MISSOURI QUALITY AWARD

SSM HEALTH · CARE℠ DePaul Health Center

2006 Missouri Quality Award Application Summary

P.1 Organizational Description

P.1a(1) Health Care Services/Delivery Mechanisms
SSM DePaul Health Center (DPHC) is a private, not-for-profit acute care. Celebrating 177 years of providing patient-centered health services, SSM DePaul Health Center (DPHC) is the oldest continuous business in St. Louis, Missouri, and the first U.S. hospital west of the Mississippi River. Founded in 1828 by the Daughters of Charity, DPHC has served the community at several locations. The current North County campus was established in 1975. In 1995 DPHC was purchased by SSM Health Care (SSMHC) and is now sponsored by the Franciscan Sisters of Mary (FSM). DPHC is a member of SSM St. Louis (SSMSL). SSM Health Care became the first health care winner of the Malcom Baldrige National Quality Award in 2002.

Licensed for 468 beds, DPHC serves 400,000 residents of North (St. Louis) County and delivers health care services through a wide array of inpatient, outpatient/ambulatory and emergency care services. DPHC is the only Level II Trauma Center and provider of maternity services in North County. SSM Cardinal Glennon Children's Medical Center (CGCMC) provides pediatric emergency and neonatology services to DPHC. DPHC offers numerous inpatient (IP), outpatient/ambulatory (OP) and emergency (ED) services including:

Inpatient: medical/surgical care, trauma, women's services, rehabilitation and behavioral health
Outpatient/Ambulatory: diagnostic services, outpatient surgery, community health programs, radiation oncology, cardiac catheterization lab, and retail pharmacy
Emergency: emergency department, level II trauma center, medical control for six fire districts

The DPHC patient-centered care delivery process for inpatient, outpatient/ambulatory and emergency care is defined as:
ADMIT→ASSESS→TREAT→EDUCATE→ DISCHARGE

DPHC is supported by both SSMHC and SSMSL. SSMHC establishes the overall direction for the organization, facilitates regulatory compliance and sharing of knowledge. SSMHC monitors organizational performance and uses the system's size to achieve economies of scale. These functions are facilitated by the annual Strategic Financial and Human Resources Plan (SFHRP), Passport Process, SSMHC Exceptional Goals and Performance Improvement Report (PIR). SSMSL coordinates the delivery of care, facilitates communication, cooperation and sharing of knowledge and skills and provides support services (planning, finance, central business office, human resources, materiels management, clinical engineering and physician practice management). DPHC focuses on meeting the needs of the community and delivering care to the patients it serves. In early 2005 in order to improve accountability, alignment and achievement of the Exceptional Goals within the SFHRP, the prior Strategic Quality Council was reformatted into the Exceptional Council (EC) structure. There are four ECs: Exceptional Clinical Outcomes (ECOC), Exceptional Satisfaction (ESC), Exceptional Financial (EFC) and Exceptional Regulatory (ERC).

P.1a(2) Organizational Culture
DPHC's faith-based culture is reflected in its mission, vision, values (MVV) and quality principles (Figures P.1-1). As a member of SSMHC, the mission and values were developed by employees system-wide in 1999 and are used at every system entity. This provides consistency of purpose for all SSMHC and DPHC employees. The foundations of DPHC's culture are: (1) rich history of faith-based care, (2) patient-centered care, (3) staff partnership and (4) commitment to continuous quality improvement (CQI) with achievement of exceptional outcomes.

Mission Statement
Through our exceptional health care services, we reveal the healing presence of God.

Vision Statement
Through our participation in the healing ministry of Jesus Christ, communities, especially those that are economically, physically and socially marginalized, will experience improved health in mind, body, spirit, and environment within the financial limits of the system.

Core Values
In accordance with the philosophy of the Franciscan Sisters of Mary, we value the sacredness and dignity of each person. Therefore, we find these five values consistent with our heritage and ministerial priorities:
- Compassion
- Respect
- Excellence
- Stewardship
- Community

Quality Principles
- Patients and other customers are our first priority
- Quality is achieved through people
- All work is part of a process
- Decision making by facts
- Quality requires continuous improvement

Figure P.1-1 SSMHC Mission, Vision, Core Values and Quality Principles

DPHC's mission engages employees in the application of SSMHC core values every day. The values are hard-wired into a number of different processes including: employee orientation, the Passport Process, Achieving Exceptional Patient Care (AEPC) and staff/leadership/physician evaluation processes. In 2005 DPHC selected a new patient satisfaction vendor, Press Ganey, which allowed us to compare our data with more than 800 hospitals nationwide.

Patient satisfaction results identified opportunities for improvement system-wide and the need for standardization of best practices. This resulted in the development of AEPC in 2005. With AEPC our values are expressed through actions. Hardwired components of AEPC include: exceptional service standards, conversations, rounding, rewards/recognition, patient experiences, ideas management, selecting exceptional employees and service recovery. The education for this program began in 2005 with the first four elements implemented January 2006 and the later four elements to be implemented later in 2006.

DPHC 's culture is also characterized by staff partnership in shared decision making and consensus building. DPHC engages staff members in partnership and shared decision making through Shared Accountability, CQI and working together in teams. SSMHC committed to CQI as early as 1990 and was among the first health care organizations to do so. CQI is built upon the Quality Principles in Figure P.1-1.

P.1a(3) Staff Profile

DPHC has 2,270 employees and 730 physician partners who serve the needs of our patients and community. The health care staff is diverse and includes nurses, other clinical professionals, support staff, leaders/managers (Figure P.1-2). Of the 2,270 employees, 82% are female and 33% are minority. Occupations range from entry-level dietary and housekeeping staff to highly specialized physicians. Education varies from high school education to doctorate degrees. There are no bargaining units at DPHC. The DPHC medical staff is represented by a wide range of specialties and sub-specialties within 11 departments. Of the 730 physician partners with the DPHC medical staff, 194 are contracted with DPHC and 32 are fully employed by the DePaul Medical Group. Physicians are credentialed and evaluated through the Medical Staff process, which is directly linked to SSMSL and the SSMHC Board of Directors (BOD).

Position Type	Number of Employees
Registered Nurses	789
Other Clinical Professionals	665
Support Staff	746
Management/Leadership	61
Senior Administration	9

Figure P.1-2 Number of Employees by Position

DPHC maintains a work environment that contributes to the well-being, satisfaction and motivation of staff. Special health and safety requirements for employees include: ergonomics; exposure control through sharps alternatives; hazardous and biohazardous material management; life and environmental safety and emergency preparedness. This is achieved through the Exceptional Regulatory Council (ERC), Environment of Care (EOC) rounds, the Safety Committee and the Worker Safety Team.

P.1a(4) Technologies, Equipment and Facilities

DPHC maintains and develops appropriate technologies, equipment and facilities through operations, the budget management process, department planning and annually through the SFHRP. DPHC has a standardized information system maintained by the SSMHC Information Center (SSMIC), which supports DPHC's assessment, measurement, accountability and e-health activities. IS processes are designed and governed jointly by SSMHC and DPHC. When DPHC transitioned into SSMHC in 1995, the infrastructure was put in place to include LANs, system-wide WANs, initial access to external government and commercial databases, tele-radiology and other services. Software programs enable reporting, monitoring and analyzing of key performance indicators, cost, utilization, productivity and benchmarking.

DPHC's hospital campus buildings contain more than one million square feet of space. The medical office buildings are owned and operated by Lillibridge. Also under construction is a new physician's office building and ambulatory Surgery Center, built as a partnership with physicians. Construction of a new 675-space parking structure was completed in February 2006. DPHC's major medical equipment supports patient assessment and treatment within inpatient, outpatient and ED services including: PET/CT, CT, MRI, lasers, stereotactic surgery, and state-of-the-art operating rooms, Emergency Department and ICU equipment. The cancer program added the first TomoTherapy radiation therapy system in Missouri in 2005. A new state-of-the-art digital cardiac catheterization lab opened in October 2005.

P.1a(5) Legal/Regulatory Environment

DPHC operates under the requirements of city, county, state and federal regulations and is fully licensed and accredited by local, state and federal agencies including Center for Medicare and Medicaid Services (CMS) and the Missouri Department of Health and Senior Services. Clinical and support services also comply with additional regulations specific to the services being provided.

The Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) provides the accreditation for DPHC. DPHC received a score of 93 in 2003 achieving performance above national mean in its last three surveys (scores of 91 in 2000 and 96 in 1997). DPHC also holds accreditations for medical staff education, radiology, vascular lab, perinatal lab, mammography, trauma, pulmonary and cardiac rehabilitation, oncology, diabetes education and laboratory services. The Bariatric Program also received Center of Excellence Accreditation in 2006. DPHC complies with requirements of the federal regulatory agencies including: OSHA, EEOC, EPA, OIG, IRS and HIPAA. DPHC is committed to exceeding regulatory requirements and health care industry standards and considers compliance a minimum standard.

DPHC tracks charity care and community benefit to ensure that it fulfills the organization's vision and maintains its tax-exempt status as a non-profit health care organization under Internal Revenue Service (IRS) financial regulations. DPHC has a Community Benefit Inventory for Social Accountability

(CBISA) process and a Self-Pay Discount Process. The Corporate Responsibility Process (CRP) ensures that DPHC complies with Medicare and Medicaid requirements as enforced by the Office of the Inspector General. DPHC's HIPAA plan also ensures compliance with regulations on patient confidentiality under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

P.1b(1) Organizational Structure/Governance
As previously stated, DPHC is sponsored by the Franciscan Sisters of Mary, and is owned and operated by SSMHC. SSMHC has three operating regions: SSM St. Louis, SSM of Oklahoma and SSM of Wisconsin. SSMSL is comprised of six acute care hospitals, two specialty hospitals, a Managed Care Organization (MCO) and a Physicians' Organization (PO). DPHC is an entity within SSMSL. The SSMHC Board of Directors (BOD) has ultimate responsibility for the management and operations of the system. The SSMSL BOD has overall responsibility for the management and operations of the St. Louis region's organization. DPHC has an Administrative Council (AC) and Medical Executive Committee (MEC) with overall responsibility for hospital and medical staff operations and reporting requirements to SSMSL and SSMHC.

P.1b(2) Key Patient and Customer Groups/Segments
DPHC views patients and their families as its primary customers and further delineates them into three key groups: inpatient, outpatient/ambulatory and emergency service. The key requirements of our patients and families are identified and tracked by the Exceptional Satisfaction Council (ESC). Key requirements were similar among patient segments and overall satisfaction is measured and tracked for each segment in addition to the other key requirements listed in Figure P.1-3. Information from patient satisfaction surveys, rounding, patient call backs and other listening posts allow departments to respond to feedback from their patients in real time and focus their improvement efforts in areas that are most meaningful (Figure 3.1-1).

Segment	Key Customer Requirements/Expectations
Inpatient	▪ Exceptional Clinical Outcomes ▪ Responsiveness/Wait Times ▪ Pain Management ▪ Education
Outpatient/ Ambulatory Services	▪ Exceptional Clinical Outcomes ▪ Kept Informed of Delays ▪ Attractiveness/Comfort of Facility ▪ Patient Education
Emergency Services	▪ Exceptional Clinical Outcomes ▪ Wait Times ▪ Kept Informed

Figure P.1-3 Key Customer Requirements/Expectations

P.1b(3) Key Suppliers and Partners
DPHC utilizes suppliers and partners that are aligned with the organization's MVV and goals with both parties identifying expectations for each other and valuing their relationship. DPHC's most important suppliers include: Cardinal Health (pharmaceuticals/medical/surgical), Fischer (lab services), Aramark (food service) and Premier, Inc. (nation's largest health care purchasing group). Suppliers share in the achievement of organizational goals and innovation by participating in performance improvement activities, serving on DPHC teams, and AEPC/CQI training as appropriate. Suppliers also participate in monthly operations meetings, Value Analysis Team and quarterly leadership reviews. Suppliers also have contracts which include specific goals (aligned with DPHC's Exceptional Goals) and specific performance measures. DPHC and SSM Health Businesses regularly review these results with suppliers. Results are also reviewed and tracked by the Exceptional Financial Council (EFC). With the engagement and collaboration of our key suppliers, the key supply chain requirements were determined as listed in Figure P.1-4.

Physicians are DPHC's key partners and the organization seeks to make physicians true partners by sharing in the Mission, decision-making, strategic planning and performance improvement opportunities. They are the primary source of patient referrals and are essential partners in improving clinical outcomes. Partnering with physicians is considered a key strength and competitive advantage for DPHC. Utilizing the Data Management and Research (DMR) annual survey, Physician Services and available physician listening posts, the key requirements of the DPHC physicians were determined by the Physician Satisfaction Team and results are tracked by the Physician Satisfaction Team, MEC and the ESC. The key physician requirements are listed in Figure P.1-4. DPHC employs, contracts and participates in business partnerships with physicians. Physician contracts include performance goals aligned with DPHC Exceptional Goals and performance measures. Physician leaders meet with department directors and AC members to plan budgets, services and to identify equipment and supply needs. Physician participation in DPHC innovation occurs through multiple mechanisms including: participation on performance improvement teams, ECOC, physician leaders attend national conferences (including Institute of Healthcare Improvement), ongoing CME programs, physician leader training in CQI, AEPC and participation in SSM physician leadership educational opportunities.

As mentioned previously, CGCMC provides pediatric services, SSMIC provides clinical and financial information system development and support, SSM Centralized Billing Office (CBO) serves as the patient accounting department and SSM Centralized Purchasing and Materiels Management oversees purchasing and receiving activities.

