and software reliability through continuous monitoring by the IT department. Computer system downtime is tracked and reported. We have installed a Virtual Machine environment for our Meditech servers to provide hardware redundancy. A hardware recycle policy ensures that older hardware is replaced in a timely manner. An online maintenance log provides historical hardware performance

information supplied through the IT work order system. Software updates and patches are tested and applied immediately upon receiving vendor and operating system compatibility. The storage area network (SAN) technology used to store all MHCIS and PACs data provides for fast access with a high degree of redundancy.

We address data and information security through a comprehensive multi-layered approach. Physical access to critical areas is limited to appropriate staff through the use of combination locks on doors. Online access to data and information is provided through operating systems security in combination with the MHCIS role based security features. An interdisciplinary System Access Team (SAT) reviews and approves user access. Access logs are routinely monitored and a security incident policy is in place to address breaches of patient confidentiality. User IDs and passwords are required to access critical data. Anti-virus software, spyware detection, spam control systems, and firewalls are utilized and monitored by the IT department. End user education regarding safe and secure system usage is a part of every employee's annual in-service training. We ensure that hardware and software are user-friendly by seeking input from users on what capabilities and design features they need, what specific product they would like to have, testing products before purchase, evaluating data obtained from the user satisfaction survey, and by using VHA approved vendors.

To ensure that IT systems are kept current, the Director of IT develops and submits an IT Strategic Plan to support the hospital's strategic plan each year. In addition to providing support to the hospital strategic plan, the IT plan incorporates input obtained from the IT User Satisfaction Surveys that are routinely conducted to seek feedback from all those who use the IT systems. Survey results are part of the IT scorecard which is used to drive improvement planning and provides the basis for periodic reports to the QC. An interdisciplinary Technology Strategy and Support (TSS) committee is in place to provide an IT "oversight" role and ensure that IT systems meet the needs of those being served. This team, consisting of all senior leaders and key directors, meets on a monthly basis and focuses completely on IT initiatives. We also utilize teams that meet on a monthly basis to address specific I.T. needs. These include the Physicians – Clinical Information Systems Committee and Nursing – IT Team and Ancillary Systems Team. We have recently added software support and help desk personnel to keep pace with the growing demand for system enhancement and end user support. Continuing education is especially critical for IT staff members to keep pace in a rapidly changing environment. The annual IT departmental budget provides funds to assure that these needs are met.

(4) Emergency Availability - A formal Disaster Recovery Plan outlines procedures for making data and information available in case of an emergency. An automated re-sync and mirror process of all MHCIS data is performed daily. The backup tapes are taken off site and stored in a bank vault for added security. Downtime policies and procedures are developed and activated as needed to ensure continuity of patient care.

Category 5 Workforce Focus

5.1 Workforce Environment

5.1a Workforce Capability and Capacity

(1) Capability and Capacity – We assess overall workforce capability and capacity needs as part of the resource allocation step of the SPP. In support of the strategic plan, the CFO develops budget parameters and communicates them to the AT. Individual AT members and their managers review department-specific parameters and set their staffing plans based on budget realities; industry standards and best practices; plans for new health care services; and changes in technology, regulations, market factors or patient and other customer preferences. Physician capability and capacity needs are also addressed during strategic planning. The SPT annually analyzes data for physician specialty needs in our primary and secondary markets relative to factors such as demographics, healthcare utilization, physician admissions, and healthcare service availability and demand to determine if there is a need for additional physician capability and capacity. We address these needs by identifying physician specialties to recruit and hire against or by establishing relationships with referring physicians in the area to change referral patterns.

Workforce capability needs within departments are driven by industry standards and customer preferences and are assessed by managers who consistently review competencies and skills needed by staff and update job descriptions accordingly. All staff are assessed annually through the PAP to verify that job competencies and skills are maintained and managers are encouraged to take certification exams. When new services are introduced, the responsible AT member assesses workforce capability change requirements and develops supporting plans.

Workforce capacity needs in clinical areas are based upon budgeted hours per patient day (HPPD). Benchmark data has been used to determine the HPPD for each department, and calculations are made to determine the number of patients cared for in a particular nursing unit. A staffing grid has been developed based on unit census and the HPPD to suggest the number of staff required for a particular shift. The skill mix (RN, LPN, NA, unit secretary) is determined by the unit managers based on the census for each shift. To account for fluctuations in acuity, the House Supervisor (HS) and managers meet daily to discuss staffing for the next 24 hours, and for the entire weekend on Friday. A plan is developed and implemented based on this review, and the HS has the authority to adjust the plan as needs dictate. Directors are available 24/7 to assist in any difficult decisions that may suggest a need to change the plan. As staffing needs increase over the number of staff scheduled, it is a shared responsibility

of the HS and managers to work and obtain additional staffing to meet patient care needs. A per diem float pool of staff nurses who consistently work at GVMH has been identified and these individuals are scheduled on a weekly basis during times of increased census.

(2) New Workforce Members - The recruiting process includes development of an updated job description for the position being filled and listing specific job requirements in job advertisements. Staff members are recruited through various means, including the *GVMH Insider*, newspaper and trade journal advertisements, career fairs, professional recruiters, fellow employees, the internet, and interaction with nursing, paramedic, and medical schools. Student clinical rotations at the hospital often result in employment, and scholarships, grants and tuition reimbursement are available to help "grow" or retain our own employees.

Hiring follows a standardized process that is a collaborative effort between the department doing the hiring and HR. When candidates are identified, they are screened by HR and the department to determine if all qualifications are met and some are chosen to be interviewed. The department conducts the interview using **Structured Behavioral Interviewing** and **Peer Interviewing** techniques and ultimately decides if a candidate is to receive an offer. Interview questions are aligned with the Studer initiatives, Behaviors of Excellence, and PAP assessment factors; prospective employees take a physical capability test to ensure that they can meet all patient safety requirements; and HR conducts background checks on applicants who have been interviewed.

Once hired, new staff members go through an orientation process before placed in their position. A one and one-half day **New Employee Orientation (NEO)** is held for all new staff and an additional half-day is added for clinical staff requiring training on technology systems. Unit-specific orientation is then provided which is individualized and designed by each manager based upon the new employee's background and self-evaluation. An orientation completion tool is used to ensure the appropriate competency level has been attained. A two-day Nursing Orientation is provided for the nursing staff, and once completed for their assigned department, all are cross-trained on different department procedures to provide for a better trained and diverse workforce. New nurses are also assigned to a preceptor who guides them through the initial clinical experience. In addition, each new staff member completes computer-based learning (CBL) covering a variety of mandatory topics addressing core competencies, specific skills, and compliance requirements among others. New employees also attend a 21 day orientation refresher to reinforce what was learned and to permit us to obtain feedback on NEO and the hiring and recruitment process so that we might make improvements. At the 90 day point all new employees are assessed using PAP procedures.

To retain new staff, we identify and emphasize factors that are important to staff retention that have been determined through staff surveys and focus groups and input received through exit interviews. Retention initiatives for new staff include: strong communications engagement through the ELI system, participation in a self-governance approach; opportunity to serve as a preceptor; opportunity to progress to serve as a charge nurse; train or serve in a variety of clinical service areas; and early learning and development opportunities. In addition, an incentive program has been implemented for those who volunteer to work extra shifts, come in for other employees, or assist other employees in various ways; Employee recognition funds have been made available to managers to use at their discretion to recognize outstanding work or contributions to the organization; a night and weekend differential payment approach has been implemented; premium pay is provided on holidays; and scholarship reimbursement is available for hard to fill positions.

We ensure that the workforce represents the diverse ideas, cultures and thinking of the hiring community through affirmative action initiatives that incorporate diversity into recruiting practices. We develop diverse candidate pools from employee referrals, community outreach, and organizational partnerships and if there areas of under-representation our hiring staff collaborates on outreach to community organizations to identify candidates where needed.

(3) Work Accomplishment – We organize and manage the workforce to accomplish work according to the functional responsibility of individual departments where work group requirements are clearly defined in job descriptions. We maintain job descriptions for all positions, listing the reporting relationships for the job, a summary of the position responsibilities, specific qualifications for the job, other skills, analytical abilities, and the environmental and physical demands that must be met. Job descriptions are integrated with the PAP and include requirements addressing the Studer initiatives, the BOE, the MVV, work attendance, career growth and development, CQI, equipment and safety, compliance and ethics, and principle duties and competencies.

Within departments, roles are clearly defined for all staff. In health care delivery units **Interdisciplinary Care Teams (ICTs)** manage and deliver care. ICTs typically include the physician, nursing staff, social worker, pharmacists, and representatives from other disciplines required to address the plan of care requirements. ICTs implement the ICDWS and individualize care for each patient by customizing the plan for care and involving the patient and family in the planning process as described in Area 6.1b (2). In non-clinical departments work center teams are formed and aligned with ICTs as appropriate to enhance support for care delivery.

Nursing teams comprised of RNs, LPNs, and CNAs are used on the medical surgical floors. These care teams are empowered to coordinate and plan care for patients each shift, adjusting for such things as acuity levels, age complications,

and awareness of specific patient needs. ICU and the Birthing Center utilize a primary nursing approach that promotes and encourages development of individual leadership skills to optimize patient and family education while delivering care. Report at shift change, morning huddles, educational programs, poster in-services, and staff involvement in quality management activities enhance the opportunities for skill sharing and communication between shifts. The nurse managers' role is a combination of "director of the system" and "process leader." However, each nursing unit also has formally and informally identified process leaders. The nursing supervisor helps facilitate staffing needs house-wide and problem-solves issues that arise, and provides an immediate link to respond to changes in census and customer satisfaction indicators. In addition, the **Unit Operations Committee**, comprised of all clinical managers and staff representatives, meets monthly to share information, describe improvements in care delivery, discuss operational issues that arise, and identify actions to take to address those issues, and **Nursing Roundtables** are also used to provide a forum for sharing information and addressing issues.

Since CQI is fully integrated into our culture, we are a team driven organization seeking to constantly improve and innovate. Numerous standing teams are in place, and **CQI Teams** are chartered on a short- and long-term basis to achieve specific objectives, or design or redesign work processes. To promote agility, we use **Rapid Cycle Teams (RCTs)** on an increasing basis to reach decisions quickly when needed to address changing customer or market requirements or other challenges. CQI training is presented to new staff on their first orientation day, and team leader training is readily available to staff who are selected to serve as CQI team leaders. Staff members are encouraged to participate on teams, which are designed to include a diverse cross section of the staff in order to draw on the variety of ideas, cultures, thinking, and expertise within the organization. The work accomplished by these cross-functional teams generally addresses issues that have impact across the organization; individual departments use work center teams to solve department-specific problems**.** Figure 5.1-1 summarizes methods used to organize and manage the workforce to capitalize on core competencies; reinforce focus on patients, other customers and health care; and exceed performance expectations.

(4) Workforce Change Management – We prepare our staff for changing capability and capacity needs through a transparent and collaborative approach in which employees are encouraged and empowered to participate in planning, evaluating, and implementing new or revised plans. Managers complete a staffing budget annually based on their current and future operational needs and this budget drives their FTE utilization and allowance for the year. Any additions to the budget are reviewed for approval by the AT. A position justification is completed for any new position that is added to the budget. We have been very fortunate in that we have been able to grow staff over the last 10 years by an average of 3.5% per year despite the difficult economic times. We added a number of physician positions and associated support staff in the Physician Clinics, the Outpatient Treatment Center, and the Emergency Department to meet increasing patient volumes, and inpatient units to meet the needs of capacity changes.

Requirement	Method
Accomplish Work	Organizational structure
	Job descriptions
	ICTs
	Nursing Teams
	Work center teams aligned with ICTs
Core Competencies	Patient-focused care delivery and management
	Wide scope of health care services
	Integration of new technology
	Learning and development system
Patient, Other Customer, Health Care Focus	Mission, vision and values
	Behaviors of Excellence
	Leader Rounding
	Unit Operations Committee
	Nursing Roundtables
	Rapid Cycle and CQI Teams
	Incentive Bonus Plan
Exceed Performance Expectations	Golden Standard of Excellence
	BSC, LEM and MMM processes
	My Quality Commitment and PAP
	CQI Model
	Incentive Bonus Plan

Figure 5.1-1 Methods to Address Work Accomplishment Requirements

Although we have not been faced with the need for workforce reductions for some time, we have procedures in place where HR and hiring managers would partner on placement solutions that seek to redeploy people internally. We conduct adverse impact analyses and match deployed individuals to positions that are specifically suited to their qualifications and talents. If across-the-board workforce reductions are required we use attrition to the maximum extent possible to minimize the impact on the workforce. If that is not sufficient we have a systematic process in place that establishes downsizing priority based on mission requirements, employment status, job performance and seniority. If people are displaced, we assist them with resume development, interview techniques, and career counseling. A displaced employee who leaves GVMH receives severance pay and may be recalled in the future. We prepare for and manage periods of rapid workforce growth by conducting workforce planning sessions with HR, finance, and department managers, and add volunteers to supplement staff as needed.

5.1b Workforce Climate

(1) Workplace Environment – We ensure and improve workplace health, security, and workforce accessibility through the programs described in Figure 5.1-2. To address environmental factors that promote a healthy work environment, the **Employee Wellness Program Committee** is in place and has implemented the **Strides Taken Everyday Produce Success (STEPS)** program that encourages employees to pursue a healthy lifestyle and complete wellness requirements. These are updated annually and are combined with results from wellness screenings to project and plan future wellness needs. Employees earn points for fulfilling requirements and are rewarded with $75 and $150 bonuses when they achieve certain thresholds. Initiatives such as podcasts and online test completion have been implemented to make it easy for staff to participate. In addition, the committee implemented the **Healthy Rewards Program**, which motivates employees to improve their health by obtaining a biometric screening and a risk appraisal, staying tobacco free or completing a tobacco cessation program, and completing a wellness challenge in exchange for accumulation of points leading to lower individual health care premiums. Employees can save up to $780 on their health coverage by participating. A new group, the **Health & Productivity Team,** has been created to oversee this program. We have also created the **Great Weight Race** to encourage weight loss where teams of four compete to reduce body mass of all on the teams, and we also offer Lunch and Learn (live and pod cast for shifts), "In the Know" online programs, Smoking Cessation classes, and health forums.

We place a strong emphasis on accessibility and completed an internal renovation of our patient care areas where ADA improvements were made by converting semi private rooms to private rooms, thereby providing additional space. With the additional space we placed bars in bathrooms, computer workstations in each room, overhead lifts, and air mattresses, all of which has made accessibility easier for employees in need. In addition, provisions are made for employees with disabilities or injuries to continue working through a light duty program with mobility devices such as crutches or wheel chairs provided. To ensure security, unarmed personnel are on duty during evening and night shifts and security incidents are reported, tracked, and acted upon for corrective action. Security cameras, alarms, and automatic lockdown capability are resident in the emergency department, pharmacy, intensive care unit, birthing center, and on the ground floor.

(2) Workforce Benefits and Policies - We support the workforce through the following services and benefits, some of which are tailored to the needs of the staff as indicated: a competitive compensation plan; multiple retirement plans to choose from; health insurance with individually tailored plans; dental insurance; an optional cafeteria plan; vision plan; learning and development programs, an incentive-based employee wellness program; flexible work schedules; scholarship programs; tuition reimbursement; long-term compensation; team opportunities; recognition for good ideas; and recognition for service and employee satisfaction.

In addition, an Employee Assistance Program confidentially provides help or services to employees and we have implemented a formal benevolence program with a staff steering committee providing oversight. A benevolence fund is established and staff members contribute money voluntarily through payroll deduction to the fund and numerous fund-raisers are held throughout the year by various departments to build its assets. The Benevolence Committee allocates the funds to meet the financial needs of individual staff members when an emergency occurs. Staff members have access to the Wellness Centers, can purchase medications and supplies at 10% above GVMH cost, can obtain discount services from AT&T, Sprint, Verizon and Dell products and services, and are reimbursed for membership in Life Flight on a graduating scale based on tenure.

5.2 Workforce Engagement

5.2a Workforce Performance

(1) Elements of Engagement - We determine the key elements that impact workforce engagement through the HealthStream Staff Satisfaction Survey. We partnered with HealthStream in 2012 to provide staff perspectives pertaining to a wide variety of environmental factors that impact engagement and satisfaction. HealthStream analyzes the results and provides a report providing insights as to the primary factors that drive engagement. The same approach is used for all workforce groups and segments.

(2) Organizational Culture - We established the ELI system to foster creation of multiple methods to communicate up and down and across the organization and chartered a CQI team to redesign our communications approach. This team collected data from physicians, managers, and staff from all departments and determined that an upgraded intranet capability was needed. Based on their analysis the team designed and produced the **GVMH Insider** and guidelines for its use to disseminate information, provide educational opportunities, provide a forum for communication, and a method for feedback throughout the organization. In addition, all staff members are provided with their own e-mail address to send and receive information. Further, regular department/unit meetings, hospital-wide meetings, Leader Rounds, nursing roundtables, Skills Fairs, *GVMH in Action*,

Factors	Programs	Measures	Goals
Health Services	STEPS	# Rewards	300
	Great Weight Race	# Participants	50
	Health Screenings	Completion Rate	90%
	Health Appraisals	HC Cost/Employee	75th %
Security	Incident Prevention	Incident Rate	<.1
Benefits	Benefit Programs	Benefits/Employee	75th %

Figure 5.1-2 Workplace Climate Factors

Capsulized News, Town Hall meetings, and distribution of meeting minutes make major contributions to our ability to effectively communicate, cooperate, and share skills across the organization. As indicated in Figure 1.1-3, information flow and two-way communications with leaders is a high priority with numerous methods in place to assure ample opportunity for the entire workforce to be involved.