Suppliers
DPHC Requirements of Suppliers: • Timely availability of inventory • Invoicing accuracy • Cost savings **Supplier Requirements of DPHC:** • Timely payment of bills • Sales
Physician Partners
DPHC Requirements of Physicians: • Business growth/patient referrals • Resource management • Exceptional patient care/outcomes (shared) • Patient satisfaction with physicians **Physician Requirements of DPHC:** • Skilled nursing • Exceptional patient care/outcomes (shared) • Ease of scheduling (i.e. OR, radiology) • Timely report turnaround • Treat as customer

Figure P.1-4 Supplier/Partner Key Requirements

P.1b(4) Key Supplier and Partner Communication
DPHC values its relationship and collaboration with key sup pliers and partners and utilizes a number of communication mechanisms. Electronic links to suppliers are provided on the SSMHC Intranet in addition to ongoing communication by telephone, mail and e-mail. Suppliers also have quarterly business review meetings and operational meetings with SSMHC and DPHC representatives. The quarterly review meeting is designed to review supplier performance and plan future improvements; discuss SSMHC's goals and requests; address unresolved issues regarding products and service; and explore new products and programs. SSMSL representatives, along with the DPHC Central Distribution Manager, have operational meetings as frequently as weekly. Suppliers also communicate with DPHC through the participation on DPHC performance improvement teams, as appropriate.

Physicians receive formal information from DPHC through Physician Services representatives, medical staff meetings, department meetings, PI teams, bulletin boards and physician newsletters. Physicians also use SSM Connect, which permits automated review and delivery of patient reports and sharing of data by fax, PDA and PC. DPHC also regularly communicates with its physician partners face-to-face, by phone, e-mail, and personal notes from leadership. Physicians also participate in annual focused groups with the President and this information is utilized in the development of the annual SFHRP. DPHC also provides physician performance profile reports on a regular basis. These reports include information at the department and individual physician level related to the DPHC Exceptional Goals with national comparative data. At DPHC there is also an "open door" culture for physicians to discuss any issue with DPHC leadership.

P.2 Organizational Challenges

P.2a(1) Competitive Position
Conveniently located at the intersections of I-270 and I-70 in Bridgeton, DPHC serves 400,000 residents of North St. Louis County, a diverse economic and cultural community with a stable population base. The North County median income per household in 2005 was $54,058 compared to $57,173 for Missouri. In 2005 the North County population below poverty level was 12.1% compared to 14.7% for Missouri. The North County payor mix is 44.7% Medicare, 16.9% Medicaid and 38.4% other. This primary service area is 49.5% white, 45.4% African American and 5.1% other compared to Missouri which is 82.8% white, 11.5% African Americian and 5.7% other. DPHC receives 75.2 % of its volume from this primary service area in North St. Louis County. DPHC has the largest market share in North County at 27%.

P.2a(2) Determination of Success
The principal factors that determine the success of DPHC are the five "exceptionals:" patient satisfaction, staff satisfaction, physician satisfaction, clinical outcomes and financial performance. DPHC has chosen a strategy of collaboration with physicians for mutual benefit. Such partnerships bring new technology and expand service capacity while providing financial benefit to physicians, increasing loyalty and patient referrals to DPHC**.** Multiple collaborative and partnership agreements with physicians include: outpatient cardiac catheterization lab, outpatient MRI, nuclear medicine, ambulatory surgery center and medical office buildings. This relationship also improves availability of physicians and key specialists in serving our community.

P.2a(3) Comparative/Competitive Data
DPHC uses a number of key sources for clinical comparative and competitive data (Figure P.2-1). DPHC's benchmarking process and policy works to identify and focus on comparative data to leverage operational performance. The priority is to first use national benchmarks/best practices, then state-level benchmarks, then SSM and internal comparative data. Evidence-based medical literature is also utilized to identify clinical best practices and benchmarks. Limitations on comparative data availability exist at the local competitor level.

P.2b Strategic Challenges
The SFHRP process allows DPHC to identify and address its multiple strategic challenges.

Key Strategic Challenges:
- **Health care services:** Patient satisfaction, continuous improvement in clinical outcomes and ED efficiency/satisfaction
- **Operational:** reimbursement limitations, Medicare and Medicaid changes, capacity limitations, aging

equipment, changing technology and increasing supply costs

- **Human Resources:** staff satisfaction and retention, physician satisfaction, workforce and physician shortages in key professions and specialties,
- **Organizational Sustainability**: Sustained patient/staff/physician satisfaction, clinical and financial outcomes relative to competition; St. John's increasing focus on North County; physician independent outpatient ventures
-

P.2c Performance Improvement System

CQI/PDSA methodology and Malcolm Baldrige National Quality Award (MBNQA) criteria provide the framework for strategic planning and process improvement initiatives. Continuous quality improvement (CQI/PDSA) principles are integrated throughout the organization and provide a common methodology for systematic performance improvement at DPHC. DPHC also stays focused on the need for new and redesigned services and process improvements through our annual Performance Improvement and Patient Safety Plan (PIPS). DPHC focuses on organizational learning through its education plan and communication processes ((Figure 1.1-5). Process-improvement (PI) teams and projects are aligned with DPHC's SFHRP and reported through the Exceptional Councils (EC). The purpose and function of the EC structure is to improve accountability, alignment and achievement of the Exceptional Goals within the SFHRP. It also commissions PI teams, monitors PI team performance, reviews department Passport goals, ensure use of CQI methodology and tools and ensure appropriate use of benchmarks. There are four ECs: ECOC, ESC, EFC and ERC with each having a PIR aligned with the SSMHC PIR. All ECs report directly to the AC. PI teams are assigned to an appropriate council based upon the team's charter and primary alignment with one of DPHC's Exceptional Goals. Manager PIRs are also linked to DPHC and department goals. Through these processes, the EC structure creates focus on patient needs and drives innovation and sustained change.

Comparative Information	
Clinical ▪ JCAHO/CMS ▪ Maryland Hospital Association ▪ Missouri Hospital Association	▪ Premier ▪ Solucient ▪ Society of Thoracic Surgeons (STS) ▪ Medical Literature ▪ SSMHC
Satisfaction ▪ Press Ganey starting 2nd QTR 2005 for Patient and 2006 for Staff ▪ HR Solutions prior to 2006 (Staff)	▪ Internal SSM survey prior to 2nd QTR 2005 (Patient) ▪ Data Management and Research (DMR) (Physicians) ▪ SSMHC
Operations/Financial ▪ Solucient Market Planner Plus ▪ SSMHC ▪ Premier ▪ CHS (Financial)	▪ Missouri Hospital Association's Health Industry Data Institute (HIDI) data ▪ WCCMS (Worker's Comp)
Out-Of- Industry ▪ Boeing ▪ AA Bond Rating	▪ OSHA ▪ Ritz Carlton

Figure P.2-1 Comparative Information

"Every day, we have an opportunity to make a difference in people's lives. We must care for people in a way that touches their souls, so that everyone—including ourselves—is in some way healed. What we do is more than a career. It is a sacred trust." *--Sr. Mary Jean Ryan (CEO SSMHC)*

1.1 Senior Leadership
1.1a Vision and Values
1.1a(1) Set and Deploy Vision and Values
SSM DePaul Health Center (DPHC) is a "mission and values driven" organization committed to providing exceptional health care services to every person in need of care. The SSM Health Care (SSMHC) Board of Directors sets the organization's Mission, Vision, Values (MVV) and Quality Principles (Figure P.1-1) with annual affirmation during the Strategic, Financial and Human Resource Planning process (SFHRP) and utilizing feedback from all entities, including DPHC. Created in 1999 based upon a best practice at SSM St. Michael's Hospital in Oklahoma City, the annual SFHRP is the process by which senior leaders, called the Administrative Council (AC), deploy mission and values through the leadership system to all staff, key suppliers, partners, and patients. Strategic and operational plans are aligned and measured against progress towards the objectives within the SFHRP through Passports and DPHC Goals, Exceptional Council (EC) Performance Improvement Reports (PIRs), Department Posters, manager PIRs and individual performance appraisals. At all levels of the organization, the SFHRP is translated into action plans and measurements that allow DPHC to "manage by fact" the effectiveness of mission and values deployment. (Figure 1.1-1). Each employee develops an annual Passport–a card containing the Mission and Values, five key characteristics of Exceptional Care, DPHC's strategic goals, department and individual goals. The Passport links the individual's daily work to the department's goals and to the goals of the organization. It also sets the stage for employee development needs to be discussed between the manager and the employee.

The Mission and Values are also communicated to key physician partners and suppliers. These messages are communicated to physicians through physician contracts, Medical Executive Committee (MEC), medical staff meetings, PI teams, physician newsletter, performance feedback reports, physician satisfaction and rewards processes. The medical staff bylaws, Rules and Regulations contain a Code of Conduct and Expectations of the Medical Staff which reflect the Mission and Values. The bylaws reference the Ethical and Religious Directives for Catholic Health Care Services (ERDs). Key suppliers are selected using a systematic process that identifies key commitments that uphold the mission and values expectation of SSMHC and DPHC through the accomplishment of SFHRP objectives. Communication of the Mission, values and goals to suppliers occurs as a part of the contract review process managed by SSMHC and DPHC. Business agreements and contracts are the tools used to communicate values and objectives.

Senior leader actions are held accountable to reflect a commitment to the MVV. Leadership philosophy and performance expectations are published in the SSMHC Executive Leadership Handbook and guide the behavior of executive leaders. (Figure 1.1-2) The expectations

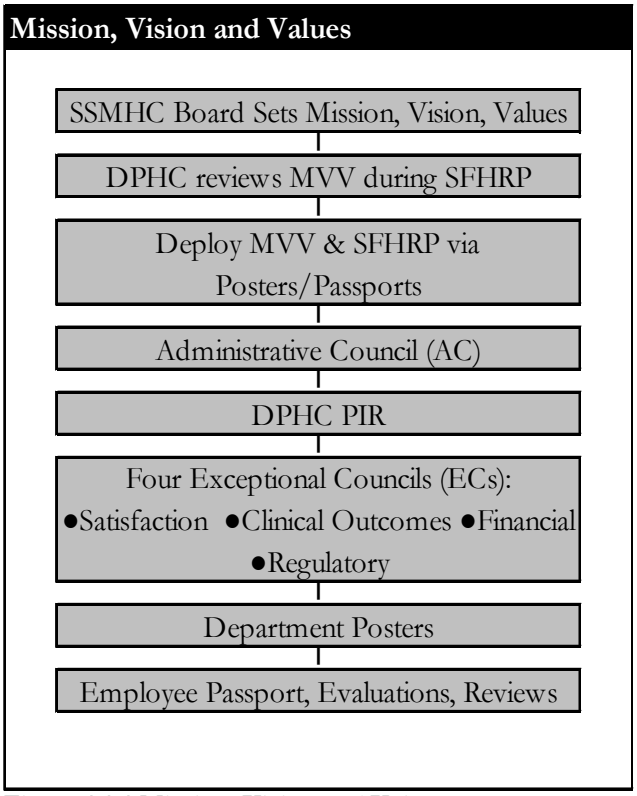


Figure 1.1-1 Mission, Vision and Values

provide a standard of accountability and form the basis for learning through the Leadership Development Process as described in Section 5.1c(3). Senior leaders participate in a 360 degree evaluation process, receiving input regarding their behavior and management skills and their commitment to organizational values.

The Mission and Values are deployed to patients and their families through AEPC, pastoral care services, admission information, public posting of the Mission and Values and results, the DPHC web site and community programs. With AEPC the Values are expressed to patients through staff actions. The hardwired components of AEPC are identified in Section 3.2a(1). Mission retreat days give employees a full day each year, with pay, to reconnect with the mission and values.

1.1a(2) Foster and Require Legal & Ethical Behavior
DPHC has several systematic processes to promote legal and ethical behavior at all levels of the organization, which includes senior leaders (Figure 1.2-1). The Exceptional Regulatory Council (ERC) is responsible for monitoring legal compliance and performance**.** The Corporate Responsibility Process (CRP) creates an open and direct, non-punitive culture for addressing legal and ethical issues and provides education and training. A 24-hour hotline features a confidential follow-up process to reach quick resolution of these issues. At least annually, policy and procedures are updated to guide behaviors and performance in all areas. DPHC also utilizes an Ethics Committee to address the difficult clinical ethical issues. The Pastoral Care Department further promotes

Seven Senior Leadership Expectations
1. Superior results in clinical, operational and financial performance
2. Fact-based decision making
3. Involvement and shared accountability
4. Continuous quality improvement
5. Customer focus
6. Information sharing
7. Developing people

Figure 1.1-2 Senior Leadership Behaviors and Expectations

ethical clinical behavior, by working with patients to complete advance directives (Section1.2b).

Senior leaders promote an environment that fosters legal and ethical behavior by providing training during new employee orientation regarding Mission and Values, CRP and reference to the Ethical and Religious directives for Catholic Health Care Services (ERDCHS). Non-punitive reporting of incidents is strongly promoted throughout the organization. The non-punitive approach is addressed in annual education, supported and discussed by department management at department meetings and reinforced by Risk Management.

1.1a(3) Create a Sustainable Organization

Senior leaders create a sustainable organization through a commitment to MVV, the SFHRP, Passport process, CQI/PDSA, MBNQA criteria, and the EC framework. The SFHRP identifies a one-year operational plan and three year strategic plan which outline clear expectations, outcomes and necessary steps to reach performance excellence, and are provided to AC and ECs for review, input and deployment [Section 2.1a(1-2)]. In 2006 the annual operational review will continue and the long term strategic plan will be expanded from three to five years. DPHC is deploying Project 2014, an initiative to address long term positioning. The integration of SFHRP objectives with EC, department, manager and employee goals helps to create a sustainable organization that is focused on the achievement of strategic objectives (Figure 2.2-2). Continuous quality improvement (CQI) principles and MBNQA criteria are integrated throughout the organization and provide a common methodology for systematic performance improvement at DPHC. The DPHC EC PIR process is a balanced approach for setting clinical, operational, financial and regulatory indicators that are linked to the SFHRP (Figure 1.1-3). EC PIR measures use DPHC benchmarking processes to ensure that comparative data is driving performance excellence.

Senior leaders create an environment of innovation and agility through AEPC, CQI, senior leader involvement in PI and membership in the SG2 health care futuristic advisory group. Other methods include: healthcare publications; senior leader participation in national meetings; visits to national best practices (including IHI and Premier); DPHC and annual SSMHC Sharing Conferences; participation in SSM Collaboratives, benchmarking; and regular review of current market information.

Senior leaders create an environment of organizational and staff learning through an annual education plan, educational funding, educational management processes, accreditation for physician CME, benchmarking with external best practices, and communication of learned information. DPHC also has a staff educational fund, which is managed by the Education Committee and AC. Senior leaders at AC approve educational expenditures, programs and business development to ensure that programs are aligned with organizational goals. Numerous staff educational programs are provided on a regular basis throughout the year and are managed by the Education Department and the Education Committee. Physician CME is promoted through medical staff educational funds, medical staff CME coordinator, state accreditation for physician CME and numerous programs at DPHC.

Senior leaders personally participate in leadership development: through the annual 360 degree evaluation process, Right Management Programs, mentoring/instructing and president referrals to an external consultant. Leadership development is incorporated into the annual leader 360 degree evaluations. Feedback from 2004 annual DPHC manager report cards, EOS and leadership performance management process indicated a further need for leadership development. In partnership with Right Management, focus groups were held with AC and the LT to identify learning needs. Curriculum was developed, and classes began in 2005 in the areas of sustaining a high-performance culture, leading innovation, courageous leadership and personal accountability, performance improvement, employee engagement, building commitment and leading change.

Senior leaders participate personally in leadership development through mentoring and coaching opportunities and serving as instructors in educational classes. Senior leaders at the recommendation of the president may receive an extensive leadership evaluation process from an external consultant (Collarelli and Meyer, Assts.) with development recommendations. Several leaders per year also participate as MBNQA and MQA examiners. Additional leader opportunities are available through the SSM University program implemented in 2006. Succession planning for senior leaders is achieved through the SSMHC Executive Career Development Program [Section 5.1c(3)].

1.1b Communication & Org. Performance

1.1b(1) Senior Leaders Communicate

Senior leaders use a variety of methods to communicate with, empower and motivate staff throughout the organization (Figure 1.1-5). These methods include: Shared Accountability Councils, EC structure, town hall meetings, newsletters, leadership rounding, Mission Retreat Days and Lunch with the President. DPHC empowers staff through partnership and shared decision making through Shared Accountability (SA), CQI and working together in teams. SA provides an organizational structure that gives staff greater decision-making authority

Key Characteristic	Measure	Figure
Patient Satisfaction- Inpatient	Overall Patient Satisfaction Score (Press Ganey)	7.2-1
Patient Satisfaction- Outpatient	Outpatient Surgery Satisfaction Score (Press Ganey)	7.2-1
Patient Satisfaction- ED	Overall ED Patient Satisfaction (Press Ganey)	7.2-1
Physician Satisfaction	Physician Satisfaction Score (DMR)	7.2-7
Employee Satisfaction	Employee Satisfaction Score (Press Ganey)	7.4-7
Financial Performance	Overall Operating Margin %	7.3-1
Clinical Outcomes: • AMI • CHF • Pneumonia	• AMI Core Measure Scores • CHF Core Measure Scores • Pneumonia Core Measure Scores	7.1-2 7.1-1 7.1-3

Figure 1.1-3 Key Measures from the Exceptional Councils PIRS

and overall accountability for performance improvement. This model has been implemented in nursing services and is being expanded to other departments. This best practice strategy was adopted from SSM St. Mary's Medical Center in Madison, Wisconsin, which implemented this program in 1993 and demonstrated improved staff satisfaction and reduced turnover. Shared Accountability (SA) is an organizational structure that gives staff greater input related to the work they do and deploys decision-making at the level of greatest impact. The EC structure is designed to communicate and monitor performance expectations [Section 1.1b(2)].

Senior leaders encourage two-way communication by encouraging a blame-free culture and reporting, teamwork culture and rounding. Rounding by senior leaders focuses on assuring that the needs of patients and employees are met. Monthly staff luncheons with the president provide earnest dialogue about current issues at DPHC. Staff drives the agenda, and the president personally follows-up on both positive and negative issues discussed. On many occasions, staff have taken this opportunity to praise their peers, and afterwards the president sends a written note acknowledging the staff member's efforts. Leadership also reviews staff and physician surveys as a formal method to understand drivers of satisfaction.

Senior leaders have an active role in reward and recognition through the staff evaluation process, AEPC linked to patient satisfaction, personal notes, newsletters, rounding, employee of the month, physician value awards, Mission awards and the annual Employee Recognition Dinner. The Spirit of Mission award is both community and value-based recognition where employees nominate their peers to recognize performance excellence and for exemplifying our values. Senior leadership also participates in the rewards and recognition of the medical staff as described in the Physician Satisfaction Plan. This includes writing personal notes for recognition of top performers in patient satisfaction and participation in the Physician Awards Dinner (which includes the DPHC Physician Value Awards).

<u>1.1b(2)</u> Senior Leaders Create a Focus on Action
Senior leaders create a focus on action through the SFHRP (including the one year operational plan), EC structure and PIRs, Passport process, department goals, data driven decision making and CQI. Using MQA feedback, DPHC re-aligned its mature leadership system into Exceptional Councils (ECs) in 2005 (Figure 1.1-4). ECs were designed to improve organizational alignment and accountability. Each EC utilizes a scorecard (PIR) to measure overall and individual PI team progress towards the attainment of exceptional goals. Scorecard measures are derived from the SSMHC PIR, SFHRP, department posters and PI teams to ensure alignment and integration with DPHC. The departments utilize a monthly scorecard and results are reviewed monthly with the appropriate senior leaders. Variances and action plans are assigned to the appropriate EC. AC regularly reviews department performance and action plans. The ECs recommend department goals for the Passport Process. Senior leaders focus on creating and balancing value for patients and stakeholders through the annual SFHRP, the EC structure, AEPC and utilizing key patient feedback provided by multiple listening and learning tools (Figure 3.1-2).

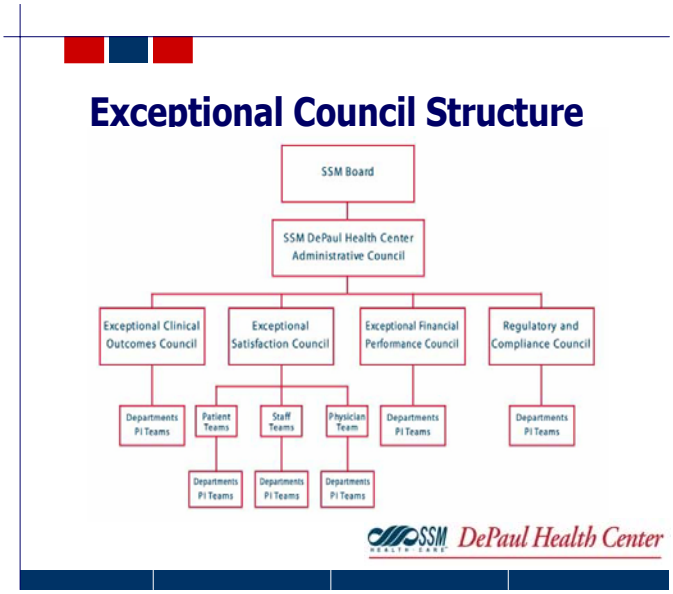


Figure 1.1-4 Exceptional Council Structure

Key Communication Methods	Frequency	Audience
SSMHC Link e-Newsletter	Weekly	AC
DPHC Newsletter	Bi-Weekly	Employees, Physicians, Patients, Families
Physician Newsletter	Every 2 Months	Physicians
Executive Presentations at Orientation	Semi-monthly	Employees
Town Hall Meetings	Quarterly	Employees
Leadership Meetings	Monthly	Leadership and Employees
AC Meetings	Weekly	Senior Leadership
MEC Meetings	Monthly	Physician Leadership and AC
Exceptional Councils	Most are monthly	AC, Leadership, Employees and Physicians
Community Advisory Board	Three Times per Year	Community Leaders
Foundation Board	Every 2 Months	Community Leaders
President's Address to Community	Semi-annually	Community Leaders and Members
DPHC Intranet and Internet Websites	Continuous	Employees, Leadership, Physicians, Patients/Families and Suppliers
Leadership Rounding	Continuous	Employees, Physicians and Patients
Medical Staff Meetings	Monthly/Quarterly	Physicians
Employee Councils	Monthly	Employees
Performance Improvement Teams	Generally monthly	Employees, Physicians and Leadership
Department Meetings	Monthly	Employees
SSMHC Clinical Collaboratives	Quarterly/Monthly	Employees, Physicians and Leadership
Nursing Summit	Annually	Nurses
DPHC Blitz Days	Annually	Employees
DPHC and SSMHC Sharing Conferences	Annually	Employees, Physicians and Leadership
Meetings in a Box Toolkits	As Needed	Employees, Physicians and Leadership
Patient Satisfaction Surveys	Continuous	Patients and Families
Staff Satisfaction Survey	Annually	Employees and Leadership
Physician Satisfaction Survey	Annually	Physicians
360 Degree Performance Evaluations	Annually	Senior Leaders and Employees
Employee Performance Evaluations	Annually	Leadership and Employees
Supply Chain User Meetings	Monthly	Suppliers, Leadership and Employees
Material Management Meetings	Annually	Suppliers, Leadership and Employees
Daily OPS Review	Daily	Senior Leaders and Leadership
Mission Awareness Team	Monthly	Employees, Physicians and Leadership
Mission Retreat Days	Annually	Employees and Physicians
Ethics Committee	Quarterly	Employees, Physicians and Leadership
Thank You Notes from Leadership	Continuous	Employees and Physicians
Site Visits by SSMHC President and Senior Leadership	Annually	AC, Leadership, Physicians and Employees
PC Screensavers	Continuous	Employees and Physicians
Bulletin Boards	Continuous	Employees, Physicians, Patients, Families, Suppliers
"Illuminator"- Shared Accountability Newsletter	Quarterly	Employees

Figure 1.1-5 Communication and Knowledge Sharing Methods

1.2a Organizational Governance

1.2a(1) Key Factors in Governance System

Senior leaders have established daily, weekly, monthly and quarterly reports to assess organizational performance. Senior leaders are held accountable to the BOD, SSMHC and SSMSL for operational and financial performance. Written reports, action plans, meetings and conference calls are used for reporting. DPHC addresses fiscal accountability through a daily productivity monitoring system called Daily Ops Review. Daily OPS is a process which measures productivity of departments on a daily basis with managers reporting departmental worked hours per unit of service (WHPUOS) to the COO. If budgeted and actual WHPUOS for any given day are not aligned, corrective action is taken immediately to adjust staffing levels and align the department by the end of the week.

A monthly budget variance review process is utilized by each director to report the department's performance as it relates to the budget. Results are also reviewed monthly at the EFC. Utilizing this process allows the organization to understand performance as it relates to the budget and to make necessary positive or negative adjustments to proactively anticipate performance trends. DPHC and SSMSL conduct Quarterly Operation Review (QOR) meetings using the SSMHC PIR to review operational performance. If an unfavorable variance occurs beyond an established performance threshold in DPHC PIR indicators, responsible parties are required to develop and submit an action plan to SSMHC or DPHC ECs with final review by DPHC AC using a standard format. Corrective action plans may include: a root cause analysis, detailed implementation plans, descriptions of support needed, timelines and responsibilities.

Transparency of the organization is demonstrated by the public reporting of JCAHO results, Missouri State Clinical Outcomes and utilization of a hospital informational web site. A stewardship checklist is signed by the president and Chief Financial Officer (CFO) quarterly to attest to the accuracy and disclosure of financial statements. Annual external audits are conducted to provide transparency and ensure performance within necessary checks and balances, based on accepted accounting practices. DPHC addresses independence in internal and external audits through SSMSL oversight of financial processes, DRG review process and contracts with external auditors. External auditors, KPMG and CHAN, are responsible for reporting findings to SSMHC and SSMSL, as well as DPHC, on a scheduled basis.

Protection of stakeholder interest is addressed through discussions at AC, MEC, CAB, medical staff meetings, and community groups where senior leaders hold membership or leadership roles. Senior leaders use three forms of analysis to understand how DPHC is protecting SSMHC interests. Measurement of the success of short- and longer-term objectives is reviewed on a monthly basis through the Monthly Utilization Report (MUR), which indicates market volume changes. The second form is through reviews of market information using state market share data and physician commitment reports. These two data systems give a detailed perspective to shifts in market volume by hospital, service line and physician. The third form is through the annual community market research analysis to allow senior leaders to evaluate community perception of services. Factoring these three analyses together, senior leaders create a detailed understanding of market performance compared to goals outlined in the SFHRP, which are built from SSMHC and DPHC Exceptional Goals. DPHC also participates in the SSMHC annual Bond Rating Assessment with onsite reviewers.