To focus on high performance work and engagement we have focused on the Studer initiatives to not only enhance our service to patients and other customers, but also to stimulate workforce high performance and engagement. Workforce-related initiatives that are hardwired include: Leader Rounding; Behaviors of Excellence; Thank You Notes; No Pass, No Punt; Gold Coupons; the LEM and MMM processes; and the MQC process. **Leader Rounding** requires that all leaders round on each of their employee stations at least monthly to engage with them and receive input**. Behaviors of Excellence** identify behaviors we want all employees to demonstrate in dealing with patients and other customers, and fellow staff members. **Thank You Notes** requires leaders to distribute a prescribed number of personally written notes to the staff weekly praising their efforts and their outcomes they have achieved. **No Pass, No Punt** requires that staff members do not "pass" or "punt" a patient or other customer to another staff member when they are confronted with a need or an issue that a patient or other customer has. **Gold Coupons** are rewards that staff members can give to fellow employees when they observe positive behavior worthy of recognition. The **LEM** and **MMM** processes deploy the organizational plans, measures, and goals to the managers and their departments and ensure that monthly meetings are held to review progress and adjust department plans as needed. These approaches serve to drive high performance and further engagement between senior leaders, managers, and all staff. The **MQC** process brings the department plans, measures, and goals to individuals within the department to drive individual high performance and further engagement with them.

To benefit from diverse ideas and cultures, we seek to create a workforce that represents the diversity we see in our community and our patient population. When committees, councils or teams are formed, we consciously appoint members who represent the diversity that exists within the organization. Many of our teams include patients and/or members of the community and we promote diversity in perspectives by ensuring cross-functional membership on major committees.

(3) Performance Management – Our workforce performance management system, the **Performance Appraisal Process (PAP),** is designed to align an individual's personal goals and development plans to key organizational objectives. PAP consists of a self-evaluation, peer evaluation, and assessment of an individual's performance by his/her supervisor on an annual basis, a discussion of the assessment outcome, and creation of a written report including a summary assessment, a quantitative rating, a development plan for the coming year, and MQC goals. The assessment addresses the individual's performance in six areas: Commitment to Customers; Professionalism; Commitment to GVMH Team; Quality Improvement; Safety and Equipment; and Principal Duties. Figure 5.2-1 demonstrates how the PAP supports high performance (HP) and workforce engagement (WE); reinforces intelligent risk taking (IRT); reinforces a focus on patients, other customers and healthcare (PCF); and reinforces achievement of action plans (AP). An asterisk indicates that there are rating factors within the assessment area that supports or reinforces the objective.

Objective Assessment Area	HP	WE	IRT	PCF	AP
Commitment to Customers	*	*		*	
Professionalism	*	*	*	*	*
Commitment to GVMH Team	*	*		*	
Quality Improvement	*	*	*	*	*
Safety& Equipment	*	*		*	
Principal Duties	*	*	*	*	*

Figure 5-2-1 PAP Alignment with Objectives

The PAP is also linked to our compensation system. We receive salary survey information from MHA and other hospitals and health care organizations in our area annually to support our objective of maintaining competitive pay schedules, and make market adjustments so that all job categories are competitive with other healthcare organizations within 100 miles. The PAP is used to determine salary adjustments for the workforce annually. Based on the PAP rating, an individual may receive a higher or lower merit increase each year, thereby linking an individual's performance to their compensation. The EIB was instituted to reward the workforce as a team if performance criteria are met in financial and customer service areas. Under the financial criteria, we must attain an operating margin of two percent or more. Under the customer service criteria, patient satisfaction must achieve GSE performance or improve over the prior year. If these criteria are met, 10% of our operating margin is paid to the staff using a workforce derived formula based on hours and length of service to the organization. Figure 5.2-2 summarizes the reward and recognition methods used to promote workforce high performance.

5.2b Assessment of Workforce Engagement

(1) Assessment of Engagement – We assess workforce engagement using both formal and informal methods. We initiated the **HealthStream Employee Satisfaction Survey (ESS)** in 2012 as a result of an evaluation and improvement

initiative and this is our primary method of assessing engagement. The survey is conducted annually using both electronic and paper submission methods. Employees and volunteers provide input in eight different areas: Your Immediate Supervisor; Pay and Benefits; Hiring, Promotion, and Opportunity; Upper Management; Quality and Competence; Job Engagement; Organizational Engagement; and Overall Indicators. While all of the areas rated play a role in our assessment, the Job Engagement and Organizational Engagement areas have the greatest significance. Survey results are segmented by work status, shift, position, longevity, and age group. HealthStream also provides comparative data permitting us to determine our percentile rank amongst all other health care organizations in the database.

We use other measures and indicators to assess and improve workforce engagement as well, including MQC participation, retention rate, productivity, grievances, incidents, Leader Rounding, exit interviews, focus groups, and various leadership communication channels.

(2) Correlation with Organizational Results – Staff results from the ESS and other workforce performance results are correlated to identify opportunities for improvement and assess workforce engagement by the AT and HR Director on an annual basis. Staff performance results that are reviewed include retention rate, grievances, productivity, and safety. Any opportunities for improvement are fed into the SPP under the human resource Pillar for review and consideration based on a systematic process to prioritize and select key actions based on the strategic direction of the organization.

5.2c Workforce and Leader Development

(1) Learning and Development System – Our learning and development system focuses on meeting the business needs of the organization and the development needs of employees. We ensure all employees have the necessary skills needed to address our Key Actions and Key Workforce Plans, and to perform in a rapidly changing environment of healthcare and technology. Identification of learning and development needs is annual and ongoing, driven by processes and factors such as: 1) the SPP, regulatory requirements, retention data, and the VOC; 2) new policies and evidence-based practices for departments; and 3) performance reviews for individuals. Individual departments, teams, and units also plan and carry out professional development activities with the help of the Education (EDU), which also sponsors hospital-wide learning and development initiatives on general subjects of interest throughout the year, many of which are also offered to the community.

Process-wise, learning and development needs are determined in a variety of ways. A learning needs assessment is conducted biannually by the EDU. This assessment seeks to identify what

Method	Recipients	Incentive Area
EIB	All staff	Customer service; financial performance
Merit Raises	All staff	PAP ratings
Preceptor Bonus	Preceptors	Mentoring
Referral Bonus	All staff	Referral of new staff
Awards Banquet	All staff	Appreciation
Excellence in Nursing	One RN/LPN; one support staff	Overall performance
Staff Member of Month/Year	All staff	Overall performance
Service Excellence Award	Staff, physicians, students, volunteers	Customer service
Gold Coupon Award	All staff	Mission accomplishment
HealthStream Results	Staff, physicians, students, volunteer	Patient satisfaction
STAR Award	All staff	CQI: customer service improvement: financial savings
Thank You Notes	All staff	Job performance; good deeds
Falls Trophy	Caregivers	Patient Safety
Director's Breakfast	All staff	Appreciation
PR Releases	All staff	Job performance; good deeds
Volunteer of the Month	Volunteers	Job performance
Recognition Banquet	Volunteers	Appreciation

Figure 5.2-2 Reward and Recognition Methods

type of learning and development is required, when it should occur, the length of the offerings, and the preferred mode of delivery. The assessment is accomplished through a review of strategic plan requirements and determination of learning and development needs related to Strategic Advantages and Challenges, Core Competencies, SOs and KAs; consultation with managers and staff members; development requirements resulting from PAP evaluations; and through survey inputs. Based on the results of this assessment, an education plan is developed. The system addresses key factors as follows:

Core Competencies, Strategic Challenges, Action Plans - Core Competencies, Strategic Challenges, SOs and KAs are addressed as described above. Existing or emerging Core Competencies normally require new or recurring learning and development opportunities. Some Strategic Challenges, SOs, and KAs also require new or recurring learning and development and some KAs include professional development action steps. Specific learning and development opportunities are identified during the needs assessment process.

Performance Improvement and Innovation – CQI training is provided as part of new employee orientation, with follow up training available when staff members are assigned to

teams. Teams work interactively to solve problems, design processes, identify improvement options, and create innovations, all of which provide significant reinforcement of performance improvement and innovation methods and represent a core approach we use for learning and development in this area. In addition, senior leaders and managers serve as MQA Examiners each year providing our leadership team with greater insight and understanding improvement and innovation methods and techniques.

Focus on Patients and Other Customers – Significant learning and development is underway to support implementation of the Studer initiatives. All leaders and managers attend the quarterly Leadership Development Institute (LDI), which is heavily focused on these initiatives, and all leaders and managers are attending one TYYO (Take You and Your Organization to the Next Level) learning event, which is a Studer Group sponsored conference. We are using a structured learning approach where managers are expected to cascade their learning from these activities to their staff.

Transfer of Knowledge – Our standard operating procedures require defined work documents outlining work processes and procedures; a comprehensive system of policies, procedures, and protocols documenting our knowledge base so critical information does not reside solely with one person; and a preceptor program mentoring new and returning nurses. In addition, we ask departing staff to mentor their replacements wherever possible, exit interviews are used to obtain information from those leaving, and some departing individuals are asked to continue to work with us on a part-time or temporary basis to provide help in transitioning to new employees as needed.

Reinforcement on the Job – Occurs through: new hire checklists and competency verification sheets; the preceptor program; return demonstrations on the job or in learning labs; LDI Linkage requiring leaders to apply skills and concepts learned at LDI sessions; post tests; questions leaders use during rounding on staff and patients, which reinforces new skills and ensures they are being applied, such as AIDET and BOE.

(2) Learning and Development Effectiveness - Learning and development events are evaluated by participants and instructors to answer the following questions: did participants find the programs beneficial; did they learn useful information; were the facilities conducive to learning; were good adult learning techniques used; can students apply and/or use the information; what difference the program makes for staff, customers, GVMH results; and will the information improve patient care and satisfaction. Most programs also use testing to determine learning and are evaluated for cost effectiveness, effective means and timing of delivery, and usefulness in other areas of the organization. In addition, application of learning is evaluated by leaders during rounding and through observation in skill labs where learners are evaluated and scored; if a passing grade is not attained they are required to retrain and undergo another evaluation.

Further, employees who attend an outside learning opportunity are provided an **Education Opportunities Feedback Report** in which they assess the program attended, indicate value to GVMH, and key benefits that can be obtained from implementing new ideas generated. In addition, our entire educational programming is evaluated by staff for quality improvement. This information, stratified by department as well as individual staff members' issues, helps us determine the effectiveness of the program, look for quality improvement areas, and determine particular issues, needs, or program presentations that were/were not effective in helping us meet our goals, and what improvements can be made in the educational process. Verbal follow-up and feedback is procured from directors to determine performance improvement as a result of the educational program or to determine if follow up training is needed. Results are tabulated monthly and changes made as needed.

(3) Career Progression - We support career progression by providing significant opportunities for professional growth, by enabling all staff to avail themselves of learning, by posting job openings internally before offering them to the public, and by giving qualified staff members first priority to fill positions. Managers use the results of competency evaluations, incident reports, patient satisfaction surveys, and individual staff development plans to request and/or plan learning and development programs for staff. Managers assign a preceptor for new staff, and staff interested in additional responsibilities may take advantage of the mentoring program. Individual staff may request time and payment of fees to attend job-related workshops, and managers are encouraged to belong to at least one professional group and to attend professional updates to keep abreast of industry changes. Managers are also encouraged to study and sit for job specific certification exams and this is reinforced during Nurses Week when those who have successfully attained advanced certification are honored at a luncheon.

Administration and managers are keenly aware of the need for succession planning. LDI workshops are held quarterly, and managers are encouraged to send key assistants and/or those with management potential. All managers, as well as others with leadership ability, are encouraged to complete personal development courses, and managers discuss succession planning with administration when a move is being anticipated. Assistant managers are involved in budgeting and staffing, and are included on the MT. We maintain a policy of hiring from within whenever possible, thereby encouraging workforce morale and reducing the time needed for new leaders to adapt to the organizational culture.

Category 6 Operations Focus

6.1 Work Processes

6.1a Service and Process Design

(1) Design Concepts – We use the **CQI Model** (Figure 6.1-1) to design health care services and work processes to meet all requirements. This model was created based on the Plan, Do, Check, Act concept to ensure process teams and owners across the organization would have a consistent and easy to understand approach to use to design processes effectively. It is fully deployed throughout GVMH, has been used for more than ten years and has undergone several evaluation and improvement cycles. Every staff member is provided an introduction in the use of the CQI Model during orientation, and CQI team members and process owners receive more detailed follow-up training as needed. It consists of seven steps, and each step contains an **Objective** statement, a set of **Key Activities**, **Checkpoints** to ensure that the step is being applied effectively and the expected **Outputs** of the step. A trained facilitator in process design helps guide design teams in the use of the quality improvement tools and data analysis techniques when the model is applied.

The need to design a new service, service delivery process or an innovation is often determined during strategic planning based on data compiled from working sessions held during planning; physician input; evidence-based care determinations; technology advances; community input; input from the complaint management process; regulatory and safety requirements; and/or process performance results in pursuit of the GSE. Existing process improvement and innovations typically are driven by initiatives such as process analysis, benchmarking, new technology acquisition or research. If a service is being designed or an innovation or a significant process redesign is being undertaken that impacts multiple departments, the QST becomes involved. A concept proposal is presented to the QST or other appropriate leadership team, which evaluates and prioritizes proposals using standard criteria pertaining to linkage to the strategic plan; linkage to patient, other customer and market requirements; linkage to evidence-based care procedures; and cost and cycle time considerations. The QST determines if the proposal should be recommended to the QC for approval and if a team should be chartered to design the service or process. If approved by the QC, projects with specific time requirements are given timelines for implementation and the QC receives reports on team progress each quarter.

CQI Model steps typically include the following.

Identify Opportunity – form the team; establish a mission statement to define the need, the outcome expected, identify measures, and identify constraints; establish team structure to include former patients, when possible, process/service suppliers, physicians, community members, and employees.

Figure 6.1-1 CQI Model

Develop Conceptual Design – determine patient and other customer needs, regulatory and accreditation requirements, evidence-based care procedures, and organizational needs; identify process requirements; develop ideal process flow to achieve maximum efficiency and effectiveness; explore technology and benchmarking opportunities; create initial design; evaluate financial impact; confirm targets and timelines; develop outcome statement.

Analyze Process –if new design, present to stakeholders for review; assess efficiency and effectiveness of design to include cycle time, productivity, and cost controls; confirm measures and performance goals; apply Failure Modes and Effects Analysis to analyze and address potential safety issues and proactively address potential errors and rework; if an existing process, identify problems and solution alternatives; conduct root cause analysis if needed; select best solution.

Implement – develop implementation plan including barriers to implementation; set goals for efficiency and effectiveness; conduct a pilot or test of the service, process, or innovation; identify and correct problems to ensure a trouble-free launch; finalize evaluation approach

Measure Results – collect performance data to determine if patient/other customer needs are being met and requirements are fulfilled; analyze data to provide a clear understanding of performance; reach conclusions about performance.

Standardize – hardwire the new process in the organization through documentation and education; assign ownership.

Develop Future Plans – identify initiatives to improve the process; identify areas for replication; evaluate and improve the design process; share information about the effectiveness of the process; report outcomes to the QST, QC and Board.

(2) Service and Process Requirements – We determine key service and process requirements by collecting data directly from patients and other customers in accordance with the CQI Model. The VOC process provides the majority of the data that are used by service and process design teams to formulate customer-driven requirements, but teams often make direct contact with customers themselves to verify needs and expectations. In addition, we recognize that there are "operational" requirements for services and processes that may have to be established based on stakeholder needs or concerns including the community, GVMH teams and staff members, suppliers, collaborators, partners, and other interested parties, so we research this area as well. The regulatory and accreditation environment is also a driver of process requirements and it too is evaluated as a step in the requirements definition process. Key work processes and associated requirements are shown in Figure 6.1-2.

6.1b Process Management

(1) Process Implementation – We ensure that day-to-day operation of our work processes meet key process requirements by establishing process measures that align with key process requirements. Patient and other customer requirements are originally factored into the design of work processes in the **"Conceptual Design"** step and again when measures are identified to evaluate the performance of those processes. Staff members monitor in-process and outcome measures on a predetermined schedule to ensure that desired measures of success that were identified during design in performance levels are being achieved based on the key accordance with the **"Measure Results"** step of the model. Key process requirements were developed during the design phase and integrated into the measurement system, therefore, the measurement approach allows us to determine if these requirements are being met.

Included in the measurement approach is establishment of baseline performance, expected performance of the process, and outcome goals or objectives. This permits staff members to determine if process performance is meeting expectations. If a process exhibits excessive variability or a problem is identified, process owners **"Analyze Process"** to determine root cause and generate solutions. Both in-process and outcome achievement measures are used. The use of in-process measures allows for the opportunity to prevent variability in process outcomes. Outcome measures are used to create baselines and track performance over time. Patient and other customer satisfaction is a standard measure for GVMH processes, and this policy drives collection of feedback from customers on a routine basis. Key process measures are shown in Figure 6.1-1. These are mainly outcome measures and are provided as examples of the measures we use to control and improve process performance. Space does not permit identification of all the measures used. In-process data are collected regularly to ensure the processes are performing effectively and although not all in-process measures are aggregated, some in-process data and many outcomes are aggregated, analyzed, and trended at the department and/or organization level to allow us to identify opportunities for improvement and innovation at all levels.