1.2a(2) Senior Leader Performance Evaluation
Annually, all AC members participate in a 360-degree evaluation, which provides input regarding their behavior and management skills on a designated scale. This evaluation includes assessment of the SSMHC's Leadership Behaviors and Expectations (Figure 1.1-2). The results drive the annual leaders' personal development plan to further identify opportunities to develop leadership skills. Each senior leader may also customize the survey with one or more questions designed to measure a particular area of development. Performance of senior leaders is also evaluated through a review of results related to senior leaders' individual Passport. The governing BOD performs an annual assessment which is shared with the Board and the organization to support improvement.

1.2b Legal and Ethical Behaviors
1.2b(1) Adverse Impact on Society
DPHC addresses the impact of health care services and operations on society by assessing community needs through the use of data and the Community Advisory Board. In addition, stakeholders' suggestions, regulatory compliance reviews and inspections are also used to assess how services and operations impact communities served. Environmental and employee focused issues are reported and addressed by the ERC, Safety Council, and the SSM Exceptional Safety Collaborative Team. Figure 1.2-1 outlines the key requirements, processes, measures and goals for legal and ethical behavior.

DPHC addresses regulatory, legal and accreditation requirements through participation in Joint Commission on Accreditation of Healthcare Organizations (JCAHO); CRP to ensure ethical business practices; Health Insurance Portability and Accountability Act (HIPAA) process; contract review process; and Risk Management. AC, MEC, ERC and leadership team identifies new or modified regulations from OSHA, CMS, EEOC, EPA, CDC, HIPAA, State, JCAHO, etc. and shares this information with leadership and employees when appropriate. Risk Management identifies and evaluates risk events and variances for trends that could adversely affect patients, visitors and employees and develops and implements action plans as defined in the annual Performance Improvement and Patient Safety Plan (PIPS). Trended data is evaluated and reported to the ERC and AC.

CRP identifies and investigates events that ethically or legally impact the organization. The CRP coordinator deploys information throughout the organization and staff designated job categories complete annual training requirements. Key risk reduction strategies include: benchmarking within SSMHC, pathology specimen collection process, crash cart verification process and developing strategies and initiatives that promote a non-punitive culture to enhance identification and elimination of medical errors.

The SSMHC Policy Institute assists DPHC executives in keeping current with changing trends and proactively anticipates and addresses public concerns regarding health care. The Institute researches and analyzes health and social welfare issues, proposals and project possibilities at the national and state level and educates employees and physicians on current public policy. AC members also receive Health Care Advisory Board publications and,

when appropriate, attend conferences and seminars related to changing health care trends and opportunities. As part of the annual SFHRP, an external environment and market assessment is conducted including an analysis of public policy and regulatory issues, which is used to develop action plans. DPHC uses both primary and secondary market research to anticipate public concerns regarding current and future services and operations within the community. The Catholic Healthcare AuditNetwork (CHAN) performs focused audits to proactively assess compliance in priority areas identified by the CRP and health center leaders. The key functions of addressing risks associated with the management of health-care services are outlined in Figure 1.2-1. Key clinical results are reviewed and tracked through the ECOC and the ERC.

Requirement	Key Process	Measures	Goals	Figures
Regulatory and Legal	▪ CRP ▪ Regulatory Review/Inspections	▪ CHAN Recommendations ▪ Citations for Cause by Regulators	▪ No Recommendations ▪ No Citations	Figure 7.6-3 Figure 7.6-5
Accreditation	▪ JCAHO Survey	▪ JCAHO Accreditation Scores	Full accreditation and Score >91% with No Recommendations	Figure 7.6-4
Risk Management	▪ Employee Safety	▪ Back Injury Cases ▪ Lost Time Injuries	▪ Zero ▪ Zero	Figure 7.4-2 Figure 7.4-2
	▪ Patient Safety	▪ Medication Errors with Harm ▪ Falls with Injury	▪ Zero ▪ Zero	Figure 7.1-9 Figure 7.1-8
Community Health	▪ Charity Care ▪ CBISA	▪ Total Charity Care ▪ Dollar Contribution	▪ Increasing Contribution ▪ Increasing Contribution	Figure 7.6-6 Figure 7.6-6

Figure 1.2-1 Requirements, Processes, Measures, and Goals for Legal/Ethical Behavior and Health Care Services

1.2b(2) Promote and Ensure Ethical Behavior

DPHC values, faith-based heritage and CRP create an ethical environment. All employees are required to participate in standardized education that addresses ethics, risk and CRP at new employee orientation and then annually. DPHC's ethics program and CRP span the entire organization and include a mechanism to address societal requirements associated with regulatory, legal and ethical compliance in providing health care services. The Ethics Committee provides support and leadership for all employees, physicians, volunteers and key vendors and is a diverse resource for assisting in challenging situations. The Ethical and Religious Directives are the basis for ethical decision-making. Ethical practices are also communicated in orientation to new employees and are reviewed annually during blitz days for all employees.

Specific policies reinforce ethical behavior throughout the health center. When an issues surfaces, the employee grievance process is a formal channel for the reporting of unethical behavior. Part of the CRP, the grievance process, encourages expression and resolution of employee problems, questions or complaints without fear of retribution. Ethical behavior is monitored through the CHAN audits, HIPAA process, CRP process and OFI system (Figure 1.2-1). DPHC's contract review process in coordination with SSMHC's process and the CHAN audits ensure that ethical, legal and regulatory practices are adhered to in stakeholder transactions and interactions. All contracts are reviewed by the contract review coordinator. SSMHC also contracts with a law firm that reviews high risk contracts and litigation.

1.2c Support of Key Communities

Consistent with the MVV, DPHC has identified improving the health of the community as an area of emphasis. The SFHRP is used to identify goals and initiatives related to community health. During the SFHRP process, an external market analysis determines market position and key growth areas for designated product lines utilizing the prioritization method in Section 2.1a(2). Designated service areas are used to identify key community organizations where DPHC will focus its support. Rotaries, Chambers of Commerce, key charities and health improvement entities are selected using the same process. As a major employer in the community, DPHC sponsors and/or participates in many community events including: heart walks, cancer walks, wellness screenings and health fairs and provides multiple support groups for various diseases. DPHC also supports community charities including: United Way, American Heart Association, Guardian Angel Settlement and St. Jane Catholic Family Services. An Employee Relief Fund helps to support employees in need and a DPHC Parish Nurse Program helps provides additional resources to the community. DPHC provides the only North County trauma center, obstetrics services, maternal fetal services, TomoTherapy program, and accredited bariatric program. Senior leaders and staff are also members and/or have assumed leadership roles in various community organizations including: Rotary Club, North County, Inc., Chambers of Commerce, and key charities.

2.1 Strategy Development

2.1a(1) Strategy Development Process

DPHC's strategic planning process was developed by SSMHC. SSMHC's Strategic, Financial & HR Planning Process (SFHRPP) combines direction setting, strategy development, human resources, and financial planning (Figure 2.1-1). The process has undergone several improvement cycles since being developed in the mid-90s. The latest improvement has taken the Plan from a three-year to a five-year plan. The SFHRP involves all of the SSMHC's networks and entities in a five-year (long-term) planning horizon, with annual updates (short-term). The SFHRPP ensures that the networks and entities set strategic goals clearly oriented toward benchmark performance.

Annual SFHRPs are designed using SSMHC's Quality Principles (Figure P.1-1) and methods, and stresses planning as a way of learning more about customers, responding to their needs and expectations, as well as, identifying new market opportunities. The SFHRP ensures that DPHC sets strategic goals clearly oriented toward achieving SSMHC's mission and vision.

The SFHRP begins in December when the Vision Statement, set by SSMHC's Board of Directors, is reviewed. The Vision and Mission statements serve as the foundation for the planning process. Each January, corporate planning, in conjunction with corporate finance and HR, evaluates the SFHRP by surveying the previous year's key participants. As part of the planning cycle Plan, Do, Study, Act (PDSA) in 2005, a task team of entity and regional planners recommended separate submissions of strategic (five-year) and operational (one-year) plans.

SSMHC has determined that five years provide optimal time to implement, fully deploy, and realize the results of its initiatives across the vast organization. Because of the rapidly changing health care industry, each year the SFHRPP participants study and validate the system's focus on patients, other stakeholders and markets (Category 3), information and analysis (Category 4), staff focus (Category 5), and process management (Category 6). Figure 2.1-1 depicts the steps in the process at the system, network, entity and departmental levels. At times during the planning cycle, these steps occur concurrently.

In February, the Innsbrook Group, consisting of SSMHC entity presidents, assesses key challenges, reviews comparative data, and sets the system-wide goals for the next five years, using the Vision and Mission Statements as a framework for the system. DPHC's planning process begins shortly thereafter, when the vision and mission, which serve as the foundation of the SFHRP, are reviewed by senior management and physician partners. Beginning in February and continuing through April, DPHC conducts Internal and External Assessments based on minimum data set requirements. This assessment is refreshed every five years and is updated and validated annually. Data and information from a variety of internal and external sources are integrated to form the minimum data set (Figure 2.1-2). DPHC's planning staff gathers information from various sources, such as patient, medical staff and employee surveys, competitive market intelligence, and performance indicator reports (PIRs). This information provides the assurance that a comprehensive analysis has been conducted of key elements influencing the business. The minimum data set, introduced in 1998, and refined over the years, is a robust tool that ensures DPHC maintains a balance in addressing stakeholder needs in a consistent manner.

In March, SSMHC distributes standardized templates to entity planners. DPHC receives a submission packet with standardized forms and definitions to ensure a consistent format and alignment of plans with SSMHC goals. SSMHC Corporate Planning also distributes Strategic Assumption Guidelines and Operational Guidelines to the entities and networks to ensure the consistent use of financial, economic and benchmark assumptions by network and entity staff preparing their strategic and operational plans.

At DPHC, during April and May, leaders analyze the minimum data set findings to determine the organization's strengths, weaknesses, opportunities, and challenges and to identify gaps between current and desired performance levels. The administrative staff and physician leaders then set measurable, five-year strategic goals to achieve the system goals related to exceptional health care services and other areas of strategic focus. Annually, a Governance Retreat is held for the parent and local board members to provide an additional opportunity for input into the five-year plan. In addition, DPHC hosts the Community Advisory Board (CAB) and SFHRP community updates semi-annually. Attendance includes community leaders, state legislators, city mayors, religious and business leaders. Medical staff is given updates semi-annually at general staff meetings. Strategy Review sessions are also conducted during this time to help DPHC discern priority areas of focus, and provides an opportunity to share assessment findings and preliminary strategies with corporate planning, finance and human resources staff to ensure alignment and to identify potential blind spots.

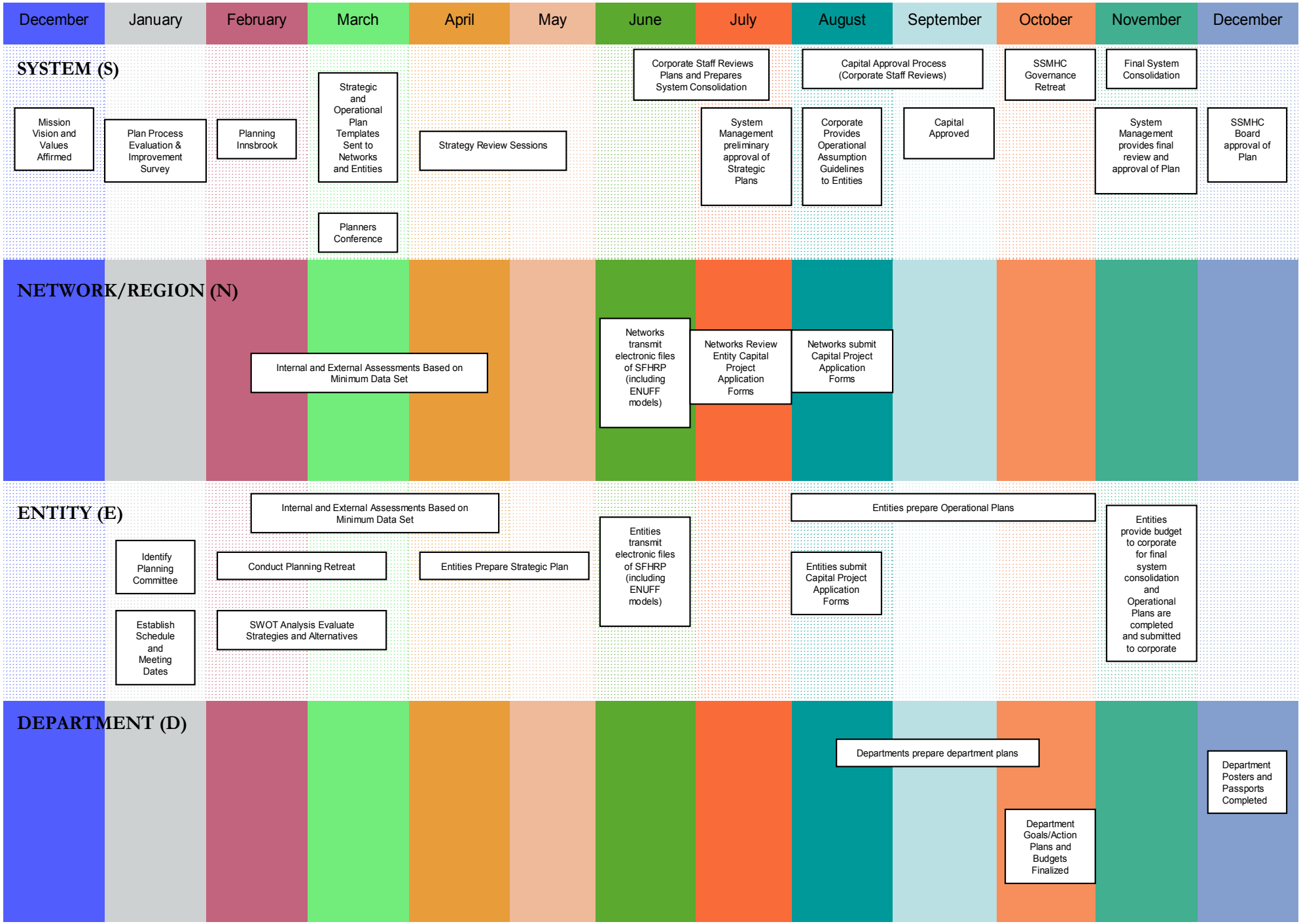
As an additional method to better address long-term strategic planning, DPHC is in the process of deploying Project 2014, an initiative to determine the long term positioning of the hospital and of SSMSL as a whole. This process was established to ensure long-term sustainability of the organization and to determine how resources should be invested across SSMSL.