Work Systems and Key Processes	Key Requirements	Key Measures
ICDWS		
Scheduling	EFC Care Safety Prompt Service	Admitting Data Accuracy Care Delivery Outcomes Core Measure Performance Mortality Readmissions Length of Stay Patient Satisfaction
Admission		
Assessment		
Planning		
Intervention		
Discharge		
Follow-up		
CDSWS		
Diagnostic Services	EFC Care Safety Prompt Service	Blood Usage Compliance Radiology Overreads Infection Rate Medication Errors Patient Falls Customer Satisfaction
Food and Nutrition Svcs		
Pharmacy Services		
Infection Control		
Environmental Services		
Engineering Services		
OSWS		
Materials Management	Accuracy, Low Cost, Prompt Service	Contract Procurement Rate Fill Rate
IT Management	Availability, Ease of Use, Prompt Service	EMRAM Score
Financial Management	Accuracy, Timeliness	Days in Accts Receivable
Workforce Management	Accuracy, Prompt Service	Days to Fill
Health Information Mgmt	Accuracy, Availability, Prompt Service	Coding Errors

Figure 6.1-2 Work Systems, Key Processes, Key Requirements, Key Measures

(2) Patient Expectations and Preferences - Patient expectations are originally factored into the design of health care services in the **"Conceptual Design"** step of the CQI Model and again when measures are identified to evaluate the performance of services and delivery processes. However, we seek to personalize our healthcare delivery by addressing the individual needs of patients when they enter the care delivery work system, therefore, patient and family expectations are addressed in each process within the ICDWS. The **Scheduling** process may be initiated by the patient or by the physician, while the **Admission** process is initiated by the physician based upon the patient's stated need and the physician's determination of a need for assessment. Admission criteria are developed by the physician in cooperation with the patient and family. Admission initiates the **Assessment** and **Discharge** processes, with

consideration of patient and family needs and preferences factored into each of these processes. During the initial assessment of the patient, the patient's and family's expectations and preferences are obtained through a consultation with the physician and RN. In addition, the RN assesses the family to determine need areas and strengths.

The assessment process further incorporates patient needs as a physician problem list, which leads to a nursing problem list, and generates input from other members of the ICT. Based upon all of this information, the physician and RN collaborate with other members of the ICT to accomplish the **Planning** process and formulate the **Plan of Care (POC)** and communicate that plan back to the patient and family so they have a full understanding of how care is to be delivered and what likely outcomes are to be expected. Patients and families are provided sufficient information about the nature and goals of care to make a knowledgeable decision about their options, i.e., availability of services, costs, and alternative settings. Patients are informed of likely risks and outcomes to help establish realistic expectations, and have input into the treatment plan and setting of goals before the plan is finalized. In addition, discharge preferences are addressed to include patient care needs for dismissal, plans for dismissal, patient status, discharge location, social issues for the family, and the hand-off report from the physician. The initial and ongoing patient assessment includes determining patient preferences regarding spiritual, education, nutrition, and pain management needs, as well as needs related to other aspects of care. Once finalized, the POC is documented based on practice standards for specific diagnoses, procedures, and patient types.

On a daily basis, ICT members and other care providers monitor the POC to ensure it is being followed and to determine the level of progress being made. Daily huddles are used seven days a week to check status and discuss any developing issues. The **Intervention** process is used to produce an optimal level of health for the patient. Treatment procedures are evaluated to determine the patient's response and are modified as necessary based on patient needs and his or her perception of the quality of care. As part of these procedures, ICT members and support personnel collect data to track performance against the predetermined key measures of success that were identified during service design. Measures are defined as outcome measures, in-process measures, high-risk procedure indicators, or regulatory/safety measures. Performance requirements, including regulatory, accreditation, patient safety, and payor/employer requirements were developed during the design phase and integrated into the measurement system. The measurement approach, therefore, allows us to determine if these requirements are being met. The measurement approach also includes performance goals, so ICT members and support personnel can determine if process performance is meeting expectations. If a problem is identified, care providers analyze care delivery to determine root cause and generate solutions. In addition, patient feedback and various quality assurance monitors are used to ensure that requirements are being met.

(3) Support Processes – We determine our key support processes based upon the needs and expectations of our patients, other customers, and the GVMH care givers that are responsible for our health care delivery operations. These processes are identified in Figure 6.1-2 and are components of the Care Support Delivery Work System and the Operations Support Work system. We use the CQI Model to ensure that these processes meet key organizational support requirements in the same manner that is explained in Area 6.1b (1).

(4) Service and Process Improvement - Work process improvement efforts are initiated in a number of ways. First, individual process owners may identify excessive variation in the performance of their process and generate a process improvement initiative on their own. Second, the QST may initiate a CQI team or RCT as a result of underperformance of a process, customer feedback, a review of comparative data, advanced technology opportunities, benchmarking, or some other means of identifying a need for improvement or innovation. Third, an improvement or innovation initiative may result from BSC and LEM progress to plan reviews that are conducted by senior leaders. When scorecard or LEM performance is below expectations, reviews typically produce requirements for improvement. These are communicated to teams, departments and process owners as appropriate so actions can be initiated. This may involve formation of CQI teams, action by department teams or individuals. The overall results of scorecard reviews are also shared throughout the organization so key process owners can use the information provided during their regular process evaluation and improvement sessions. Fourth, improvement initiatives are undertaken as part of the GVMH Tracer Initiative. TJC identifies areas for hospitals to focus on each year, and we "trace" processes in those areas to evaluate and improve.

When improvement initiatives or innovations are undertaken using RCTs or a CQI Team, a simplified version of the CQI Model is used as shown in Figure 6.1-3. The **Identify Problem** step has two parts: set objectives and understand the process; the **Analyze** step has three parts: collect data, analyze the data and determine root cause; the **Identify Potential Solutions** step requires the identification of alternative solutions to the problem; the **Choose Best Solution** step involves analyzing the alternatives to determine the best one; the **Implement and Standardize** step requires development of an implementation plan, testing of the new approach, identifying and resolving potential issues, and implementing the improvement or innovation.

6.2 Operational Effectiveness

6.2a Cost Control

In an effort to meet a key requirement of our community customer, we have taken a number of steps to keep our cost of

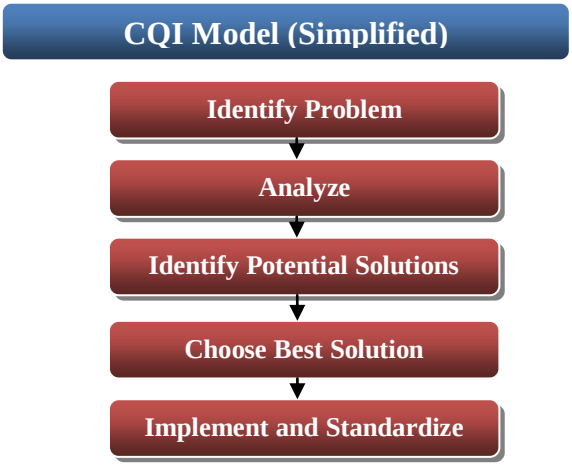


Figure 6.1-3 CQI Model (Simplified)

operations to the lowest level possible. Efficiency and effectiveness factors are integrated into the design of processes in accordance with the "**Conceptual Design"**, **"Analyze Process"** and **"Implement"** steps of the CQI Model. Process efficiency and effectiveness are initially addressed by eliminating bottlenecks and redundancy in process steps, identifying those responsible for decision points so there is no ambiguity, seeking the shortest possible cycle time for the process, and establishing in-process measures at key points. The process is then assessed to ensure that efficiency and effectiveness are maximized, and goals are established prior to implementation. Measures to track progress and determine if efficiency and effectiveness goals are being met are used to monitor the process once implemented. A number of techniques are used to prevent rework and errors, and minimize the costs associated with inspections, tests and audits. Among those are new technology, automation, procurement partnerships, effective process management, and collaboration across the organization to ensure seamless transitions from one process to another. For example, the MHCIS has permitted us to transition to a system of electronic order entry for health care tests and procedures, and eliminates the need for manual entry and frequent checks to ensure that hand written orders are read and acted on properly, thereby reducing the potential for medical errors. Further, the MHCIS has allowed us to manage inventory electronically rather than manually. This has reduced the amount of time and effort needed to accomplish this work, and also the number of inspections to ensure effective inventory control. We have also instituted a "dangerous abbreviations list" and eliminated the use of those abbreviations which could cause confusion and result in a medication error; we have created a list of "sound-alike and look-alike" drugs to emphasize the need for care in using these medications and have now stored them separately to help avoid confusion; and we installed an Accu-Dose system which automatically dispenses drugs to prevent human error and allow after-hours dispensing at locations other than the pharmacy.

6.2b Supply Chain Management

We manage supplier purchases through the following group purchasing organizations: Mid-America Service Solutions (MSS); Novation (NVHA) and Associated Purchasing Services (APS). MSS was established as an independent group of Missouri and Kansas health systems that maximizes cost savings for all its members by agreeing to commitment levels of utilization and providing the same low price for all members regardless of size, thereby providing us a significant cost reduction opportunity. As a result, we are transitioning to MSS as our primary source of supplies as the number of contracts MSS has in place grows. NVHA has been our primary supplier prior to the inception of MSS and we will continue to use NVHA in the future as our secondary GPO to take advantage of the cost savings opportunities available. APS is a Kansas City area group focusing on smaller local purchases and we will continue to use this option as needed.

MSS uses Owens & Minor as a distributor and Global Heathcare Exchange (GHX) as an electronic order collaboration site. Electronic orders (EDI) are placed with GHX which verifies pricing and availability within just a few hours. Orders are sent to Owens & Minor and other trading partners whom then process and ship the orders within one or two days. Each MSS member has the opportunity to provide recommendations and report supplier non-conformance issues utilizing the MSS internet site. Issues are sent to manufacturers for response and corrective action is taken as appropriate. If a supplier does not resolve an issue they are subject to a fine and possibly removal. Performance of all suppliers is reviewed when contracts are renewed. The MSS internet site offers additional information including a listing of all contracts, contract initiatives, a link to the VHA website, recall notices and help responding to recalls, and finding replacement items where needed. The site also includes Knowledge Share, where members can post questions seeking help from other members; Green Corner; Member Contracts; New and Announcement; and Team Discussions. MSS provides monthly reports summarizing performance results.

6.2c Safety and Emergency Preparedness

(1) Safety – The interdisciplinary **Safety Committee** is responsible to provide a safe operating environment and addresses safety issues for staff, physicians, volunteers, patients, and visitors, including life safety protocols, staff and patient incidents, falls, medication safety, infection control, communicable disease exposure, bio-hazardous waste control, staff safety, and emergency preparedness. The committee supports the **Safety Director** in identification of potential or real safety issues and proactively addresses modifications needed to maintain a safe and healthy environment.

A number of methods are in place to address accident prevention. All staff members attend safety training during orientation and participate in recurring training annually, including Code Red (fire prevention and response) training that emphasizes use of fire extinguishers and Evac-u-sled procedures that allow for safe evacuation of patients during an emergency. Code Blue (emergency response) and Code Angel (child abduction) training are also conducted on an annual basis. We also do a safety assessment annually which requires all staff to take a safety competency test online through NetLearning; all must successfully pass this test to demonstrate required safety knowledge. Additionally, each month representatives of the Safety Committee conduct "safety rounds" to discuss safety issues with the staff and seek out unsafe practices or environments, and Environmental Services, Engineering, Safety, and Infection Control conduct full blown safety inspections twice per year. Safety drills are also conducted on a frequent basis: Code Red each month; Code Blue twice per month; and Code Angel twice per year.

These initiatives, along with individual departmental safety procedures, our "Hazardous Event" form, and direct reporting to the Safety Officer, are all used to identify and report possible unsafe practices or conditions so that corrective action can be taken prior to an incident occurring. In addition, results from inspections and drills are compiled and reported to the Safety Committee, which analyzes and trends the data to identify future safety risks and improvement needs. Should a safety incident occur, an in depth analysis is accomplished and appropriate recovery actions are directed by the Safety Officer and the Safety Committee.

(2) Emergency Preparedness - We ensure our preparedness for disasters and/or emergencies through the Safety Committee and the Emergency Operations Team. The Safety Committee develops plans to address all types of disasters and emergencies, initiates actions to prevent emergencies, ensures the workforce is trained in disaster and emergency response, works with local agencies to coordinate an integrated community response effort, plans and directs exercises to ensure readiness, and determines effectiveness of the overall program. The Disaster Response Plan addresses both internal and external disasters and emergencies. Drills are conducted regularly to include fire drills, severe weather, external disaster plan execution, and activation of the infant abduction plan. The Safety Committee analyzes various components of the response plans including review of drill results and plan implementation and makes adjustments as needed. To prevent emergencies, the committee has implemented a number of security measures including installation of cameras by the pharmacy and cafeteria, implementation of an infant monitoring system, and installation of lockdown systems with controlled access, cameras, and locked entry in the birthing center, ICU and ER. The Incident Command System is activated if an emergency or disaster is declared. The Emergency Operations Team is responsible to assume command and control of any disaster or emergency situation to effectively manage our response. This team is led by a member of the AT and consists of a variety of people with assigned responsibilities within this structure A Job Action Sheet describes these responsibilities so that backups can assume positions if needed. Team members are trained through required study and during exercises. We have identified locations where patients needing continuous care can be taken in the event operations must be shut down and use EMResource to confirm space availability at these locations should this situation arise. Patients who can be discharged are taken to the community center to await pickup by family members. Recovery actions are taken at the earliest possible time once the emergency situation subsides and vary depending upon the nature of the crisis.

As a result of increased attention to all types of hazards, the city, county, region, and state are partners with us in developing and maintaining a plan for emergency response to all hazardous threats. We took the lead in developing the all-hazard plan for the community and have coordinated the efforts of all agencies involved. Staff members attended training and now provide instruction regarding all-hazard threats to emergency responders throughout the community.

6.2d Innovation Management – We manage innovation from both an organizational perspective and a department/process owner perspective. Organizationally, the SPT conducts a SWOT analysis during the strategic planning retreat, which produces a list of key opportunities that GVMH might pursue as explained in Area 2.1a (2). The SPT is broken down into sub-teams, one of which evaluates these opportunities in terms of potential benefits and the risks associated with them. If the outcome of this "intelligent risk" assessment suggests that the opportunity should be pursued, the team then identifies it as a Key Strategic Advantage or Challenge. These advantages and challenges become requirements for inclusion in the strategic plan as Strategic Objectives and/or Key Actions, or initiatives that will move us in the direction of the GSE, and are then given high priority in the budget allocation process. Our decision to engage with the Studer Group to create innovations to move patient and other customer satisfaction to a higher level, as-well-as increase physician and employee engagement. This is an example of how this approach works organizationally.

From a department/process owner perspective, individuals are empowered and encouraged to create improvements and innovations and implement them directly if the impact does not go beyond the department and the manager concurs. If the impact is more widespread a proposal is submitted to QST which conducts an intelligent risk assessment and decides if the proposal should go forward. If yes, the proposal goes to QC for a decision and funding, and the appropriate actions are taken to create a team, design the process, etc.

Category 7 Results

7.1 Health Care and Process Results

7.1a. Health Care and Patient-Focused Results

Health care outcomes are critical indicators of GVMH effectiveness in achieving the GSE, with mortality, readmissions and length of stay among the most important. Figure 7.1-1 indicates that mortality rates have declined from 1.9% to 1.1% from FY09 - 13, a reduction of 42.1% and well below the historic average of other Missouri hospitals as reported by HIDI. Readmissions (Figure 7.1-2) have also declined although slightly from 9.7% to 9.5 % over the same time period. However, GVMH has **achieved the GSE** and continues to rank among the top performers in the state and country as indicated by the comparative data provided by PEPPER that shows the 80th percentile rank levels in the 20% range both in Missouri and overall across the U.S. Length of stay has improved from 3.5 to 3.1 over the same time period and ranks considerably better than the average of other Missouri hospitals as shown in Figure 7.1-3.

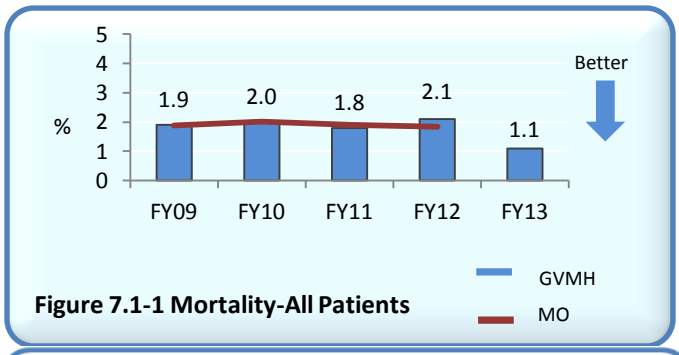


Figure 7.1-1 Mortality-All Patients

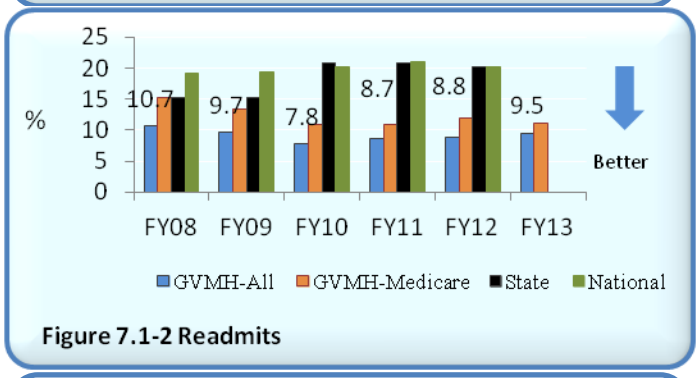


Figure 7.1-2 Readmits

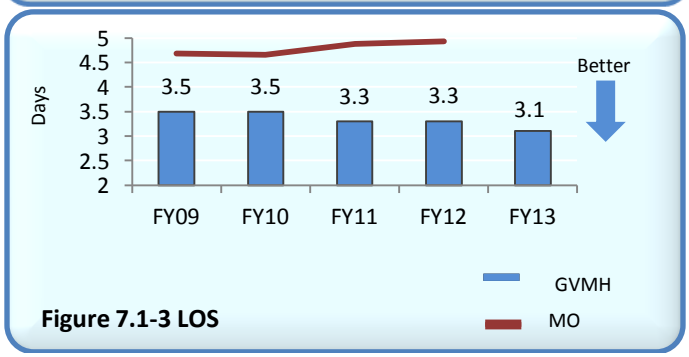


Figure 7.1-3 LOS

Figure 7.1.4 demonstrates the outcome associated with treatment of diabetes, a high volume and high risk diagnosis group. The American Diabetes Association has established a standard level of 7 or less for HbA1c, which indicates that diabetes complications in patients are at an acceptable level. Our results show that we have reduced HbA1c levels for these patients from when they enter treatment until treatment is complete by an average of 1.6 points per year and have achieved or exceeded the ADA standard every year except 2009. Figures 7.1-5 through 7 depict the level of ORYX Performance attained in the areas of Heart Failure (HF), Pneumonia (PN), and the Surgical Care Improvement Project (SCIP). Although performance in HF has improved only slightly to 90% compliance and falls below the levels of both Missouri and the nation, both PN and SCIP have improved considerably, with PN attaining the Missouri and U.S. average compliance level and SCIP exceeding that level.

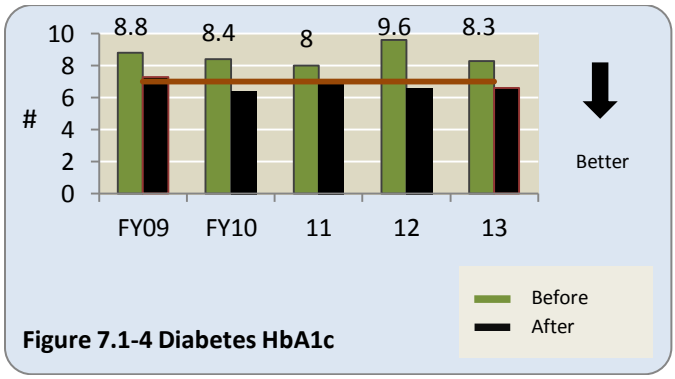


Figure 7.1-4 Diabetes HbA1c

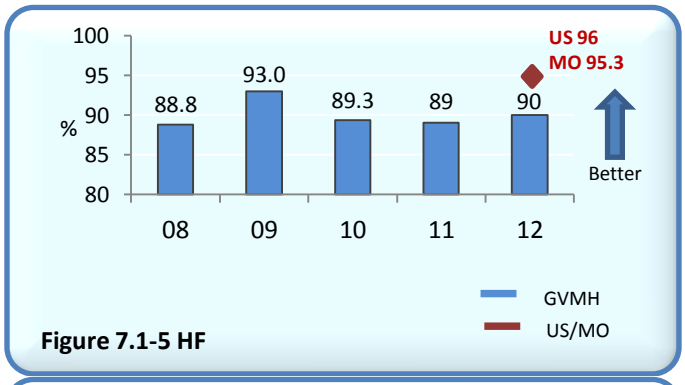


Figure 7.1-5 HF

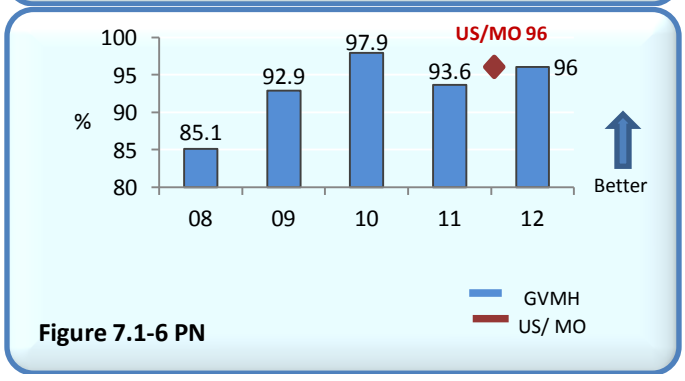


Figure 7.1-6 PN

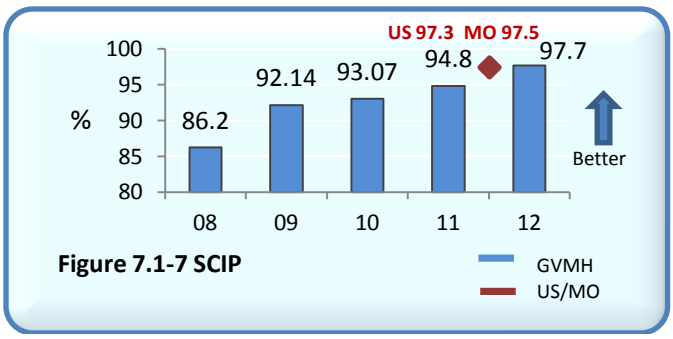


Figure 7.1-7 SCIP

Figures 7.1-8 and 9 demonstrate the performance of physicians in complying with standards of excellence in patient care delivery. Figure 7.1-8 focuses on completing History and Physical (H&P) within 24 hours of admission; completing medical records within 15 days of discharge; outpatient reports within 24 hours of service; and H&P prior to surgery. In all areas, physicians are achieving a high level of compliance. Figure 7.1-9 focuses on achieving Meaningful Use requirements and demonstrates our performance in the first year of record-keeping against the targets set by CMS. We have exceeded the target in three of the five measures.

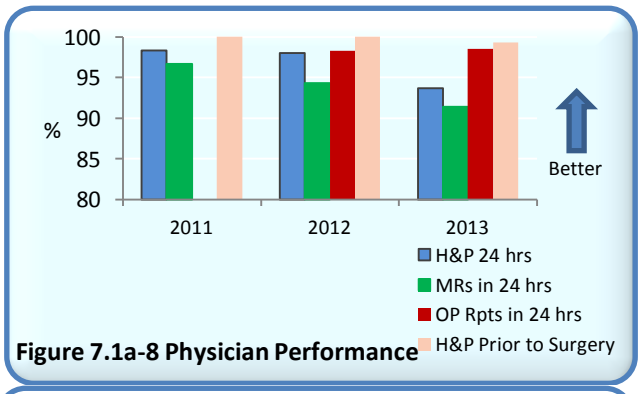


Figure 7.1a-8 Physician Performance

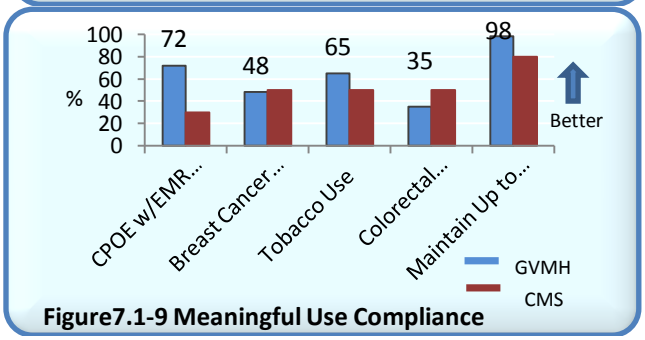


Figure7.1-9 Meaningful Use Compliance

Patient safety is a critical area for us and results are shown in Figures 7.1-10 thru 12. Patient Falls have been reduced by more than half from 8.9/1K pt days in CY09 to 4.4 thus far in CY13 (Figure 7.1-10) while Medication Errors (Figure 7.1-11) have declined dramatically from 575 in CY10 to 184 (annualized) in CY13, an anticipated drop of 68%. Infection Rates for some infection types are **among the best in the country** as shown in Figure 7.1-12. According to the National Health Safety Network (NHSN), CL-BSI, VAP, and SSI per 1K patient days show results that exceed the national average by a considerable margin, and we have had no CL-BSI and VAP infections the last three years. MRSA, C-Diff, and CA-UTI per 1K patient days all show improvement; unfortunately, a meaningful benchmark could not be found. We have also been working to reduce the use of catheters to help limit infections, and our success there is shown along the Cath Prevalence line with a reduction from 25 to 18% of patients requiring one over the last two years. Figure 7.5-13 shows Leapfrog patient safety assessment results where we have received an "A" grade as compared with direct competitors.

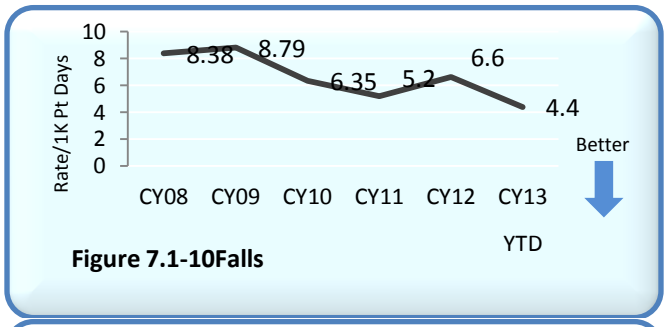


Figure 7.1-10Falls

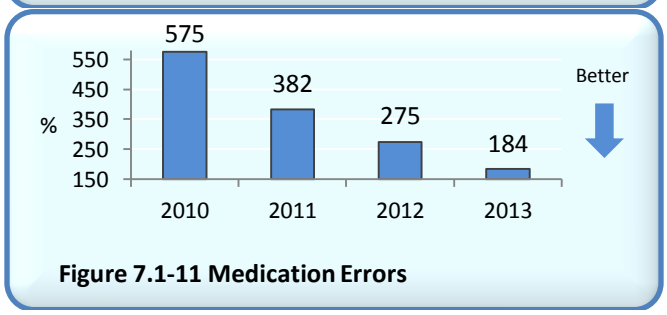


Figure 7.1-11 Medication Errors

↓Better	FY 09	FY 10	FY 11	FY 12	FY 13	Benchmark
MDROs	0.7	0.6	0.7	0.8	0.2	N/A
C-Diff	0.7	0.6	0.4	0.4	0.3	N/A
CL BSI	0.5	0.1	0	*0	*0	NHSN - 0.9
CA-UTI	0.7	1.2	1	0.9	0.9	N/A
Cath Prevalence	N/A	N/A	25%	21%	18%	N/A
VAP	0	0.1	0	*0	*0	NHSN - 1.1
SSI %	N/A	**0.4	**0.8	**0.6	**0.8	NHSN - 2
SSI-100% Rpt 11-13			*Measure now 1K/Device Days			
Figure 7.1-12 Infection Rates			**30 Day Post-Discharge Surveillance (PDS) all cases			

Home Health has achieved national prominence with an announcement by the Council of State Home Care Associations that our outcomes, shown in Figure 7.1-14, have placed us at the **100th percentile rank in Missouri the last two years and the 99th percentile rank in the U.S.** during that same time period. As can be seen, we exceed state and

	2011				2012			
	GVMH	MO	US	%tile Rank	GVMH	MO	US	%tile Rank
Started Care in timely Manner	99	90	89	88	99	91	91	86
Taught Patients about meds	100	89	86	100	99	91	90	80
Assessed risk of falling	100	97	93	100	100	97	94	100
Assessed for depression	100	98	96	100	100	99	97	100
Checked for flu shot	78	70	66	69	81	72	70	72
Checked for pneumonia shot	86	70	65	83	82	72	69	71
Diabetic foot care	100	90	88	100	100	92	91	100
Checked for pain	100	99	97	100	100	99	98	100
Treated for pain	100	97	96	100	100	98	97	100
Treated heart failure symptoms	100	98	96	100	100	98	98	100
Bed sore prevention (Dr.)	100	93	92	100	99	95	95	58
Bed sore prevention (Plan)	100	95	93	100	100	97	95	100
Bed sore risk assessment	99	98	97	56	100	99	98	100
Started Care in timely Manner	99	90	89	88	99	91	91	86
Taught Patients about meds	100	89	86	100	99	91	90	80
Assessed risk of falling	100	97	93	100	100	97	94	100
Assessed for depression	100	98	96	100	100	99	97	100
Overall				99				99

Figure 7.1-14 Home Health Outcomes

national scores in every outcomes measure and are at the **100th percentile in 8 of 13 indicators**, with only one falling below the 70th percentile rank.

Leapfrog Hospital Patient Safety Score	
GVMH	A
Bothwell Regional Health Center	C
Western Missouri Medical Center	C
St Luke's South	B
St Joseph's	C

Figure 7.1-13 Leapfrog Results

7.1b. Work Process Effectiveness Results

(1) Process Effectiveness and Efficiency – Key process effectiveness measures for the Laboratory, Radiology, Pharmacy and related medication management processes, Birthing Center, Nutrition Services, and IT are shown in Figures 7.1-15 through 20. Blood Usage Compliance in the lab has improved considerably over the last five years, while Radiology Overreads have declined to almost zero. Processes to support patient medication requirements have all improved with reductions in the number of errors, while timeliness in C-Section decisions has improved and is better than the national standard. Patient satisfaction with food services has achieved **top decile performance nationally**, and IT has also achieved **top decile performance** in adoption of electronic medical records requirements as measured by HIMSS.

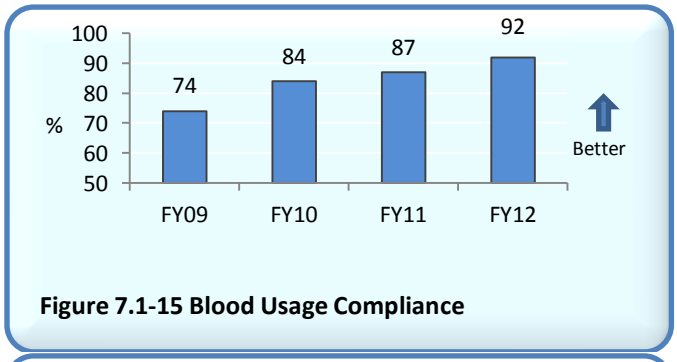


Figure 7.1-15 Blood Usage Compliance

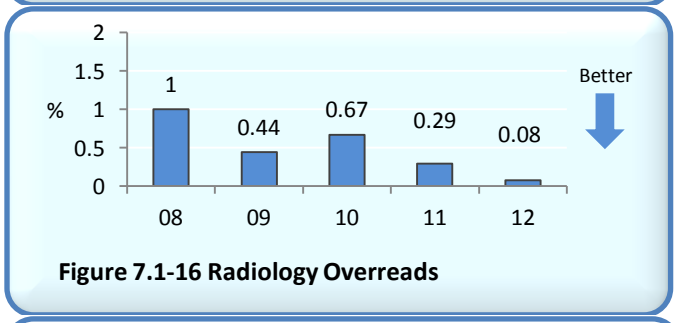


Figure 7.1-16 Radiology Overreads

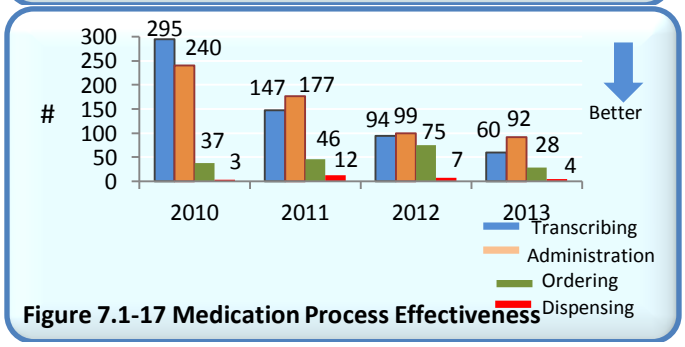


Figure 7.1-17 Medication Process Effectiveness

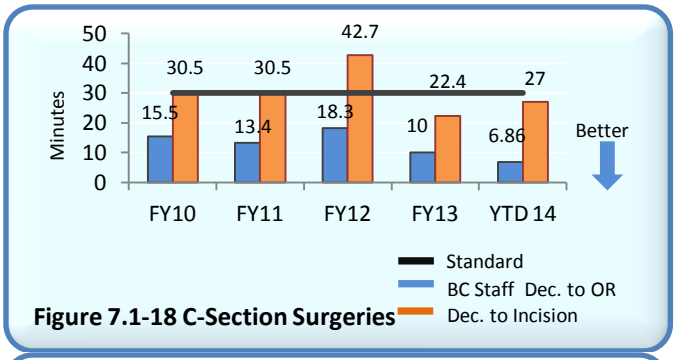


Figure 7.1-18 C-Section Surgeries

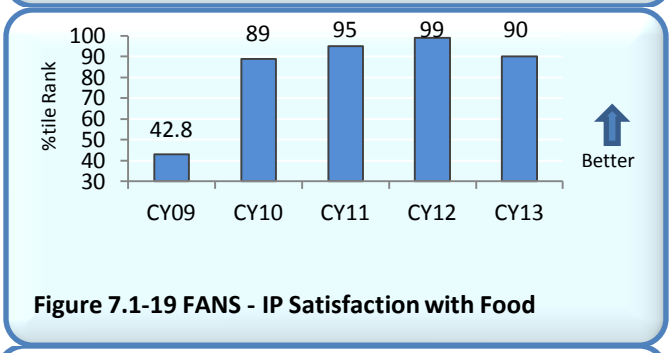


Figure 7.1-19 FANS - IP Satisfaction with Food

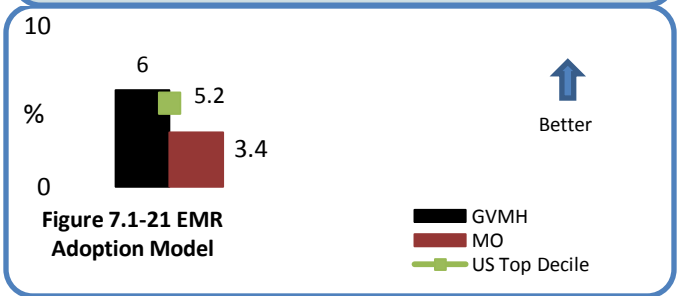


Figure 7.1-21 EMR Adoption Model

Figure 7.1-22 shows a sampling of process measures that are contained on Department LEM reports. Data date back to Qtr 2 of 2012, which coincides with LEM implementation.