2.1a(2) Key Factors Addressed in Planning

Information from minimum data set and other sources (Figure 2.1-2) is reviewed, organized and presented by the planning director at retreats during the planning cycle. The HR plan and a review of DPHC operational status [6.2b(2)] are factored into the planning process to address organizational sustainability and continuity in the event of an emergency. Members of the leadership team (LT), service line

SSMHC Strategic, Financial & Human Resource Plan Process (SFHRPP)

Fig. 2.1-1



directors, representatives from the CAB and medical staff review information at retreats. Information is presented utilizing a prioritization method to determine in which services and markets DPHC should invest resources. The input from these varied retreats is synthesized and ultimately, a group of senior leadership from AC, service line leaders and other key staff hold a series of retreats to define the overall campus strategy. To ensure the effectiveness of these retreats, the membership is surveyed for satisfaction and the results are used to refine future retreats.

Key services are organized into defined product lines and are assessed based on utilization, forecasts, profitability measures, unrealized market demand (e.g., loss of patients to competitors), and medical staff capabilities. Product lines are ranked based on their performance in each of these areas and participants determine which product lines the hospital should focus its resources for continued growth. A similar process is undertaken to determine which product lines DPHC should begin to develop.

DPHC is a member of SG-2, a firm that analyzes changes in the business and technology (blind spots) of health care. Membership in this organization helps identify emerging clinical technologies and major business trends that will have an impact on care delivery, utilization, outcomes and payments. Information gained from SG-2 and other sources helps DPHC determine which technologies to invest in to support the development of clinical services. Further, DPHC participates in a combined material management and engineering effort to develop a comprehensive technology plan for the SSMSL.

Through its strategic listening posts (Figure 2.1-3), DPHC gathers information about unforeseen changes (blind spots) in the market place, consumer preferences, employee concerns and issues, and unanticipated opportunities. This information is routinely shared at AC meetings to determine whether or not the unforeseen issue or opportunity will potentially contribute to or detract from the organization's ability to achieve its strategic plan. If the issue is deemed to be significant, the AC assigns it to the appropriate EC to charter a team, commission a study and/or develop a business plan to assess the impact. Once the study or business plan is completed, the AC will determine whether to allocate resources to the project.

2.1b Strategic Objectives
2.1b (1) Key Strategic Objectives
2.1b (2) Strategic Objectives Address Challenges
DPHC's key strategic challenges, objectives, indicators and goal projections are presented in Figure 2.2-3. SSMHC has established five characteristics of exceptional health care as the basis for its strategic and/or operational objectives. By defining exceptional health care services, SSMHC is able to tie planning more closely to the Mission Statement, which results in more balanced goals. Clinical outcomes and patient, employee and physician satisfaction are placed on equal footing with financial results. This leads to the development of key strategic objectives (Figure 2.2-2), which are aligned with vision, mission and values, while meeting the needs of key customers, stakeholders and partners (Figures P.1-3 and P.1-4) and addressing the key strategic organizational challenges (Section P.2b).

DPHC's ECs are charged with deploying and monitoring progress on goals using EC PIR measures (Figure 2.2-3) that

SFHRP Minimum Data Set	
External Data	**Internal Data**
Consumer Information Analysis Patient satisfaction survey results, Market Research, market share by product line	**Medical Staff Analysis** Medical staff survey results, supply by specialty compared to market needs, geographic distribution
Demographic/Socioeconomic Analysis Population trends by age, ethnic origin; Population-based use rates, Discharges by zip code	**Product Line Analysis** Profitability, volume and consumer perception of key product lines.
Competitor Analysis Inventory of competitors, market share trends, marketing, advertising, competitive position	**Physical Plant/Technology Analysis** Major plant infrastructure and equipment assessment, IC plan, regulatory requirements, disaster preparedness emergency plan/business continuity plan
Emerging Technologies/Trends/Growth Opportunities Analysis Literature review, IC plan, Networking with colleagues in SSMHC's and other markets, vendor analyses	**Human Resource Analysis** Employee satisfaction survey results, Market analysis of compensation and benefits, turnover and diversity rates, training needs
Payor Analysis Inventory of payors, payment rates, payor and satisfaction issues	**Financial Analysis** Net revenue, expense and operating margin, use of agency staff, payor mix trends, contact profitability
Public Policy/Legislative/Accreditation Analysis Federal and state legislative and reimbursement trends, JCAHO and other regulatory standards	**Clinical Quality Analysis** Quality Report, Clinical Collaborative results, departmental performance improvement plans, regulatory survey feedback, publicly reported data

Figure 2.1-2 Minimum Data Set: Examples of External and Internal Data Collected and Analyzed to Develop the SFHRPP (Examples provided due to space limitations.)

correlate between system and entity goals. Poster and passport programs (Figure 2.2-1) are used to deploy strategic goals and action plans to all employees and align hospital, department, and individual plans with overall organizational strategy. Through this process, the exceptional measures are placed on a "passport" all employees sign and carry with them, creating a line of sight reminder from hospital to employee.

When completed, the strategic objectives and accompanying action plans are presented to AC for review and approval. Every effort is made to assure that DPHC's strategies are financially sound and balance the needs of patients, partners, and other key customers and stakeholders. Attention to the needs of all customers and partners is essential so that DPHC can address the future drivers of health care and respond to a rapidly changing environment. All capital projects are then prioritized by AC based on the strategic and financial benefits to DPHC as a whole. A prioritization tool and process is utilized as appropriate by AC.

The finalized strategic and financial plan is submitted to corporate planning, financial and human resources staff for review and system management's approval in June. The SSMHC Board reviews the SSMHC overall financial plan, and the network and entity strategies for alignment, and then grants approval. The board reviews each entity SFHRP in December, and the SSMHC president/CEO communicates board approval with a letter.

2.2 Strategic Deployment

2.2a (1) Action Plan Development and Deployment

Following the setting of strategic goals and objectives, DPHC's team defines strategies and actions, with key measures, to support its five-year goals. Electronic copies of the SFHRP are submitted to SSMHC in June, where they are reviewed for consistency with system goals and are assessed using a SMART (specific, measurable, aligned, realistic, time-specific) methodology. DPHC finalizes its plans by allocating financial, human and capital resources to support achievement of goals and objectives.

The Capital Allocation Process (July-Sept.) represents a systematic approach to capital allocation. Two pools of capital are evaluated through this process: maintenance capital (items under $500K) and strategic capital (items in excess of $500K). The Operations Council determines the maximum amount of available resources that may be spent on capital expenditures below $500K (maintenance). Networks and freestanding entities allocate their maintenance capital to their entities for use as the entity deems appropriate through a top down and bottom up approach.

Strategic capital is accessed through completion of a Capital Project Application Form (CPAF). The CPAFs are completed by campus planning, finance and HR staff and define the rationale and value proposition of the projects using a common template in all SSM hospitals. SSMHC staff analyze capital submissions to ensure that projects are strategically and financially sound and a system-level Capital Allocation Council prioritizes and approves projects. Approved projects are communicated by approval letter to the networks and freestanding entities, who adjust their baseline projections as needed.

Sources of Strategic Input	
Group	**Listening Post**
Employees	Employee Council
	Administrative department meetings
	Town hall meetings
Managers	LT meetings
	Regular updates with AC member
	Exceptional Councils
Community	Community Advisory Board feedback
	Community health fairs
	Market research and perception studies
	Community relations coordinator
Medical Staff	Medical staff department meetings
	Service line and PI team meetings
	Physician Focus Groups with President

Figure 2.1-3 Sources of Strategic Input

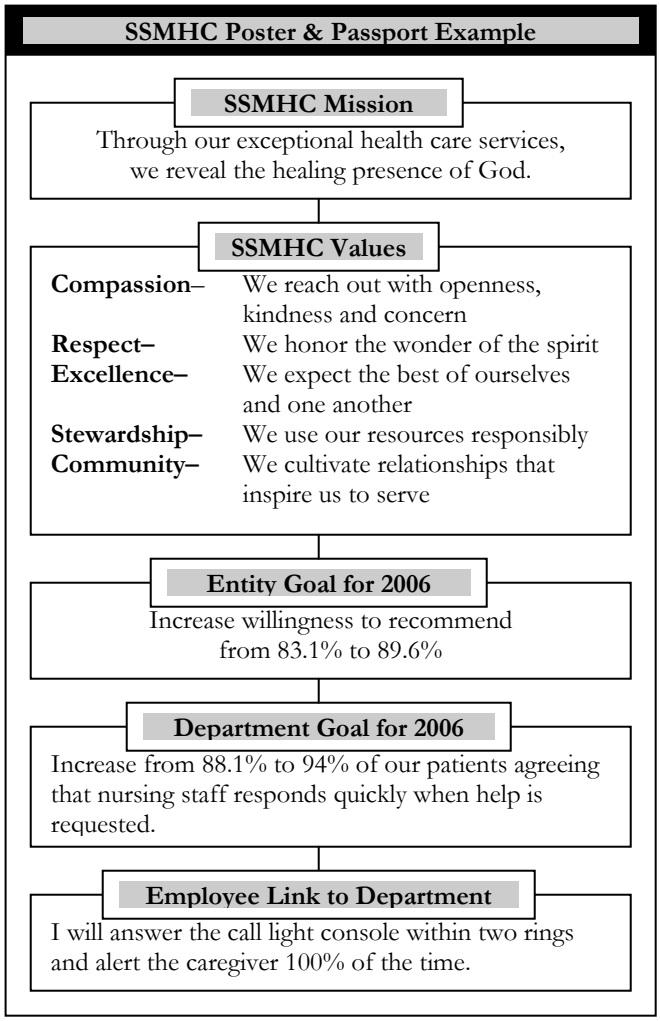


Figure 2.2-1 DPHC Poster and Passport Example

In October, each department is required to develop preliminary goals and action plans, including budgets, to support the entity's overall goals and objectives. AC and the ECs recommend and approve department goals, measures and benchmarks. The ECs also recommend and approve goals, measures and benchmarks for the PI teams. These budgets are aggregated and evaluated relative to the entity's total available resources. With this information, leaders develop operational plans with input from appropriate department staff, including physicians. Operational plans support first year actions from the strategic plan, goals related to the provision of exceptional clinical outcomes, patient, employee and physician satisfaction and financial results; and other system-wide, network and entity derived strategies. The operational plans incorporate identified champions, completion dates, expected results, and financial projections, human resource needs and capital requirements. They are approved by DPHC's AC and tracked. Concurrently, August through October, DPHC's leadership directs the development of operational and departmental plans by aligning key entity, network and system developed goals with appropriate departments for implementation. Specific departmental goals are also developed based upon legal and regulatory requirements. In November, copies of DPHC's operational and department plans are submitted to SSMHC electronically to facilitate review and sharing across the system.

The departments monitor their action plans using in-process measures, enabling early identification of performance gaps. Root cause analyses and improvement plans are used to close gaps.

DPHC finalizes and submits their strategic plan to the network planning, finance and HR staff for review in June and operational plans in November. The SSMHC Board of Directors reviews the system's overall financial plan and key network and entity strategies for approval in December. SSMHC's president/CEO communicates the Board's approval to entity and network presidents via letter. DPHC's president initiates ongoing communication about his or her entity-specific strategic and financial goals to department managers and medical staff leaders. To reach all levels of the organization, a variety of communication vehicles are used, including memos, newsletters, department meeting agenda items and presentations.

2.2.a(2) Establish & Deploy Modified Action Plans.
Action plans have short- and long-term goals associated with them (Figure 2.2-2). Progress on these plans is monitored through key indicators on the PIRs by AC, ECs and PI teams. The SFHRPP allows for rapid modification to the strategic plan as needed. Corrective action plans are developed when a material unfavorable variance between actual and plan performance occurs. The variances are predefined in accordance with SSMHC system-wide policy. Corrective action plans may include a root cause analysis, detailed implementation plans, description of the support needed, timeliness and responsibilities. This type of early evaluation is helpful in preventing further erosion in performance. In addition, to facilitate rapid execution of new plans, each strategic goal requires consideration of market positioning/differentiation, strategic challenges/risks and contingency planning before implementation.

Unanticipated changes in the market and unforeseen opportunities sometimes present themselves and require redeployment of resources. The AC and ECs continuously monitor information from various sources including listening posts and EC dashboards. Section 2.1a(2) discusses the process for addressing blind spots, unforeseen issues or opportunities.

2.2a(3) Key Short- and Long-Term Action Plans
See Figure 2.2-2 for indicators that track progress in achieving action plans**.** In process indicators are identified for each major objective in the plan documents and are tracked by identified champions. Evaluation of goals and action plans set through the SFHRP ensures alignment.