Department		FY13			
		1Q	2Q	3Q	4Q
Bus. Off	Denials <2%	2.3	3.3	2.7	0
Windsor Clinic	Hypertensive Pt. Compliance >66	58	62	59	66
Rehab	KATZ Measures >90% of Points	97.7	96	98.7	99.3
Lab	Triponin turn-around time < 27m	34.7	33.6	34	32
Surgery	Documentation >96%	99.3	100	99.3	99.7
Oncology	Plan of Care for Pain >4	87.3	96.6	100	100
Endoscopy	Comprehensive Colon Exam >6m	75	82.1	75.9	94.3

Figure 7.1-22 LEM Performance Indicators

(2) Emergency Preparedness – indicators to demonstrate our emergency preparedness compliance and effectiveness are shown in Figures 7.1-23 and 24.

Compliance Areas	Goal/Rqmt	Compliance
EOC Drills	2/Year	100%
Safety Rounds	2/Year	100%
HavBed Drills	75%	100%
Local Planning (LEAP)	Q	100%
Region Planning	M	90%
Nuclear Inspections	5/Year	100%
Workplace Violence Training	2/Year	100%
NIMS Training	NEO	100%
Biomedical Equipment	Wkly	100%
EOC Drills	2/Year	100%

Figure 7.1- 23 Emergency Preparedness Compliance

Assessment Areas	FY10	FY11	FY12
Net Learning Competencies	89.3	88.4	88.4
# to Call a Code	94.9	97	96.3
Code Angel	100	99.7	99
Code "D"	90.9	90.8	91.3
PASS	97.3	95	96.3
RACE	95.8	97.3	97.4
Department Evaluations	89.8	85.5	86.5

Figure 7.1- 24 Emergency Preparedness Outcomes

7.1bc. Supply-Chain Management Results

Figure 7.1-5 shows the key measures used by Materials Management to manage performance – Fill rate and Contract Buy Rate.

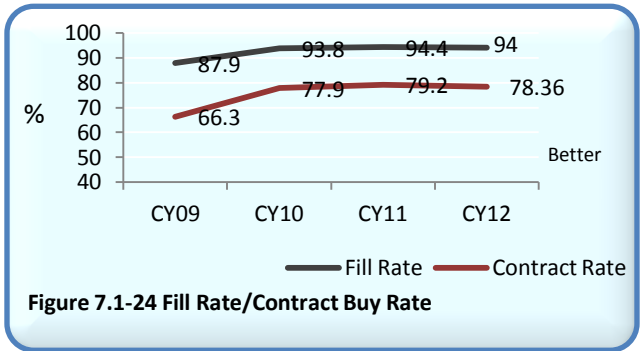


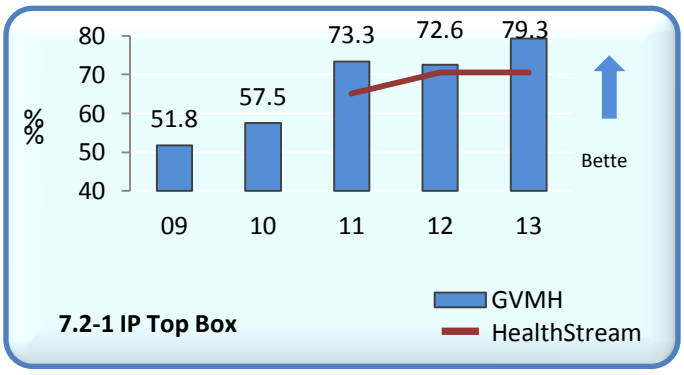
Figure 7.1-24 Fill Rate/Contract Buy Rate

7.2 Customer-Focused Results

7.2a. Patient and Other Customer-Focused Results

(1) Patient and Other Customer Satisfaction – In its effort to achieve the GSE, GVMH has decided to join other high performing organizations, including Baldrige recipients, and monitor "top box satisfaction" – a more rigorous measure of customer retention and loyalty that will permit comparisons across industries, surveys and databases. Top box is the percentage of customers who give the highest customer

satisfaction rating to a given aspect of their care. HealthStream provides "Top Box" scores for GVMH as well as its entire national database as well as the percentile rank that those scores produce. Figures 7.2-1 through 6 display these results for our three key patient segments. Our scores have improved considerably for inpatients and outpatients, and more modestly for emergency patients, but generally compare favorably with the HealthStream database, which yields percentile rank scores of **88 for inpatients (GSE level)**, 63 for emergency patients and 46 for outpatients.



7.2-1 IP Top Box

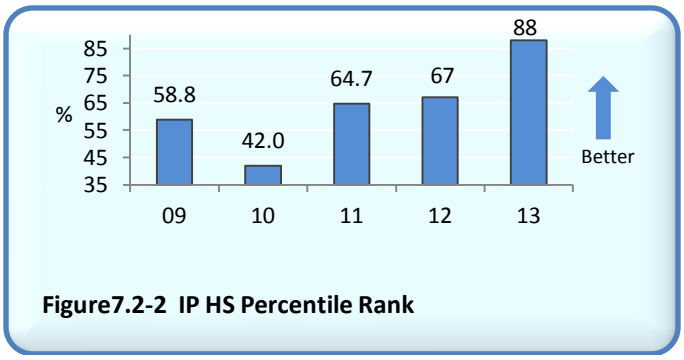


Figure7.2-2 IP HS Percentile Rank

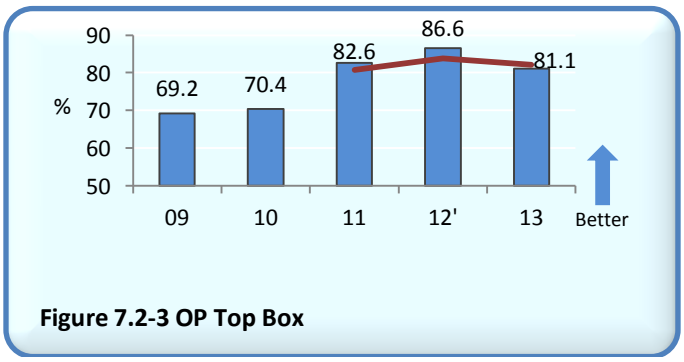


Figure 7.2-3 OP Top Box

The HealthStream data analysis identifies eight Dimensions of Care which are key indicators of inpatient satisfaction and engagement. These include Nurse Communications, Doctor Communications, Responsiveness, Pain Management, Medication Education, Discharge Instructions, Quietness, and Cleanliness. Figures 7.1-7 through 12 show results in the key areas, with our performance consistently exceeding the national database. In fact, **six of the eight Dimensions have achieved top quartile (GSE) performance** in 2013, with **two achieving top decile performance.**

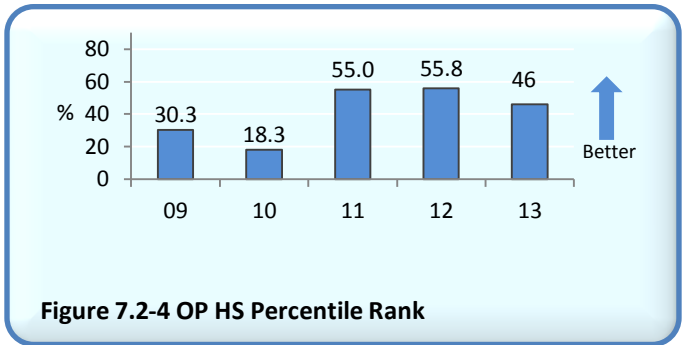


Figure 7.2-4 OP HS Percentile Rank

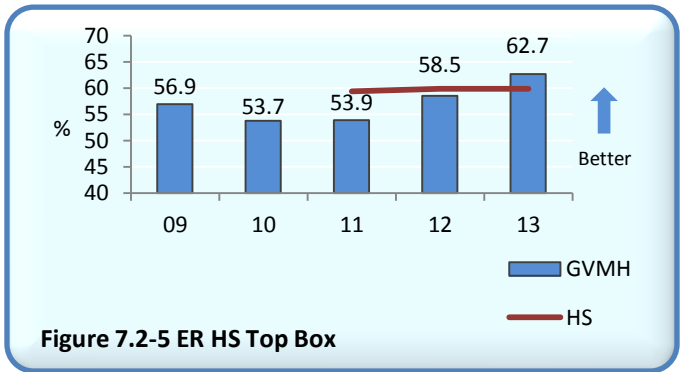


Figure 7.2-5 ER HS Top Box

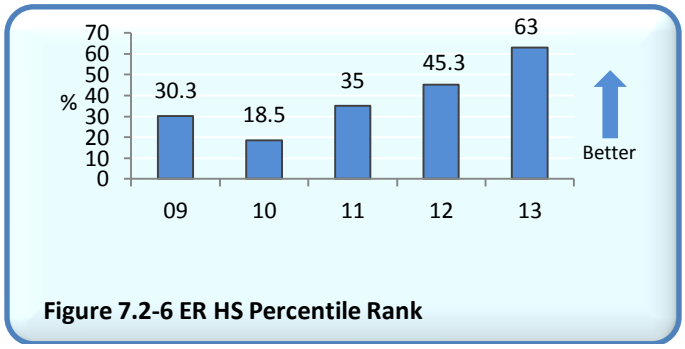
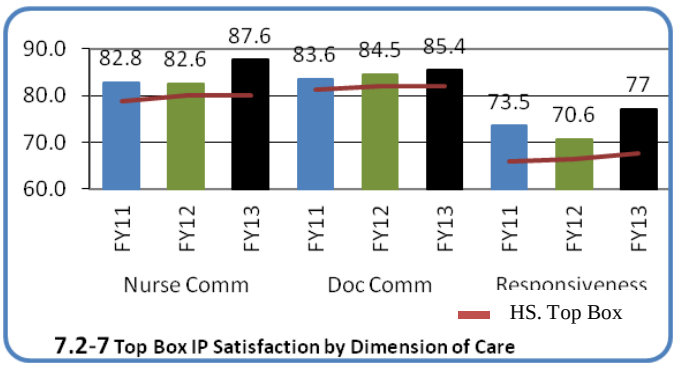


Figure 7.2-6 ER HS Percentile Rank



7.2-7 Top Box IP Satisfaction by Dimension of Care

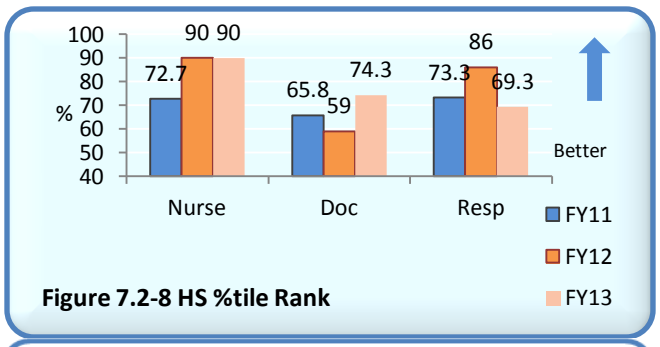
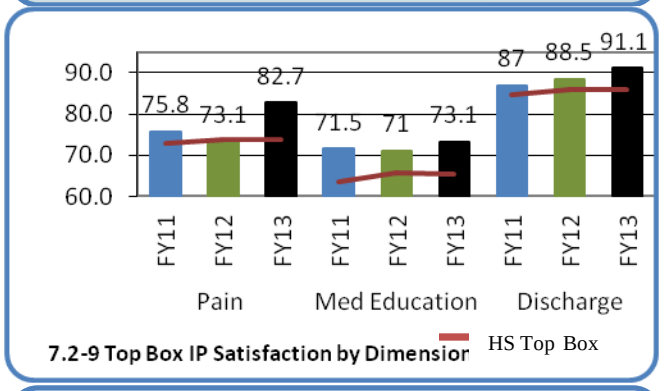


Figure 7.2-8 HS %tile Rank



7.2-9 Top Box IP Satisfaction by Dimensior

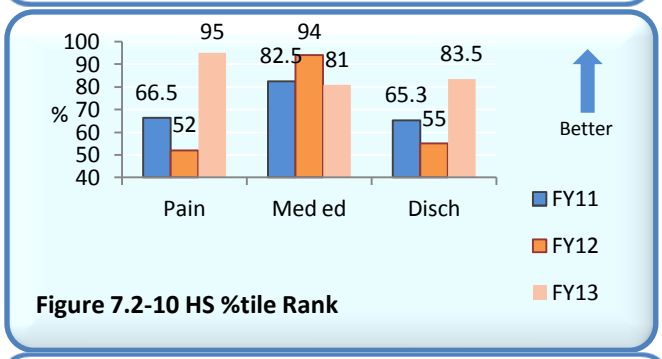
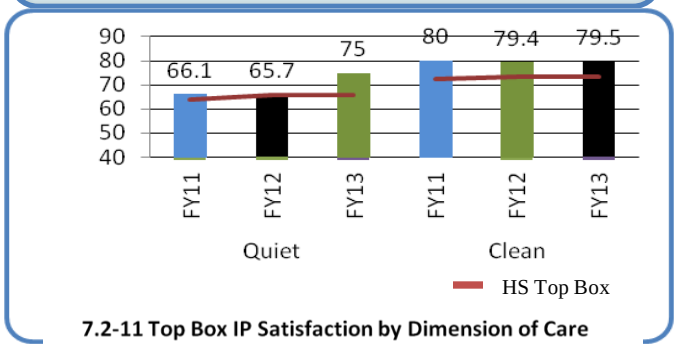


Figure 7.2-10 HS %tile Rank



7.2-11 Top Box IP Satisfaction by Dimension of Care

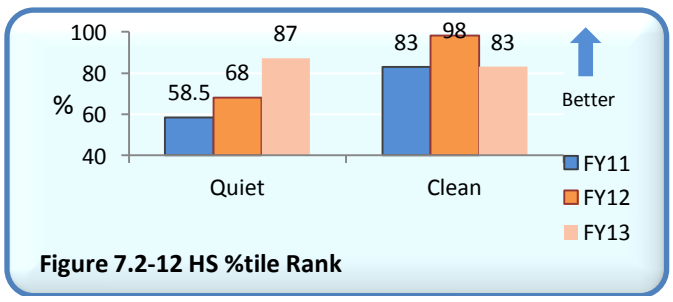


Figure 7.2-12 HS %tile Rank

Figures 7.2-13 and 14 provide inpatient satisfaction results by service area within the hospital to include surgical, medical, and birthing center floors. Results for both the medical and birthing center floors have achieved performance at the **top decile level nationally**. Key requirements of all patient segments include exceptional, friendly and compassionate (EFC) care, prompt service, and easy access. Figures 7.2- 15 through 18 provide a sampling of results that demonstrate satisfaction in these areas. **Top quartile level (GSE) performance** has been attained for OP Prompt Service and ER Staff Quality.

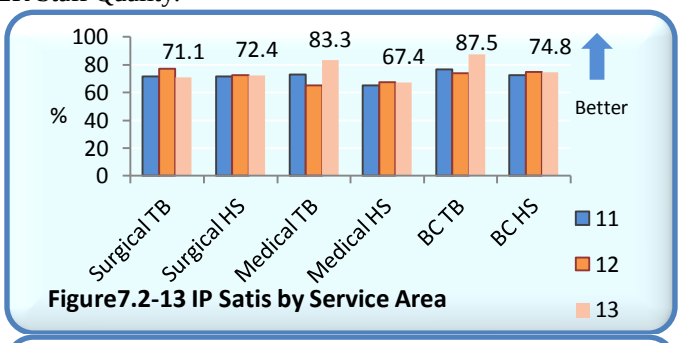


Figure7.2-13 IP Satis by Service Area

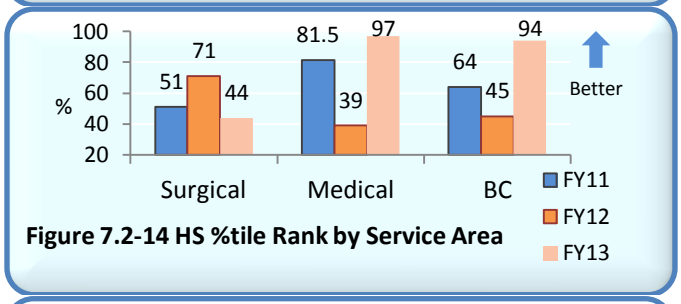


Figure 7.2-14 HS %tile Rank by Service Area

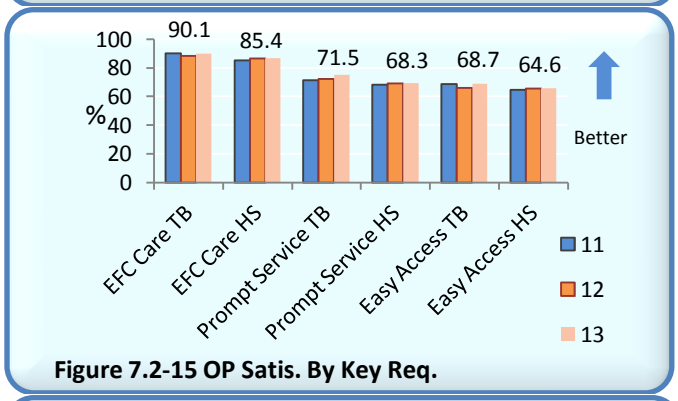


Figure 7.2-15 OP Satis. By Key Req.

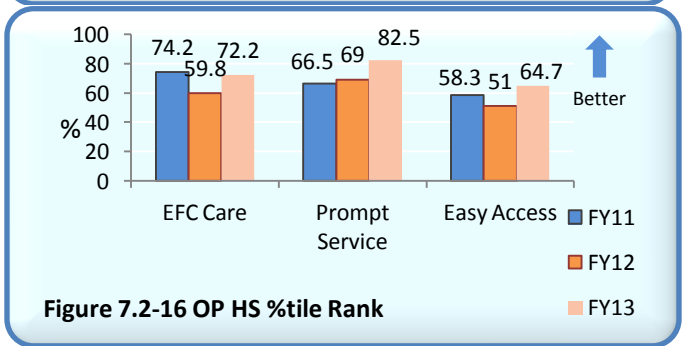


Figure 7.2-16 OP HS %tile Rank

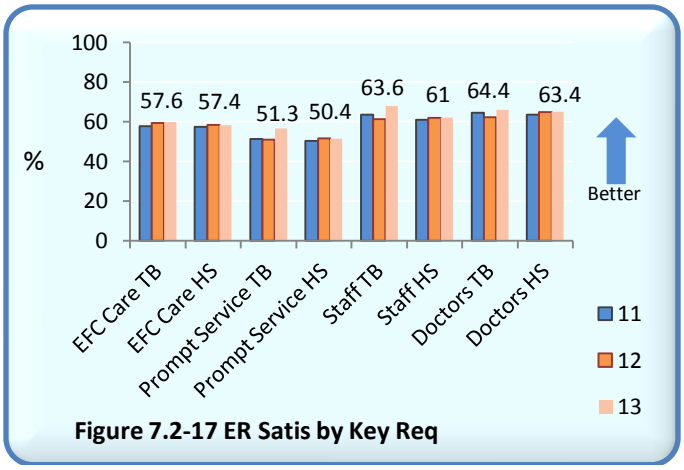


Figure 7.2-17 ER Satis by Key Req

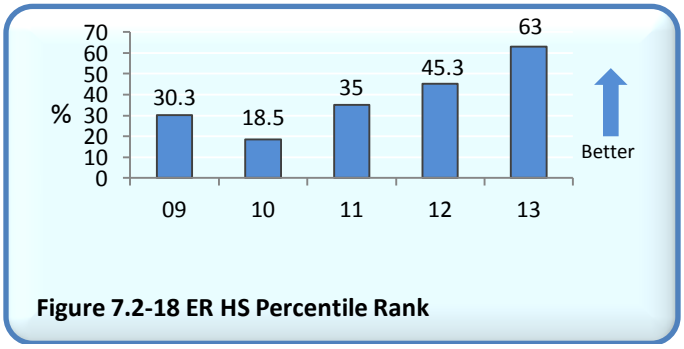


Figure 7.2-18 ER HS Percentile Rank

Figures 7.2-19 through 21 present indicators of patient dissatisfaction. For inpatients and outpatients, "low box" scores have been sustained well below one percent for the last five years, and emergency patient dissatisfaction has been held in the 3-5% range over this same timeframe. Figure 7.2-22 indicates that patient complaints have been stable over the last five years, while the percent resolved has increased and the average response time has been reduced.

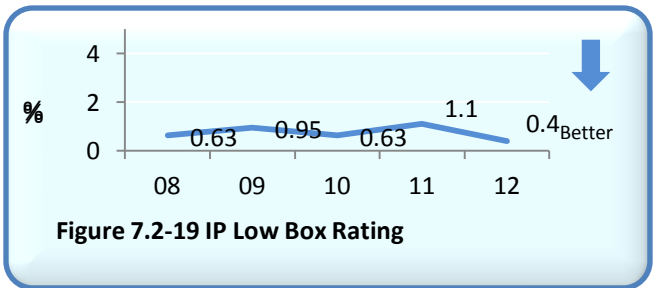


Figure 7.2-19 IP Low Box Rating

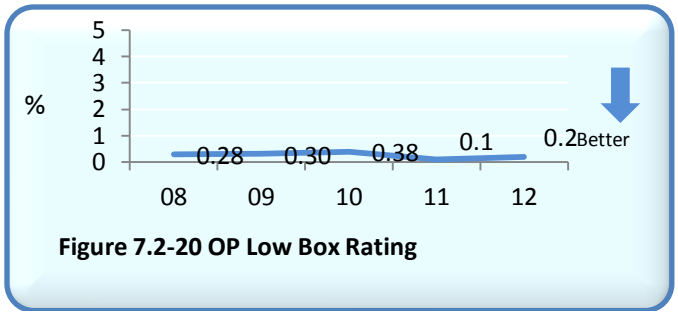


Figure 7.2-20 OP Low Box Rating

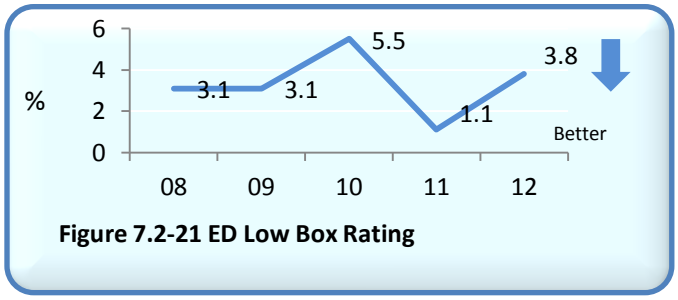


Figure 7.2-21 ED Low Box Rating

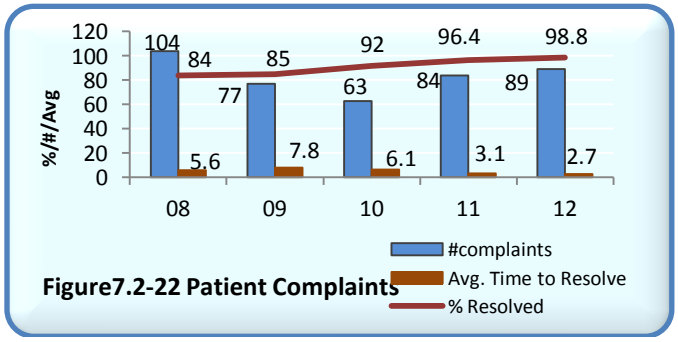


Figure7.2-22 Patient Complaints

(2) Patient and Other Customer Engagement – Patient Call Manager is a recent initiative that has been designed to engage with and build loyalty among patients. Data for the first year of implementation are shown in Figure 7.2-23 and indicate that we are successfully contacting about two-thirds of the patients we attempt to call after discharge. Figure 7.2-24 shows the improvement in staff engagement with patients to recover from service failures, mostly due to equipment issues but sometimes from patient concerns. The data indicate the number of service recovery initiatives on the part of the staff as well as the dollars expended to mitigate patient concerns as a result of the problem. Another important indicator of engagement with patients, physicians and the community is business growth. Figure 7.2-25 shows our recent percentage improvement with regard to outpatient visits, emergency room visits, home health admissions, and physician clinics visits consistent with our strategy from FY10 to FY13.

	FY12 2Q	FY12 3Q	FY12 4Q	FY13 1Q
Patient Count	3166	3328	3132	3047
% of Pts Attempted	93.4%	97.2%	99.5%	98.2%
Contacts Made	61.4%	59.8%	59.2%	66.6%

Figure 7.2-23 PCM-Discharge Call Backs

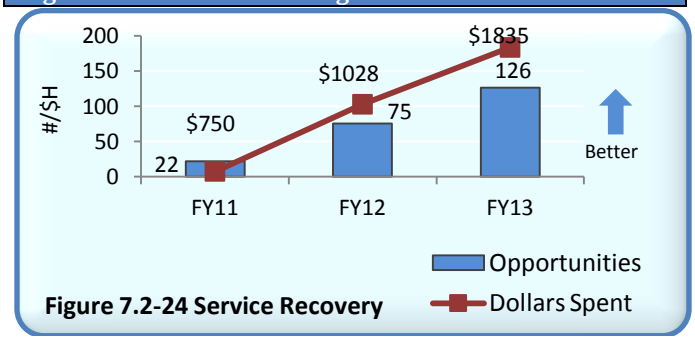


Figure 7.2-24 Service Recovery

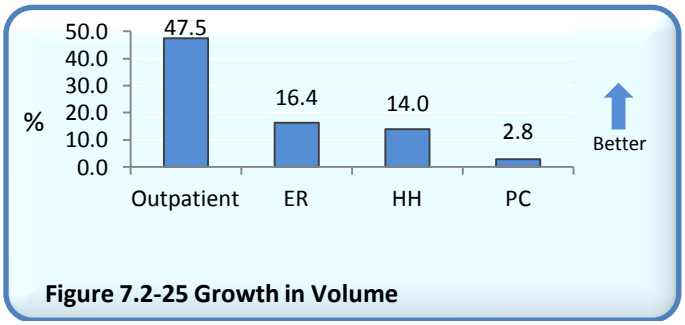


Figure 7.2-25 Growth in Volume

7.3 Workforce-Focused Outcomes

7.3a. Workforce Results

(1) Workforce Capability and Capacity - Workforce capability is illustrated in Figures 7.3-1 through 4. Operating Revenue/FTE has increased by 33.9% from CY09 to CY12 as shown in Figure 7.3-1, while Operating Cost/FTE (Figure 7.3-2) has increased by only 18.2% indicating improved capability and engagement of the workforce over this timeframe. Based on PWC/Saratoga comparative data with health care organizations similar to GVMH, our Operating Cost/FTE result places us in the **top decile nationwide**. Workforce Productive Hours has shown a sustained high level of effectiveness in the 90% range the last five years, and HR Headcount Ratio results indicate that the number of employees supported by each HR employee is at the **top quartile (GSE level)** nationwide according to PWC/Saratoga.

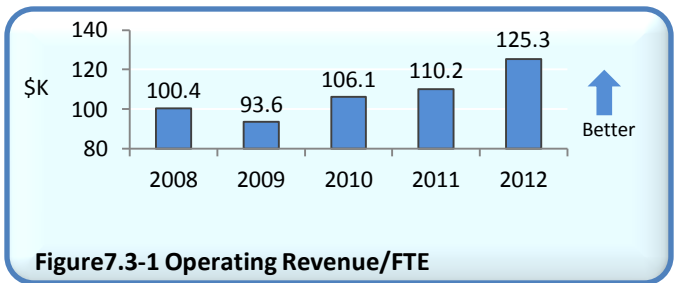


Figure7.3-1 Operating Revenue/FTE

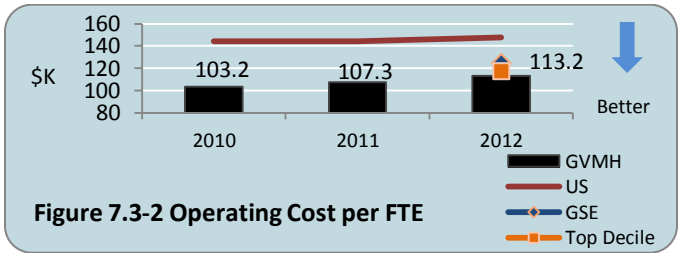


Figure 7.3-2 Operating Cost per FTE

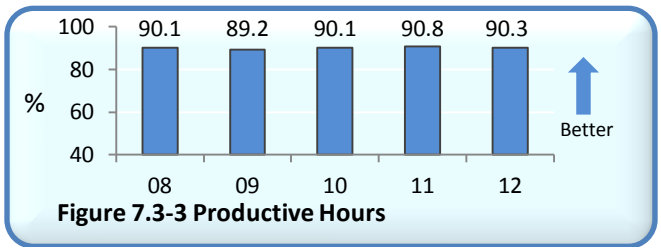


Figure 7.3-3 Productive Hours

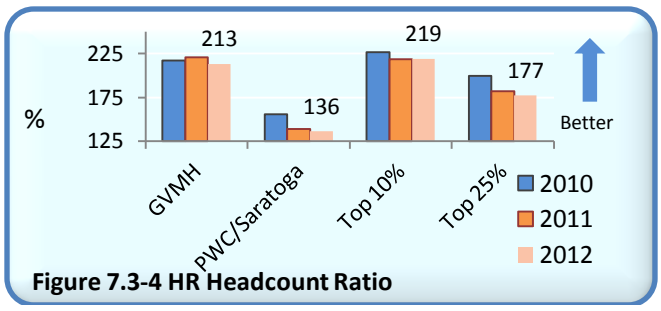


Figure 7.3-4 HR Headcount Ratio

(2) Workplace Climate - To address the workforce climate we track a number of safety, security and wellness measures. Employee Incidents/1K Hours Worked are shown in Figure 7.3-5 and have been held at very low levels over the last five years with considerably fewer than 100 incidents in more than one million hours worked in each of those years. Similarly, Needle Sticks have been sustained at very low levels with a high of only 11.2 sticks in more than one million hours of work over the last five years as indicated in Figure 7.3-6. The Staff believes there is a safe and secure environment as evidenced by the results of the satisfaction survey shown in Figure 7.3-7.

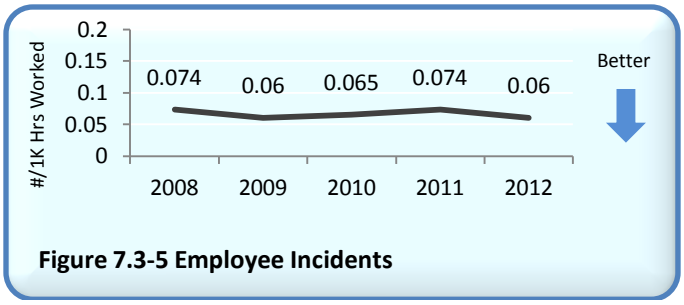


Figure 7.3-5 Employee Incidents

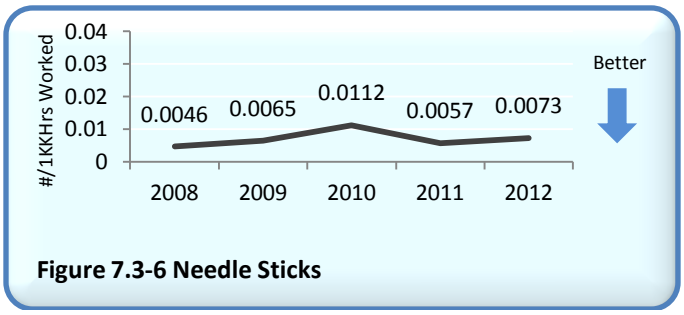


Figure 7.3-6 Needle Sticks

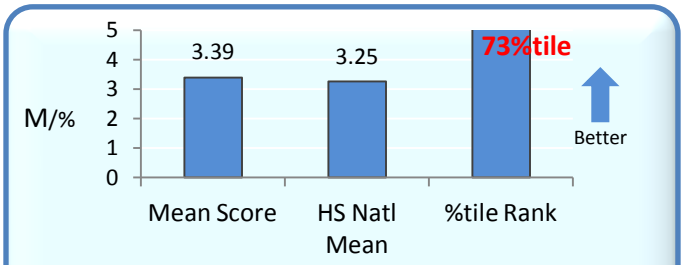


Figure 7.3-7 Staff Satisfaction/Safety-Security

GVMH places a significant emphasis on wellness as explained in Category 5. Health Screening Completion rate is high and continues to grow, which has contributed to keeping our Health Care Cost/Employee below the PWC/Saratoga comparison (Figures 7.3-8 and 9). Results in two of our key wellness programs, STEPS and The Great Weight Race, are shown in Figures 7.3-10 and 11. Indicators of workforce services and benefits include Compensation and Benefits and Average Benefits/Employee, both of which have improved and now surpass the PWC/Saratoga national mean (Figures 7.3-12 and 13).