The high-level growth plans are developed with input from finance, HR and other key individuals integral to each strategy. In June, the "action plan" phase of the planning process begins, and the AC considers allocation of resources using the following needs: financial, human resource, patient populations, customer, accessibility issues, new services and programs and major capital investments required to support identified strategies. If the capital cost of a project exceeds $500,000, the planning director, with assistance from the

strategy and business development staff, performs a strategic and financial analysis, and prepares an operational business plan for approval.

2.2.a (4) Key Human Resource Plans
Human resource planning is integrated into the system's SFHRPP. DPHC and network human resources and nurse executives provide data for the planning process as part of the Minimum Data Set and actively participate in strategic planning sessions. At DPHC and network levels, HR needs and financial impact are tied to each action plan during the SFHRPP as part of both the strategic and operational plan templates to ensure adequate resources are allocated to support strategies. Specific long- and short-term goals for each strategy are developed, with assigned timeframes and responsibilities (Figure 2.2-2).

2.2a(5) Key Performance Measures
Key performance measures are selected by the ECs and integrated into action plans (Figure 2.2-2). Each SFHRP strategy is assigned to an EC for action planning and measurement. Organizational alignment is ensured during EC performance reviews and all key deployment areas are reported at regular AC meetings.

2.2.b Performance Projection
Figure 2.2-3 reflects performance projections of DPHC's key indicators and comparisons with other organizations. Gaps are addressed as part of the corrective action process described in 2.2a(2). The minimum data set is used to stimulate consideration of changes in health care services, programs and other market issues as a component of the internal and external assessments. As an example, we modified our key clinical outcome indicator from 31-day unplanned readmit to the CMS core measure indicators as a result of impending changes and greater transparency in publicly reported data.

On a monthly basis, the AC reviews a Monthly Utilization Report (MUR) that compares DPHC's performance to competitor's growth of services. On a bi-annual basis, competitor information is reviewed by service line, physician and DRG levels using HIDI data.

Strategic Challenge	Strategic Objective	Short-Term Action Plans	Long-term Action Plans	Measures
Sustained Patient Satisfaction with Growing Expectations	Exceptional IP, OP, ED Patient Satisfaction	AEPC: service standards, conversations, rounding, recognition ED expansion	AEPC: patient experiences, ideas management, employee selection, service recovery New OP access sites	Patient Satisfaction Score
Sustained Physician Satisfaction with Growing Expectations and Shortages	Exceptional Physician Satisfaction	-Collaborative Business (AS Center, MRI, cath. lab, POB) -Rewards and Recognition Program -Removing barriers	-Collaborative Business -Rewards and Recognition Program -Physician Recruitment Physician Services Plan PACS, EHR	Physician Satisfaction Score
Sustained Employee Satisfaction to Address Work Force Shortages	Recruitment and Retention Strategies, Sign-on Bonuses, Shared Accountability	Recruitment and Retention Strategies, Sign-on Bonuses Shared Accountability AEPC	AEPC Recruitment and Retention Strategies, Sign-on Bonuses Shared Accountability	Employee Satisfaction RN Retention Rates Staff Turnover
Growing Customer, Regulatory and Payor Expectations of Higher Quality Care	AMI CHF Pneumonia Surgical Infection Prevention (SIP) Mortality	AMI: ASA, beta blockers, smoking education CHF: ACEI/ARB meds, LV assessment Pneumonia: pneumovax, blood cultures and antibiotics within 4 hours SIP: prophylactic antibiotics for CABG, hip/knee surgery Medical Emergency Team (MET) SIP Program	AMI: PCI, RN coordinator CHF: discharge instructions, RN coordinator Pneumonia: antibiotic selection, RN coordinator SIP: prophylactic antibiotics for colon, hysterectomy, vascular surgery; RN coordinator IHI 100,000 Lives Collaborative SCIP Program Stroke Program	Core Measure Indicators for CHF, AMI, pneumonia, surgical infection prevention (SIP) Overall IP Mortality Rate
Increased Financial Pressures Including Capital Requirements and Declining Reimbursement	Admissions growth, Physician Recruitment	Increase Bed Capacity, Revenue Cycle enhancements New office building, new ambulatory surgery facility	Physician Recruitment New 2 level patient tower, Primary care growth	Operating Margin %

Figure 2.2-2 Strategic Challenges, Objectives and Action Plans

Strategic Challenges	Strategic Objectives	Key Measures	2005 Actual	2006 Goals	2007 Goals	2008 Goals	2009 Goals	2010 Goals	2011 Goals	Benchmarks
Sustained Patient Satisfaction with Growing Expectations	Exceptional IP, OP Surgery (OPS), ED Patient Satisfaction	Patient Satisfaction Scores (Mean Scores)	IP: 84.3 OPS: 92.3 ED: 71.2	87.7 95.2 84.8	97.5 99.0 98.2	97.5 99.0 98.2	97.5 99.0 98.2	97.5 99.0 98.2	97.5 99.0 98.2	Press Ganey /SSMHC Top Decile: IP: 97.5 OPS: 98.2 ED: 98.3
Sustained Physician Satisfaction with Growing Expectations and Shortages	Exceptional Physician Satisfaction (Physician Satisfaction Score)	Physician Satisfaction Scores	3.2	3.22	3.23	3.26	3.3	3.5	3.7	DMR Top Decile=3.73 SSMHC Best Practice = 3.48
Sustained Employee Satisfaction to Address Work Force Shortages	Exceptional Employee Satisfaction (Employee Satisfaction Scores)	Employee Satisfaction	TBD	67.1	68.9	70.7	72.5	77.0	81.5	Press Ganey (beginning 2006) Top Decile = TBD SSMHC Best Practice = TBD
Growing Customer, Regulatory and Payor Expectations of Higher Quality Care	Exceptional Clinical Outcomes for Core Measures	AMI (ASA, beta blockers, smoking cessation) CHF (LV Assessments) Pneumonia (Blood Cultures) Surgical Infection Prevention (SIP)	92.4 81.5 86.8 94.2	93.7 83.3 87.7 TBD	96.4 89.3 88.6 TBD	96.7 90.4 89.2 TBD	97.0 91.5 89.9 TBD	97.4 92.7 90.5 TBD	97.7 93.8 91.1 TBD	CMS, Premiere, JCAHO Top Decile State of Missouri Mean SSMHC Best practice
Increased Financial Pressures Including Capital Requirements and Declining Reimbursement	Exceptional Financial Performance (Operating Margin Percentage)	Admissions growth(Incremental compound annual growth rate), Margin %	Admit growth = 10.8% Margin = 7%	1.8% 3.8%	6.8% 3.9%	3.6% 4.9%	1.9% 4.8%	1.9% 4.7%	1.9% 4.6%	AA Bond Rating Margin = 2.5% SSMSL Margin Mean = 2.7%

Figure 2.2-3 Strategic Objectives, Measures and Performance Projections

3.1(a) Patient, Other Customer and Health Care Market Knowledge

3.1a(1) Identify Customers and Markets

DPHC has defined patients and their families as its key customer group with further delineation into categories based upon site of care: inpatient (IP), outpatient (OP) and emergency department (ED). Customer groups and their associated requirements, expectations and preferences (Figure 3.1-1) are determined through surveys, feedback, OFIs, leadership patient rounding, focus groups and other listening and learning strategies (Figure 1.1-5). The SFHRP uses environmental scanning to identify potential customers, customers of competitors and future markets. The minimum data set (Figure 2.1-2) for this scan includes market research; market share by product line; population trends by age, gender and ethnic origin; population-based use rates; discharges by zip code; an inventory of competitors; market share trends; and marketing, advertising and competitive position.

To learn specifically about customers of competitors, the Planning and Marketing Departments perform a regular market patient perception survey and monitor data from HIDI database, medical staff surveys and physician contacts. Collaboration with nursing homes, participation in civic and community events by staff and leaders, focus groups and a hotline for patients and visitors provide additional opportunities to learn of potential competitor customers. To discover information about competitor's customers, DPHC also uses results from telephone surveys and intelligence gathered by physician representatives. The data is shared with AC and included in the SFHRP.

DPHC determines market segments primarily by patient type (IP, OP, ED) and product line. Gender, age, DRG, primary payor and physician segments are also analyzed. During the SFHRP market segments for growth and improvement are prioritized. The SFHRP includes an internal, as well as an environment and market assessment. (Section 2.1a[1-2] and Figure 2.1-1).

The determination of customers and market segments is facilitated by use of a prioritization method described in Section 2.1a(2). The matrix enables DPHC to look at performance and potential opportunities through the lens of mission and organizational capabilities. For example, the analysis of the minimum data set data revealed an increase in demand for adult inpatient beds. DPHC took advantage of this opportunity to discontinue partnership with a Long Term Acute Care Hospital, which had been leasing one of DPHC's patient care units, and use the beds to accommodate its increase in adult telemetry admissions in 2005.

3.1a(2) Listen and Learning

Multiple listening and learning tools are used to differentiate the requirements, expectations and preferences of customers (Figure 3.1-2). The primary tool utilized is patient satisfaction surveys. In April 2005, the survey vendor was changed to Press Ganey to allow more timely reporting of results, ease of reports, ability to identify benchmark performance and provide peer group comparisons. These satisfaction surveys provide timely correlation analyses of indicators most important to patients and a Priority Indices. These indices compare the importance of each key customer requirement and how well we are performing on them. These surveys are sent to every discharged inpatient, 60% of discharged ED patients and 14.3% of patients receiving OP services. The surveys are mailed at least weekly on a continuous basis. Survey results are reviewed at least weekly by leaders to identify opportunities for improvement. Quarterly reports compare how the hospital ranks on each indicator relative to peer groupings nationally, by bed size, AHA region or SSMHC entity. The Press Ganey database contains more than 800 hospitals. Data from the surveys is aggregated to determine factors most closely correlated with DPHC patient satisfaction. These results can be segmented by patient types (IP, OP and ED), as well as by unit or department as appropriate. These results are continuously available and reviewed weekly via the Press Ganey website. Results are also segmented by race, gender, DRG, primary payor and physician. This segmentation of results allows for improved focus on the specific needs of different patients. DPHC also evaluates trended information from rounds, complaint management system, post discharge callbacks, staff and physician surveys and focus groups to identify which service characteristics are important to patients.

Segment	Key Customer Requirements	Figure
IP	▪ Responsiveness/Wait Times ▪ Pain Management ▪ Education	7.2-2 7.2-2 7.5-8
OP	• Kept Informed of Delays • Patient Education • Attractiveness of Center	7.2-3 7.2-3 7.2-3
ED	▪ Wait Times ▪ Kept Informed ▪ Pain Management	7.2-4 7.2-4 7.2-4

Figure 3.1-1 Key Customer Requirements/Expectations

Patient satisfaction information is utilized in determining strategic initiatives and the SFHRP as well as setting performance improvement efforts at an organizational and department or level. Regular review of these results allows the organization to remain patient focused and to better satisfy customer needs. For example, in 2005 DPHC began partnership with Boeing Aerospace to leverage patient throughput and workflow improvement efforts using Lean methodology in the ED.

Customer Groups	Listening/Learning tools and frequency	Primary Owners
Former and current patients and families	• Satisfaction surveys: IP, OP Surgery, ED, OP Services (Continuous) • Physician rounds (Continuous) • Physician focus groups (Continuous) • Home Care feedback (Continuous) • Call backs (Continuous) • Complaint system and informal feedback (Continuous) • Ethics Committee (Continuous) • Administrative and Director/Manager patient rounds (Continuous) • Web Page Response System	• Department Leaders • Physician Services., VPMA • AC, VPMA • Medical Management • Department Leaders • Guest Relations • ESC, AC • ESC, AC • ESC
Potential patients and future markets	• Survey research (annual as needed) • Published studies (annual as needed) • Community Advisory Board (Quarterly) • Internet (Ad Hoc as needed) • Web pages response (Continuous) • Professional journals/associations, courses, newsletters (Continuous) • Feedback from EMS and Workers Comp. Program • Community Development Manager	• SSM Planning • SSM Planning • AC • Planning • AC/Leadership • ESC • AC

Figure 3.1-2 Customer Listening and Learning Tools

To become increasingly customer focused, DPHC:

- Implemented AEPC in 2005
- Requires each department to identify key internal and external customers and expectations at least on an annual basis within its written Scope of Service.
- Places customer expectations on department posters and individual passports as measurable goals and measures them at least monthly.
- Uses key customer requirements systematically in performance expectations, new hire orientation, employee passports and performance expectations
- Recognizes high performance in patient satisfaction at department and Town Hall meetings and sharing conferences.

With AEPC DPHC values are expressed to patients through staff actions. Hardwired components of AEPC include: exceptional service standards, conversations, rounding, rewards/recognition, patient experiences, ideas management, selecting exceptional employees and service recovery. The education for this program began in 2005 with the first four elements implemented January 2006 and the later four elements to be implemented in mid-2006.

3.1a(3) Listening and Learning Kept Current

To keep listening and learning methods current with changing health care needs, marketplace and directions the SSMHC and DPHC Planning Departments, AC and ESC evaluate patient satisfaction surveys and other listening and learning tools using CQI on an annual basis. This evaluation includes:

- Validation of survey questions for relevancy and validity (SSMHC Planning)
- Monitoring regulatory guidelines
- Gathering input from leadership and staff
- Assessing the effectiveness of customer needs determination process by matching current to benchmark performance
- Determining the need to add customized questions to the Press Ganey Survey annually

Customer service research is reviewed using intelligence from experts in the field such as Disney, Press Ganey, The Studer Group and NRC Picker. Use of CQI/PDSA has guided DPHC to aggregate data about customer service from its many sources. This allows systematic integration of feedback from multiple direct and indirect sources, such as patients, physicians and clinical director rounds. In 2005, DPHC added a prior patient from North County community to the ESC to ensure that its listening-and-learning strategies and interventions make sense to our key customer.