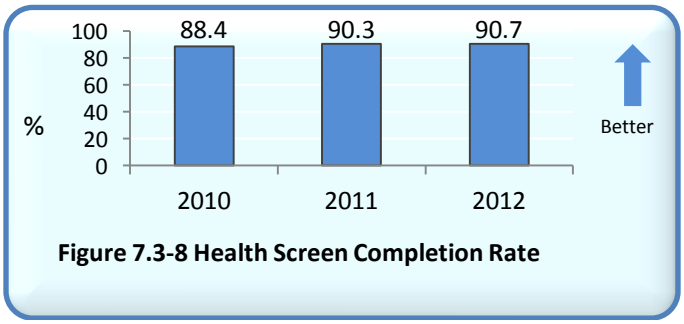


Figure 7.3-8 Health Screen Completion Rate

Figure 7.3-9 STEPs Rewards Earned

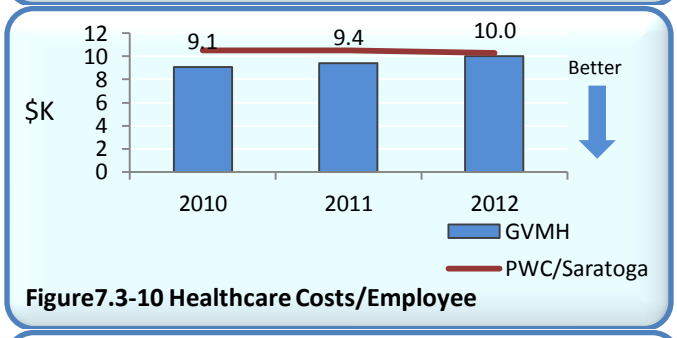


Figure7.3-10 Healthcare Costs/Employee

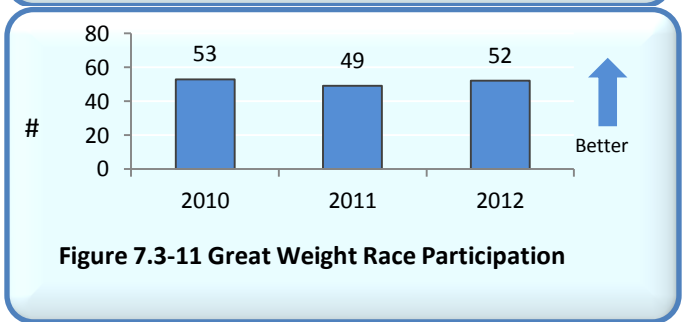


Figure 7.3-11 Great Weight Race Participation

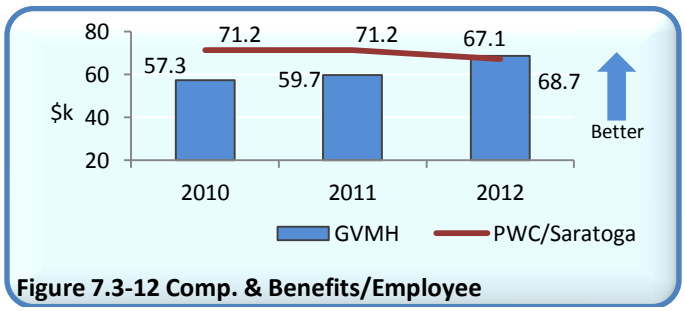


Figure 7.3-12 Comp. & Benefits/Employee

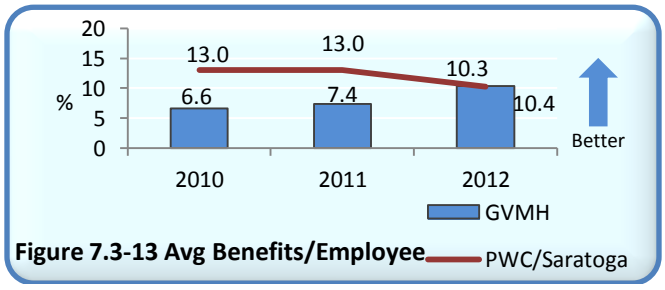


Figure 7.3-13 Avg Benefits/Employee

(3) Workforce Engagement – Turnover and Voluntary Separation are indicators of workforce engagement and are shown in Figures 7.3-14 through 16. Workforce Turnover

Rates are lower than both the PWC/Saratoga national average as well as that for Kansas City area hospitals, and have actually achieved the **top decile performance** level nationally. RN Turnover has been reduced and is lower than the Kansas City area hospitals as well, and Voluntary Separations have declined and also have achieved **top decile performance** according to PWC/Saratoga.

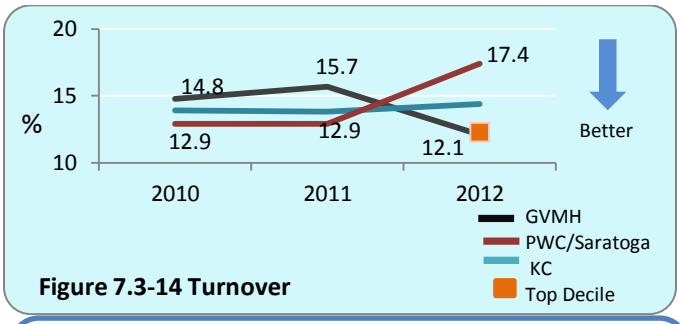


Figure 7.3-14 Turnover

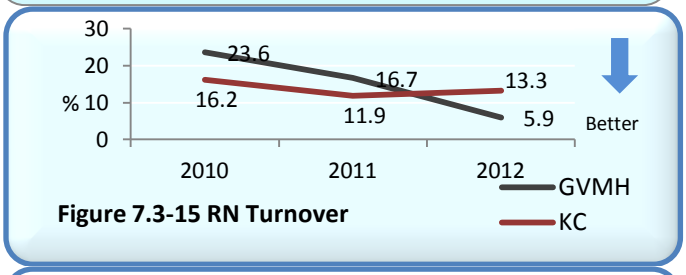


Figure 7.3-15 RN Turnover

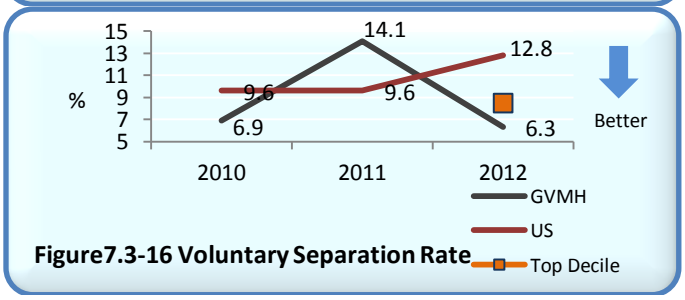


Figure7.3-16 Voluntary Separation Rate

Staff Satisfaction as determined by HealthStream is shown in Figures 7.3-17 through 20. The information provided includes the mean score for each rated factor as well as the national database mean score and the GVMH percentile rank. Figures 7.3-17 and 18 address the major survey categories, while Figures 7.3-19 and 20 segment the data by work area. Results show that all eight major survey categories scored above the national mean score and **two of the eight have attained the GSE level of top quartile performance**, including Overall Satisfaction. Results by work area shows that five of six areas exceed the HealthStream national mean score and **two have achieved top decile and one, top quartile performance**. Figures 7.3-21 and 22 address Volunteer Satisfaction. Results show GVMH exceeds the HealthStream national mean score in seven of eight major categories and has reached **top decile performance** in all seven.

Figure 7.3-17 Staff Satisfaction

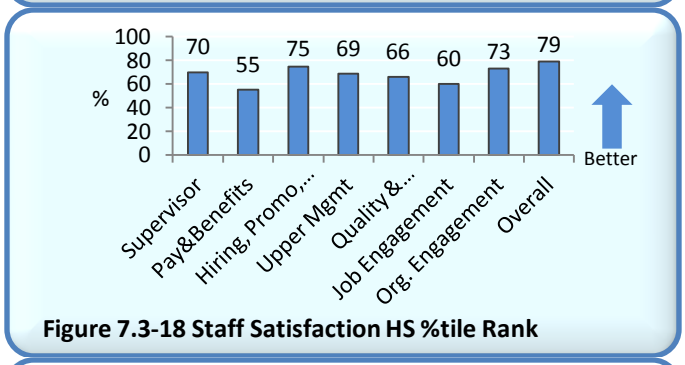


Figure 7.3-18 Staff Satisfaction HS %tile Rank

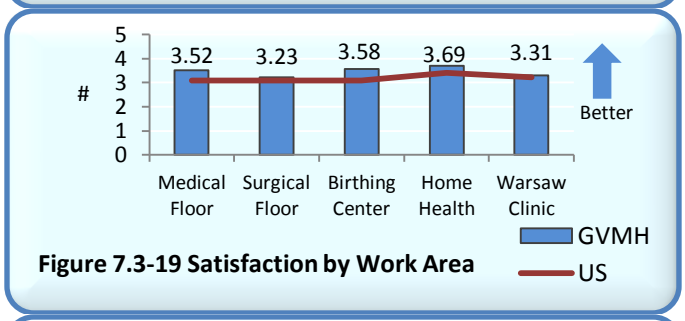


Figure 7.3-19 Satisfaction by Work Area

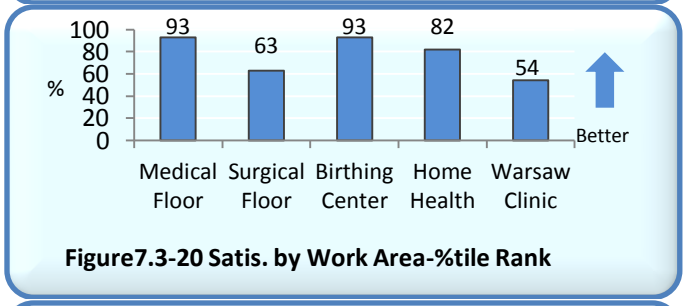


Figure7.3-20 Satis. by Work Area-%tile Rank

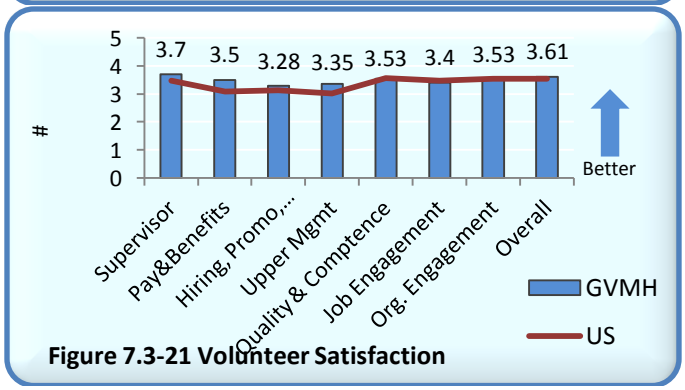


Figure 7.3-21 Volunteer Satisfaction

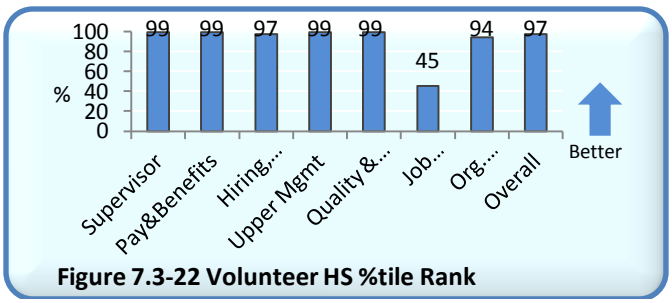


Figure 7.3-22 Volunteer HS %tile Rank

(4) Workforce Development –A significant effort is made to transition new employees into the GVMH culture; to quickly develop needed core competencies, use of performance improvement techniques and understanding of compliance and ethical behavior expectations through NEO and then on a recurring basis through Computer Based Learning and at Skills Fairs. Frequency, participation, and satisfaction data for these activities are available on site. We are tracking leadership development learning and value of the quarterly LDI sessions and the results for the first four are shown in Figure 7.3-23. Workforce satisfaction with learning opportunities is shown in Figure 7.3-24.

LDI Session	Before	After	Value
June 12	4.74	8.58	8.97
October 12	6.46	8.50	9.02
December 12	6.45	8.96	9.37
March 13	6.28	8.95	9.36

Figure 7.3-23 LDI Learning and Value

GVMH Mean Score	HS Mean Score	GVMH %Rank
3.09	2.89	80

Figure 7.3-24 Satisfaction with Learning Opportunities

7.4 Leadership and Governance Results

7.4a. Leadership, Governance, and Societal Responsibility Results

(1) Leadership - We measure senior leader effectiveness by the satisfaction of the workforce and views per leadership blog posted each month. Figure 7.4-1 indicates that each of the five key leadership effectiveness factors score above the national mean with Employee Recognition **achieving the GSE top quartile level of performance**. Leadership blogs are created weekly with views per blog the key indicator of effectiveness, as referenced in Figure 7.4-2

Item	GVMH	HS	%tile Rank
Understanding Needs	2.84	2.67	69
Communication	2.92	2.77	66
Employee Recognition	3.05	2.8	77
Managing the Facility	3.05	2.89	70
Administrator Trust	2.92	2.78	59

Figure 7.4-1 Workforce Satisfaction with Leadership

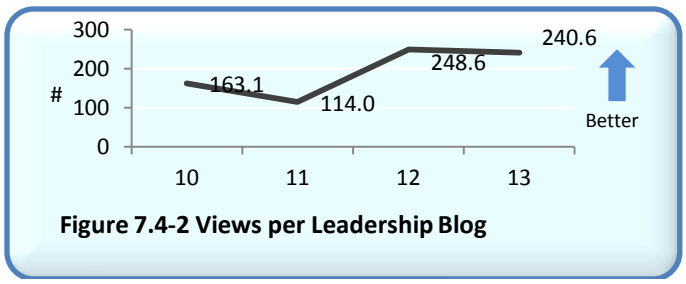


Figure 7.4-2 Views per Leadership Blog

(2) Governance – Figure 7.4-3 indicates the number and results of both internal and external financial audits that have been accomplished over the last five years. GVMH has had no major findings or discrepancies during that timeframe.

	2008	2009	2010	2011	2012
External Audits	1	1	1	1	1
Internal Audits	12	12	12	12	12
Major Findings	0	0	0	0	0

Figure 7.4-3 Financial Audit Results

(3-4) Law, Regulation, Accreditation, and Ethics – Accreditation is a major requirement for GVMH and we have a number of accrediting bodies that ensure we are in full compliance on a scheduled basis as indicated in the OP. Full accreditation has been achieved in all areas as shown in Figure 7.4-4. The Joint Commission also provides a comparative assessment based upon accreditation, patient satisfaction, and health care outcomes that place us **among the top quartile of hospitals across the nation** as shown in Figure 7.4-5. Our score is 17 where lower is better, as compared to the national mean of 23, the Missouri hospital mean of 22, and in comparison with a host of other select groups of hospitals.

Area	Results
Hospital	
Joint Commission	Full Accreditation
CLIA	Full Accreditation
NRC	Full Accreditation
Pathologists	Full Accreditation
Home Health	
Joint Commission	Full Accreditation
Missouri – Home Health	Full Accreditation
Missouri – In Home Services	Full Accreditation
Physician Clinics	
The Joint Commission	Full Accreditation
Missouri - Rural Health	Full Accreditation

Figure 7.4-4 Accreditation Results

We are constantly undergoing compliance audits from external agencies and also conduct self-initiated audits though a contracted third-party provider on a monthly basis to help us identify opportunities to improve. Figure 7.4-6 indicates the

numbers of audits and the areas of focus for each. A number of compliance and ethics effectiveness indicators are shown in Figure 7.4-7. We have experienced a small number of violations over the last five years, and have found it necessary to terminate some people due to inappropriate conduct. Figure 7.4-8 demonstrates compliance committee effectiveness based upon its assessment results.

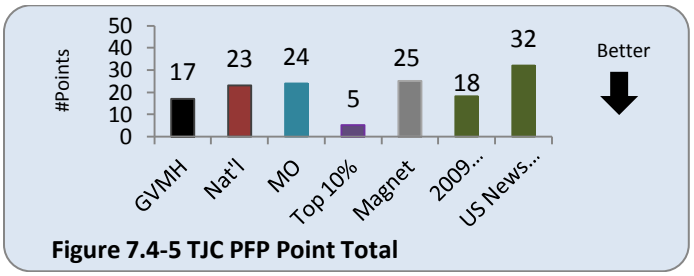


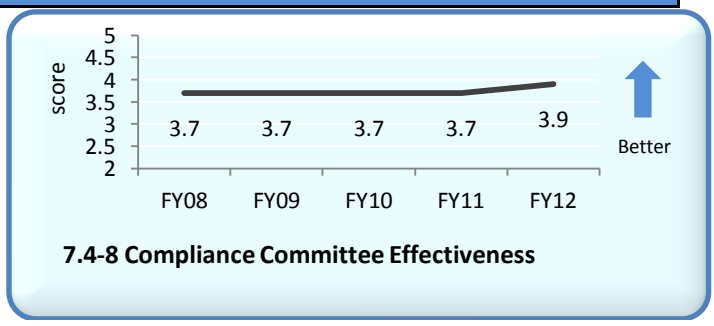
Figure 7.4-5 TJC PFP Point Total

Audit Type	9	10	11	12
External Compliance	Multiple Times per Month			
Self-initiated Compliance				
Patient Billing and Coding	6	7	3	3
PC Billing and Coding	2	2	2	2
HH Billing and Coding	3	3	3	4
Ancillary Billing and Coding	1	1	2	4
Other Billing and Coding	2	1	4	2
Total	14	14	14	15

Figure 7.4-6 Audit Frequency

Assessment Factors	9	10	11	12	13
Licensure %	100	100	100	100	100
Compliance Training %	100	100	100	100	100
Compliance Violations	2	0	1	1	2
Compliance Terminations	2	0	1	1	1
Ethics Training %	100	100	100	100	100
# Ethics Violations	1	0	2	3	2
# Ethics Terminations	1	0	2	1	0
Journal entries	2	2	2	3	N/A

Figure 7.4-7 Compliance/Ethics Results



7.4-8 Compliance Committee Effectiveness

(5) Society – Results in key measures associated with our fulfillment of societal responsibilities are shown in Figures 7.4-9 through 14.

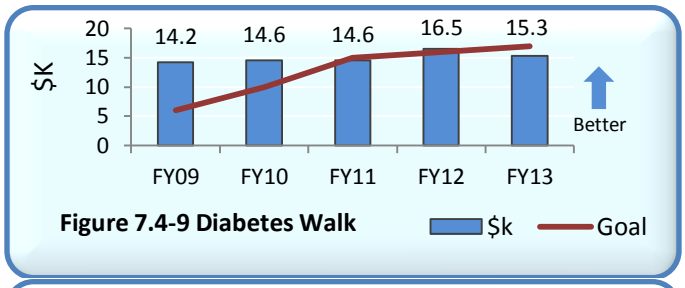


Figure 7.4-9 Diabetes Walk

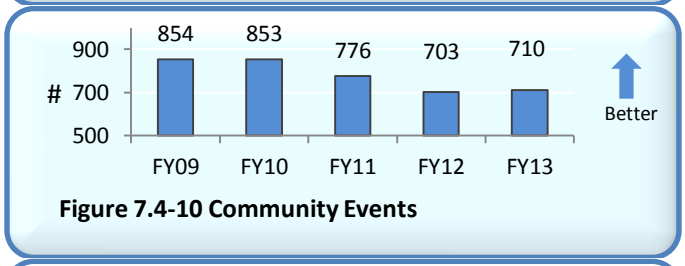


Figure 7.4-10 Community Events

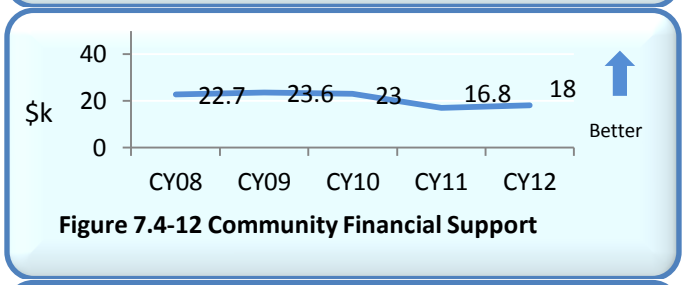


Figure 7.4-12 Community Financial Support

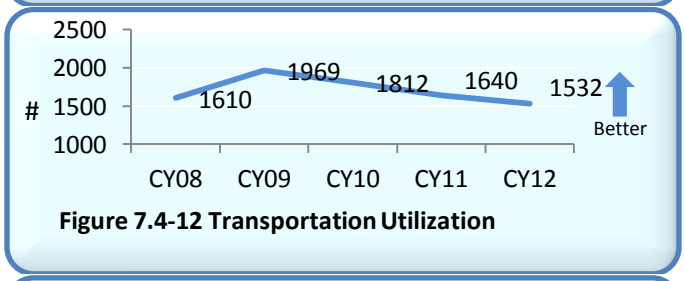


Figure 7.4-12 Transportation Utilization

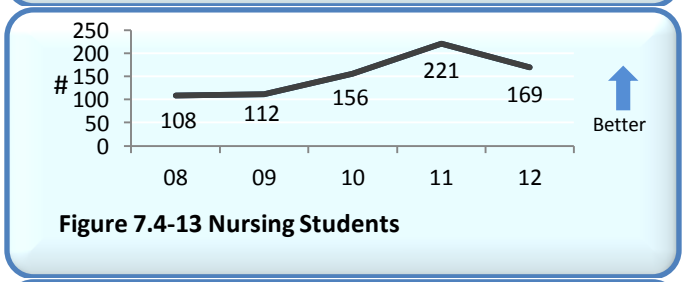


Figure 7.4-13 Nursing Students

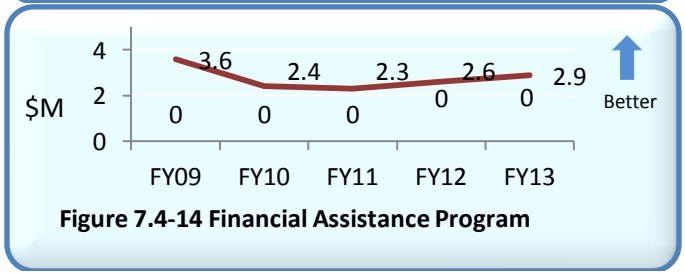


Figure 7.4-14 Financial Assistance Program

7.4b Strategy Implementation Results

2012 Results associated with implementation of our strategy over the last three years are illustrated in Figure 7.4-15.

Key Measures	Three Year Strategy Results
IP National % Rank	+ 109.5%; Achieved GSE
OP National % Rank	+ 151.4%
ED National% Rank	+ 240.5%
Readmissions	Achieved GSE
ORYX Performance	+5.7%
Patient Safety	Leapfrog Grade A
Staff Sat National % Rank	Achieved GSE
Turnover Rate	Achieved GSE
Operating Margin	7.5% Growth
Days Cash on Hand	+23.3%
Operating Revenue	+ 25.4%
OP Volumes	+47.5%

Figure 7.4- 15 Strategy Implementation Results

7.5 Financial and Market Results

7.5a. Financial and Market Results

(1) Financial Performance - Financial results (Figures 7.5-1 through 7) demonstrate significant improvement in all key measures and are reported for our FY of April 1st through March 31st. Operating Margin finished FY13 at a very healthy 6.8% and Total Revenue continues to climb with an increase of more than 25% from 2010 to 2013. Long-term Debt to Total Capital has been reduced again this year and Expense per Adjusted Discharge shows only a modest increase in the face of significantly rising costs. EBIDA continues a positive improvement trend and Days Cash on Hand is at a healthy level and exceeds the historical Missouri hospital average by a wide margin. Foundation Gifts have also shown a positive trend since 2009.

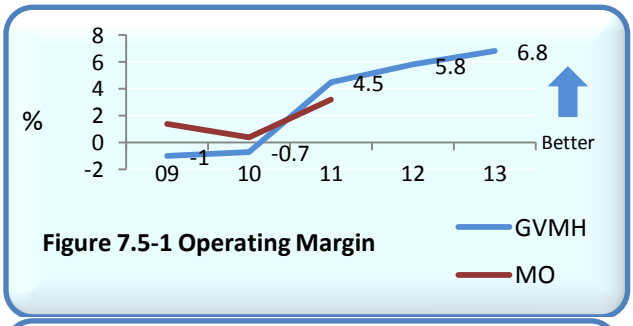


Figure 7.5-1 Operating Margin

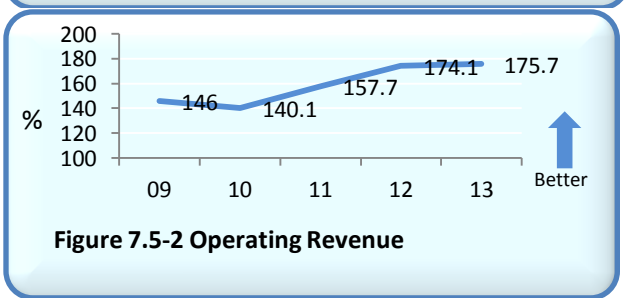


Figure 7.5-2 Operating Revenue

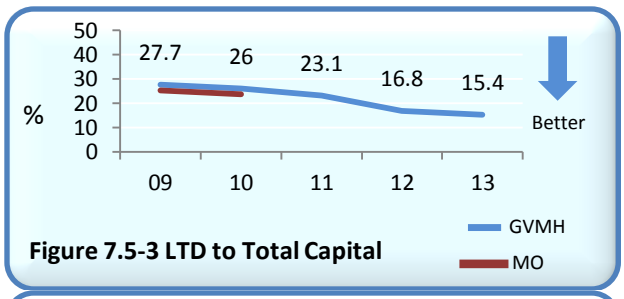


Figure 7.5-3 LTD to Total Capital

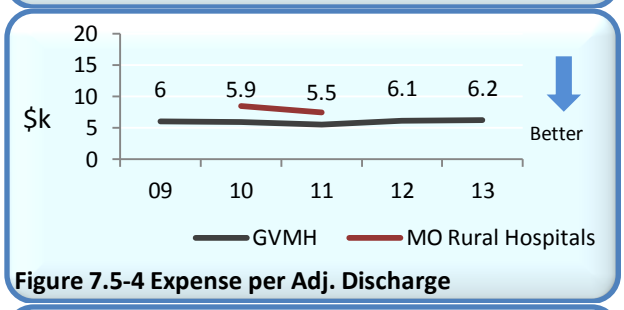


Figure 7.5-4 Expense per Adj. Discharge

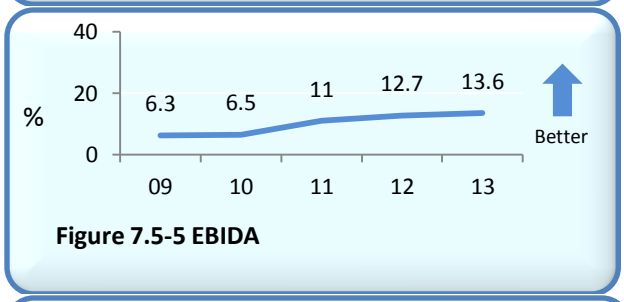


Figure 7.5-5 EBIDA

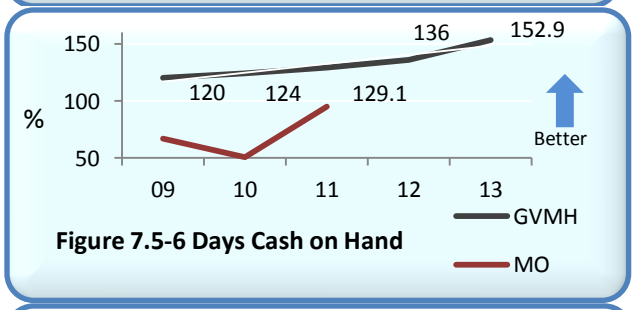


Figure 7.5-6 Days Cash on Hand

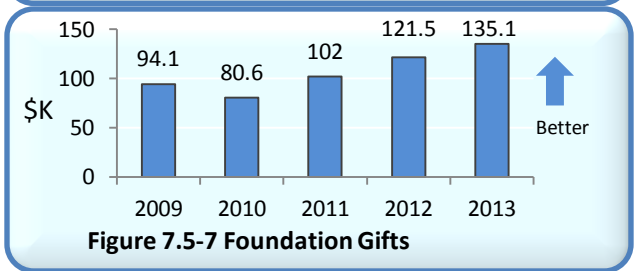


Figure 7.5-7 Foundation Gifts

(2) Marketplace Performance - Volumes in various patient segments and market share are measures used to indicate marketplace performance. Figures 7.5.8 through 12 provide information on patient volumes. Consistent with our strategy of focusing more on outpatient visits, inpatient volumes have decreased slightly as more and more non-acute procedures are being handled on an outpatient basis and we do not provide a full range of acute care services. Consequently,

patients in need of acute care services are using hospitals in the Kansas City area where those services are available from a variety of providers. On the other hand OP Visits have increased by more than 50% since 2009, ER Visits by 18.3%, Home Health Admissions by 22.5%, and Physician Clinics Visits by 2.7% over that same time period.

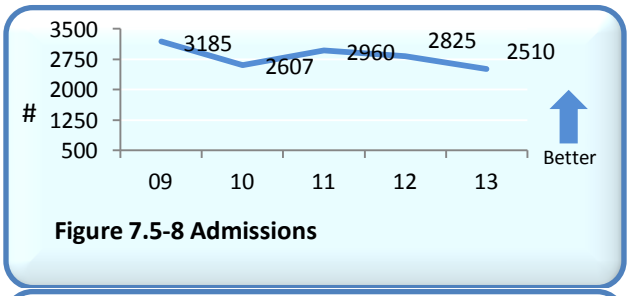


Figure 7.5-8 Admissions

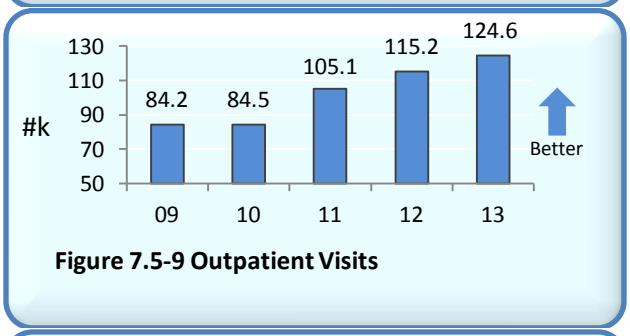


Figure 7.5-9 Outpatient Visits

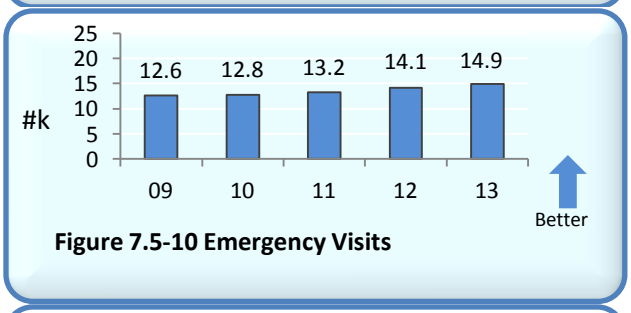


Figure 7.5-10 Emergency Visits

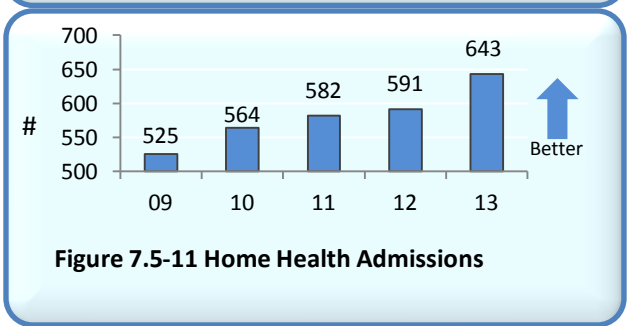


Figure 7.5-11 Home Health Admissions

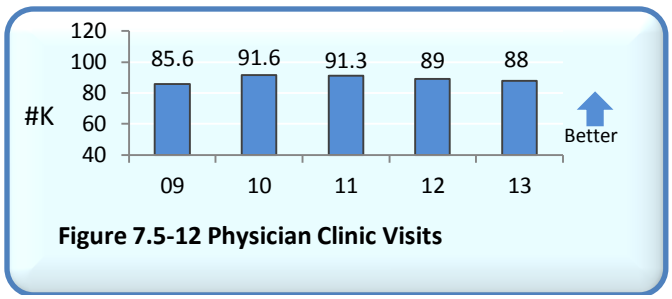


Figure 7.5-12 Physician Clinic Visits

Although market share has declined for inpatients and outpatient due to migration of patients to Kansas City area hospitals to obtain services which are not available in our PSA, we remain the market share leader and outperform our direct competitors by a wide margin (Figure 7.5-13). On the other hand we have achieved a clearly dominant position for outpatients and clinical services as a result of our strategy to expand clinical services in the market area as shown in Figures 7.5-14 and 15.

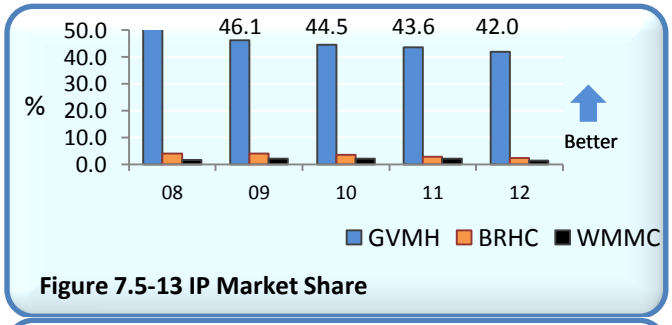


Figure 7.5-13 IP Market Share

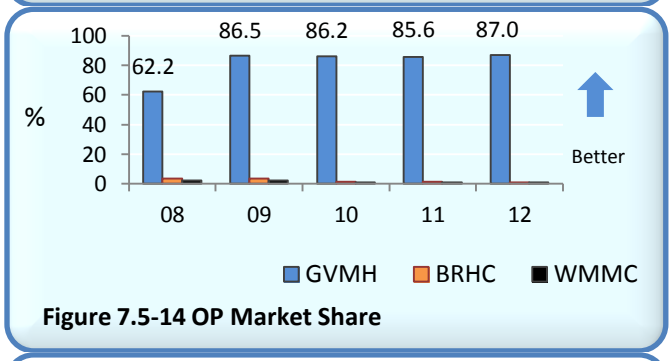


Figure 7.5-14 OP Market Share

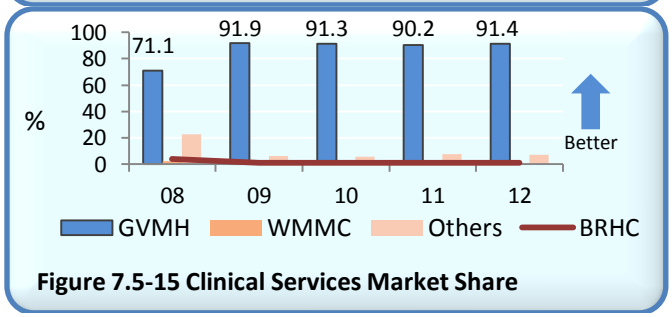


Figure 7.5-15 Clinical Services Market Share