3.2a Patient/Other Customer Relationship Building

3.2a(1) Build Relationships

Through the SFHRP, strategies are developed and implemented to build relationships and grow referrals in order to achieve organizational success. Through the ESC, EFC and AC, satisfaction and service line volumes are tracked on a regular basis to assess these strategies. The SFHRP has identified that physician referrals and the ED are the primary sources of patient customers.

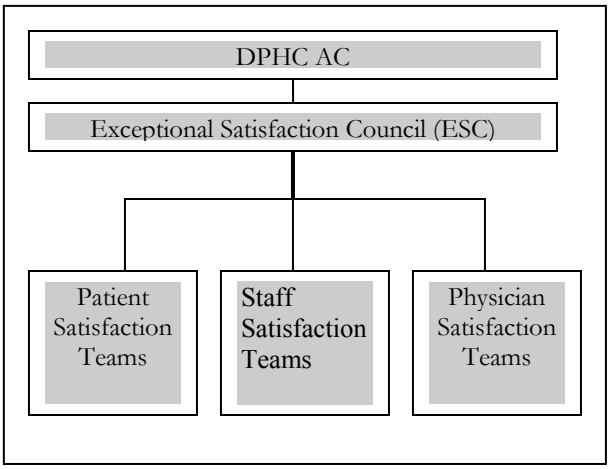


Figure 3.2-1 ESC Structure

Physicians are considered key partners of DPHC having a critical role in patient referrals and achievement of exceptional clinical outcomes. The ESC, Physician Satisfaction Team, Physician Services and VPMA have responsibility for physician satisfaction processes. Physician satisfaction is primarily determined and measured annually through the DMR Satisfaction survey tool. Physicians' key requirements are listed in P.1-4. Physician Services representatives are used specifically for the purpose of obtaining physician feedback and building relationships. Members of AC, as well as key service line directors, visit selected physician offices on a regular basis. Technology is used to more tightly align physicians with the organization, as the physician portal offers easy access to patient lists and key patient information [Section 4.2a(1)].

AEPC is the primary strategy to build relationships with current patients. Hardwired components of AEPC include: exceptional service standards, conversations, rounding,

rewards/recognition, patient experiences, ideas management, selecting exceptional employees and service recovery. The education for this program began in 2005 with the first four elements implemented January 2006 and the later four elements are to be implemented later in 2006.

3.2a(2) Key Access Mechanisms

DPHC provides a number of key access mechanisms to enable patients and customers to seek information, obtain services and make complaints (Figure 3.2-2). These customer contact requirements can differ from one patient group to another, however, their relative importance for a specific patient group is determined at the point of customer contact. For example, ED patients identified wait time from arrival to initiation of care was a dissatisfier. Based upon that input, the ED has developed and implemented a collaborative project with Boeing Aerospace to apply Lean Methodology to improve patient flow and reduce wait times.

The organization's ability to manage and meet customer requirements is deployed through the annual SFHRP, Passport Process and AEPC with accountability of results through the ESC and AC (Figure 3-2-1). Deployment of customer service requirements to staff at all levels is achieved through the Passport Process, ongoing mandatory AEPC and other customer service training for all employees and the annual performance evaluation process which evaluates staff annually related to customer requirements. Patient requirements are determined using listening-and-learning strategies (Figure 3.1-1). Individual needs are identified during admission and predetermined assessment intervals by nursing and other staff providing care or service. Needs are integrated into individualized plans of care and communicated to appropriate staff.

3.2a(3) Complaint Management Process

DPHC has a systematic, integrated complaint management process called the Opportunity for Improvement (OFI) Process (Figure 3.2-3). There are two categories of OFIs: a complaint, which is a concern voiced while the patient is receiving care; and a grievance, which is written or verbal feedback received after the patient is discharged. In accordance with policy, complaints are resolved within 48 hours and grievances are resolved within seven days, with a written response to the complainant within 30 days. This process includes an established mechanism to initiate service recovery. Employees are empowered to utilize customer service recovery mechanisms at the point of customer contact and at the time of the complaint.

A computerized system is utilized for tracking the complaint, other customer feedback and then aggregating the data for review. OFI data is systematically aggregated and analyzed by the ESC and shared with departments and AC to determine appropriate improvements. Data is analyzed to determine if systematic problems exist or if

Key Patient Access Mechanisms
To seek assistance and information
▪ DPHC caregivers and staff ▪ Internet web site ▪ Health pamphlets in health center ▪ Robert Porter Health Information Library ▪ DPHC physicians ▪ Health Quest cable shows ▪ Senior leader, director and manager rounds ▪ Guest Services ▪ Educational programs and support groups ▪ Adm. and clinical director on call 24 hr./day
To obtain services
▪ Internet web site ▪ Centralized scheduling /24 hr. online scheduling ▪ Room service phone orders ▪ Physicians ▪ Well Informed newsletter ▪ Healthy community projects ▪ Participation in health plans ▪ Policy of access regardless of ability to pay ▪ Ethics consultation ▪ Pastoral (spiritual) care
To make complaints
▪ DPHC complaint process (OFI Process) ▪ Surveys and comment cards ▪ Contact with hospital staff and physicians ▪ Leadership rounds ▪ Unit Leadership phone access 24/7 ▪ DHSS, JCAHO, BBB hot lines ▪ Web-based response system

Figure 3.2-2 Key Patient Access Mechanisms

adverse trends are developing. The information generated from this process is reported to the ESC, ERC and AC quarterly. The annual OFI report defines improvements by specific department or issues that have resulted from the OFI process.

3.2a(4) Relationship Building Kept Current
DPHC addresses patient relationships and access requirements associated with changing health care service needs and directions through the SFHRP, ongoing patient satisfaction survey information ongoing review and feedback of key indicators in the Exceptional Councils. The ESC addresses patient satisfaction results and processes on a monthly basis, which helps to identify new issues or trends. Internet research, literature searches, roundtable or focus group discussions with key stakeholders, participation in SSMHC Sharing Conference of internal best practices, participation in IHI, SG2 and SSMHC Clinical Collaboratives all help to keep DPHC leadership informed of health care's ever-changing environment. Pertinent up-dated internal and external information is passed to the ESC through the AC and EC structure. This information allows the ESC to modify approaches as necessary.

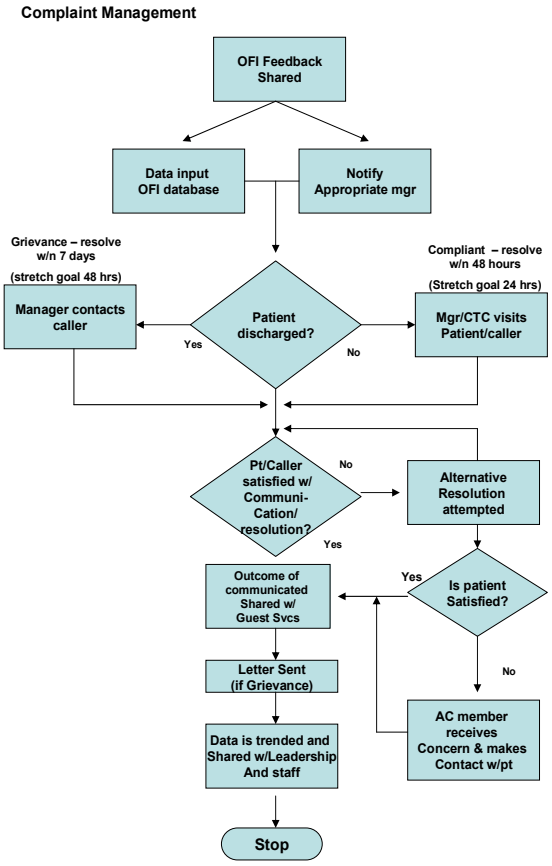


Figure 3.2-3 OFI Complaint Management Process

An example is the new Quick Triage process in the ED which was developed in response to patient requirements.

3.2b Patient/Customer Satisfaction Determination
3.2b(1) Patient/Customer Satisfaction Determination
DPHC obtains patient satisfaction and dissatisfaction data using the listening-and-learning tools identified in Figure 3.1-2. The principal method to determine patient satisfaction is a standardized written satisfaction survey tool that is currently coordinated by Press Ganey. Surveys are customized for DPHC's key patient groups (IP, OP and ED). Shorter versions are used for outpatient surgery, outpatients in the lab, radiology and radiation oncology. All inpatients receive the survey, and results are segmented by patient care unit, support services and physician. As surveys are received by the vendor, they are scanned and data updated in Press Ganey's web-based eCompass tool, which is available 24/7 for all staff working on satisfaction improvement efforts. In addition, all comments are scanned into eCompass to provide review of patient concerns or comments about how items not on the survey can be reviewed. Actionable information to secure future interactions and positive referrals is derived from looking at trends within the written survey results compared with

trends from rounding, physician data and OFI complaint data.

The key outcome indicator of loyalty is defined as a patient's willingness to recommend DPHC to others. This is measured by the mean score on the written satisfaction survey. Results of patient satisfaction surveys, rounds, physician feedback and complaint data are distributed monthly to leaders, and reviewed by ESC to detect organization-wide trends. Because surveys mainly provide information relative to questions asked, data from clinical director rounds and complaint management system are trended and compared at the patient care area level. Using this two-phase analysis, multidisciplinary teams are created to address these opportunities for improvement. Unit SA councils use the information to develop unit-specific action plans to improve performance. These processes identified the Key Patient/Customer Requirements in Figure 3.1-1.

The Physician Satisfaction team reviews data from physician satisfaction surveys currently coordinated by DMR. All active members of the medical staff receive a survey on an annual basis. An internal team of Physician Services representatives visits physicians on a daily or weekly basis and assist senior leaders in recognizing physician concerns or requirements. Recent improvements from efforts include: appropriate placement of surgical patients, development of a guideline to assist new graduate nurses with prompts when calling a physician and a wireless phone system that facilitates more timely communication with physicians.

3.2b(2) Follow-Up With Customers
All patients are given information about the process for addressing issues and complaints upon admission to DPHC's services. Key access mechanisms have been identified to obtain services, seek assistance and make a complaint (Figure 3.2-1). Processes are in place that provide for prompt and actionable feedback from patients while they are receiving care and after discharge. Employees are empowered to address a complaint at the point of customer contact. The department director or supervisor is responsible for making certain the complaint is addressed and resolved to the best of their ability. Patients are given the option of requesting personal feedback. All complaints are referred to the department director for investigation. Complaint closure includes a personal letter to the patient or family and all follow-up documentation is incorporated into the OFI System. Timeliness of the feedback report is monitored and trended.

Other mechanisms of follow-up include: leadership patient rounds with immediate feedback plus subsequent visits, and post-discharge call-backs. Leaders rounding on all patients use a specific script to obtain "live" feedback on how care and service are being delivered and received. In specific areas where follow-up clinical intervention is needed, such as women's services and outpatient surgery, discharged patients receive a follow-up phone call at home from a nurse. A script is used containing questions about the patient's clinical progress and perceptions of their experience. Following a visit, patients receives a thank-you card with contact information should they wish to call.

3.2b(3) Satisfaction Relative to Competitors
DPHC obtains and uses information about customer satisfaction relative to competitor performance through several systematic processes. A bi-annual community patient preference survey is utilized to determine residents' satisfaction with health care services received over the last two years. Missouri Hospital Association HIDI data compares health care providers in the geographic region and is utilized by planners to determine opportunities and provide input into the SFHRP. Customer service representatives obtain information from patients about their satisfaction with competitors and other health care organizations providing similar services by conducting random surveys while patients are receiving care. Physician satisfaction surveys contain specific questions comparing DPHC to other hospitals in the area. Comparative data and benchmarks are sought and obtained for patient satisfaction whenever possible.

Press Ganey provides national, regional and SSMHC comparative and benchmarking information to DPHC which is segmented by patient type (IP, OP and ED). The Press Ganey data base includes more than 800 hospitals nationwide. The physician satisfaction survey also includes specific questions regarding care related activities to elicit feedback on the performance of DPHC relative to other hospitals in the area.

3.2b(4) Satisfaction Determination Kept Current
The ESC and annual SFHRP keep DPHC's approaches to determining customer satisfaction current with patient needs. DPHC closely collaborates with SSMHC planning staff on an ongoing basis to evaluate and improve the content of the patient satisfaction survey tool. DPHC keeps current with health care service needs through regular internet research and literature reviews, networking with research vendors and external benchmarking with other health care systems and companies. Since the switch to Press Ganey, reports are available weekly on the DPHC intranet and posted publicly at least monthly in appropriate departments/units. This data is reported to staff and is included in the department's monthly report, which also includes strategies for improvement. Information is available in a timely fashion with implementation of action plans as appropriate.

CATEGORY 4: MEASUREMENT, ANALYSIS, AND KNOWLEDGE MANAGEMENT

4.1 Measurement, Analysis, and Review of Organizational Performance
4.1a Performance Measurement
4.1a(1) Select, Collect, Align and Integrate Data
DPHC's Performance Measurement Process selects, collects, aligns and integrates data and information utilized for organizational performance (Figure 4.1-1). The selection of key DPHC measures and strategy for exceptional clinical quality, exceptional satisfaction and exceptional financial performance (Figure 1.1-3) are established through the SFHRP (Figure 2.1-1). These key measures are also incorporated into the DPHC PIR, the department goals and the EC PIRs. The DPHC PIR contains 50 indicators that align and monitor operational and strategic performance of the Exceptional Goals. These indicators are assessed annually through the SFHRP process for appropriateness and revised as necessary using CQI methodology. The measures are reported monthly and distributed to AC members. The key organizational performance measures are listed in Figure 1.1-3 and 1.2-1.

Data and information for tracking daily operations and organizational performance is collected through a variety of methods as described in Figure 4.1-2. DPHC information systems are a key to this data collection and availability.

Annual hospital goals are further aligned and integrated through the Passport Process and the ECs. Through the Passport Process, the four ECs develop a recommended list of key department goals, which are selected by the departments and directors with AC member approval. Each department must identify at least two measures linked to the Exceptional Goals. Each of these measures needs to be SMART: **S**pecific, **M**easurable, **A**chievable, **R**ealistic and **T**imely. Employee passport goals are then selected with approval by the employee's manager and linked to DPHC and department goals. Departments submit department measures/results monthly to their responsible AC member and quarterly results to the appropriate EC. Up-to-date department results of key measures are also posted in department bulletin boards and distributed to staff during staff meetings.

The DPHC ECs are responsible for selecting, collecting, aligning and integrating information related to the performance improvement teams (Sections 1.1b(2) and P.2c(1-2)). Each EC establishes the key indicators for their PIR annually (Figure 1.1-3), which are linked to SFHRP and the DPHC PIR. Additional measures are also incorporated to ensure that key projects and teams are tracked and held accountable. On a monthly basis, ECs present results and action plans from their PIR to AC. The EC PIRs are also presented to DPHC leadership on a monthly basis.

At each EC meeting, action plans and strategic initiatives are reviewed to ensure key tasks are completed by the

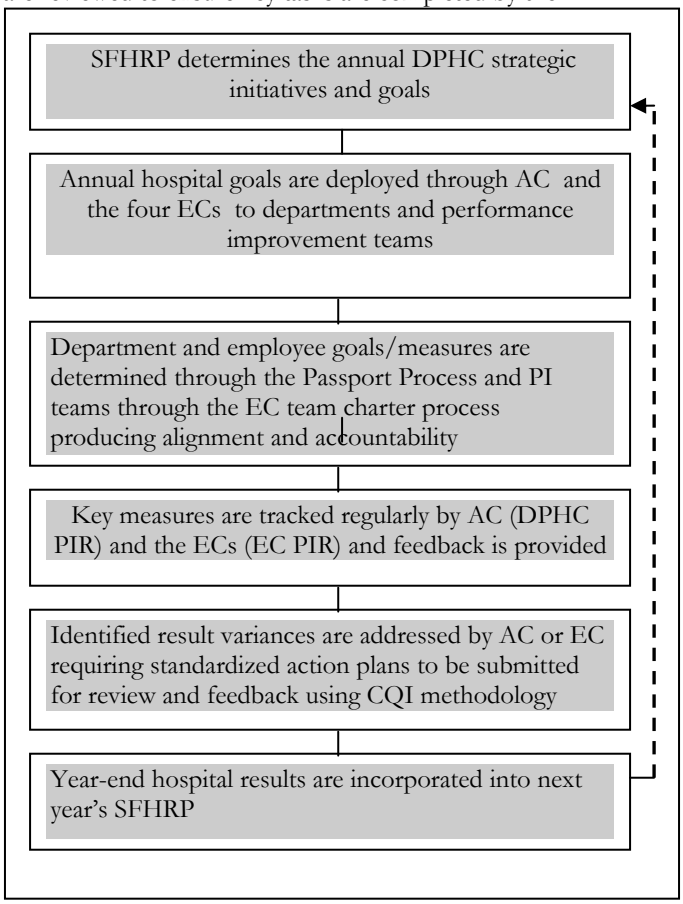


Figure 4.1-1 Performance Measurement Process

established dates. The frequencies for review and variance thresholds are also established. All performance improvement teams are required to submit an annual charter and measures of success to their assigned EC for review and approval. This process improves organizational alignment and accountability. PI teams submit key results monthly, as available, and present team updates in person to the EC at least twice each year. Teams with significant variances present more frequently as needed.

DPHC uses an organizational daily report that includes volume and revenue indicators to track daily operations. These measures have been selected by AC, EFC and the COO as indicators that impact staffing operations. This information is collected by Finance and is available daily on the electronic bulletin board to the entire management team. This information helps managers identify opportunities to adjust staffing on a "real time" basis. Since DPHC is consistently near its capacity on a daily basis, bed capacity status is communicated through an electronic paging system at several intervals throughout the day allowing managers to respond quickly to changes. Daily OPS is a process which measures productivity of departments on a daily basis with managers reporting

departmental worked hours per unit of service (WHPUOS) to the COO. If budgeted and actual WHPUOS for any given day are not aligned, corrective action is taken immediately to adjust staffing levels and align the department by the end of the week.

Since PIR goals are established based on external comparisons and benchmarks, innovation and review of external sources are incorporated into this process. Using comparative information allows identification of opportunities for improvement and best practices with top performance. DPHC has used this approach to improve heart surgery processes, ED flow, re-design of AMI/CHF/Pneumonia care processes and patient satisfaction. Also included are leadership visits to best practice sites in the United States.

4.1a(2) Comparative Data
Operational and strategic decision making are supported through the use of key comparative data and information. These are selected through the annual SFHRP process and by AC and the ECs using the DPHC benchmarking process. Additional comparative data sources for performance improvement teams are determined by the ECs. The priority is to first use national benchmarks or best practices, then state level benchmarks, then SSMHC and lastly, internal trended information. SSMHC Clinical Collaboratives and evidence-based medical literature are also utilized to identify best practices and benchmarks. DPHC attempts to use national top 20% or quartile as available. By continuously comparing and measuring work processes, DPHC gains valuable comparative and benchmarking information to improve performance. A list of key comparative data sources utilized is identified in Figure P.2-1.

4.1a(3) Keep Performance Measurement Current
DPHC keeps the performance measurement system current with health care service needs and directions through the SFHRP, EC structure and data driven decision making with frequent reporting of PIR results. Continuous customer listening and learning strategies (Figure 3.1-2) also allow DPHC's performance management processes to adapt to changing customer needs. Other resources utilized to ensure DPHC sensitivity to unexpected organizational or external changes include the SSMHC Clincial Collaboratives, SSMSL Clinical Performance Improvement Center, SSMHC Quality Resource Center, Premier and SG2.

During the SFHRP, health care service needs and directions are reassessed, evaluated and prioritized. If through this assessment, any modifications to the directions or needs of DPHC are identified, the performance measurement system is updated after discussion with senior leaders. Following the annual SFHRP cycle, AC and the ECs determine data required to measure and monitor performance of goals by developing PIRs (Figure 4.1-1). As progress is reviewed throughout the year, AC and each EC listens to and collaborates with reporting departments and teams to ensure that the most applicable data is used. This systematic review process allows DPHC to make changes in performance measures and respond to rapid changes in internal and external environments.

Category	Method of Collection	
Patient Satisfaction	-Patient Survey Tool (IP,OP,ED) - Comment Cards	- OFI System - Patient Letters - Patient Rounding
Employee Satisfaction	-Employee Survey tool -Leadership Staff Rounds -Manager Report Cards -Town Hall Meetings	- Performance Reviews - Daily Interactions - OFI System
Physician Satisfaction	-Annual survey Tool -Physician Services Feedback -Leadership Rounds with physicians	- Daily Interactions - Complaint Process - Leadership Meetings with physicians
Clinical Excellence	-Solucient/Premier -JCAHO/CMS -Missouri Hospital Association	- SSMHC - Clinical Collaboratives - Chart Reviews
Financial Performance	-SAP- Budget Variance Reports -DPHC PIR	- HIDI Data - Premier - Daily Ops
Regulatory/ Safety	-JCAHO/CMS -CHAN Reports -Missouri Department of Health	- AES Collaborative - Chart Reviews

Figure 4.1-2 Information Collection Methods

4.1b Performance Analysis and Review
4.1b(1) Performance Analysis and Review
Senior leaders review organizational performance and capabilities through weekly AC meetings and the four EC meetings. Senior leaders utilize DPHC PIR and EC PIRs for review of key organizational indicators. Senior leaders also meet monthly with their assigned department managers. Results with variances from the expected, require a formal standardized action plan. Report formats may include: trending, decision matrices, Pareto charts, line/bar graphs, and control charts. Statistical analysis and control charts are used as indicated for validation. Appropriate measures also include secondary validation processes to ensure accurate information (i.e. chart review validation of clinical data submitted for CHF, AMI and pneumonia). Comparative and best practice information are also utilized to validate and identify relative performance for these key measures. Other analytical processes utilized include root cause analysis (RCA) and failure mode and effects analysis (FMEA).

These key data sets of DPHC PIR and EC PIRs are aligned with organizational goals and this structure assures progress relative to strategic objectives and action plans.

CQI/PDSA performance improvement methodology is utilized throughout the organization to drive performance improvement. (Figure 6.1-2). This process improves accountability and monitoring of performance at all levels of the organization. The regular review of key measures with appropriate action plans and continuous input of information (Figure 4.1-2) related to these key goals allows DPHC to rapidly respond to changing organizational needs and environmental challenges. The DPHC Director of Strategy and Business Development also reviews these key measures on a monthly basis to ensure alignment and response to changing organizational needs. Communication of results of key organizational indicators is accomplished through a variety of methods using various communication tools as identified in Figure 1.1-5.

4.1b(2) Translate Findings Into Priorities

In order to prioritize organizational performance review findings for improvement and opportunities for innovation, DPHC utilizes comparative information with benchmarks and a prioritization tool. DPHC's goal is to achieve top performance relative to competitors and national benchmarks, as available. Best practices are identified and information is sought to identify specific opportunities for improvement and innovation. DPHC senior leadership also utilizes a prioritization tool to evaluate and prioritize multiple projects in an environment of limited resources. The ECs and AC prioritize performance review findings using several different criteria: impact on exceptional measures, magnitude of variance, cost/resources needed and time sensitivity. This tool was recently applied to a proposal from the Radiation Oncology Program, which requested capital for several improvement projects, requiring prioritization due to limited capital.

These priorities for performance improvement and innovation are deployed to performance improvement teams through the EC structure. Teams are commissioned through the Exceptional Councils and alignment is assured though the team charter process. Teams are required to utilize CQI/PDSA methodology and to determine effectiveness measures with goals and benchmarks as appropriate. The Passport Process also helps to align individual performance to key team and department strategic initiatives.

These priorities are also communicated to key suppliers and physician partners by methods in Figure 1.1-5 and deployed through participation on the multidisciplinary performance improvement teams and contracts. For example, physicians are participants on key clinical performance improvement teams such as CHF, AMI and pneumonia. Physician partners receive ongoing updates through MEC meetings and departmental medical staff meetings. Aramark (key supplier) leadership is a key participant on DPHC materiels management and patient satisfaction teams. Contracts with physicians and suppliers contain performance requirements aligned with DPHC's organizational goals. Quarterly meetings with suppliers are used to review performance and identify opportunities for improvement.

4.2 Information and Knowledge Management

4.2a Data and Information Availability

4.2a(1) Make Data and Information Available

Data and information are made available to staff, partners, suppliers and patients through online applications accessed from desktop computers, automatic report distribution to network printers, electronic data interchange (EDI), hard copy reports delivered via interoffice mail, committee and team meetings, PDAs, pagers, fax machines and hard copy records (Figure 4.2-1). The DPHC computer networks are connected to SSMHC wide area network (WAN) allowing staff with access to almost any application, independent of geographic location. For customers outside the SSMHC network, Business-to-Business network connections or Virtual Private Network (VPN) connections are established, where appropriate, to facilitate secure electronic transmission of information.

To support operations, departments access real-time financial information, customer service survey results, safety documents, policies and procedures, and the timekeeping system, to name a few desktop applications. Financial and patient satisfaction reports are distributed via e-mail, through software reporting applications or via hard copy. Certain key hospital and department reports (for example: patient admissions or discharge lists, census reports, daily charges) are automatically prepared via McKesson Star midnight processing or SQL and printed at secured printers or acccessed online. Department directors can access real-time financial information through SAP™ via their PC. The SAP system allows both electronic file transfer and faxing of purchase orders directly to key suppliers. DPHC claims to third party payers are submitted by the SSMHCSL Centralized Billing Office through electronic clearing houses. DPHC shares electronic information with organizations including: CMS, Premier, Solucient, Maryland Hospital Association, HIDI and SSMHC. Admitting clerks and billers check eligibility and claim status electronically via Medifax and payor websites. The appropriate areas print and post these results for all employees, physicians, patients and families to see.

Physician partners and clinical staff have access to the information necessary to provide patient care including information on-line via the PC. To facilitate inpatient care, clinical results are distributed automatically to the department (nursing, pharmacy, laboratory, radiology) printers and added in hard copy to the medical record. Standardized order sets and protocols are available real-time via the Intranet. Physicians and their office staff have the options of accessing patient information online via the Physician Portal. SSM Connect will print or fax electronic reports directly to physician offices. Physicians and appropriate caregivers also have access to the written record. Through unit-based computers, other clinical staff

have access to patient demographic information and clinical test results.

Suppliers obtain information by use of various methods including: regular face-to-face meetings with DPHC leadership, electronic file transfer, faxing, mail and e-mail. Cardinal utilizes an electronic inventory control process with DPHC pharmacy through the Pyxis system. Patients and families can access general information about DPHC through the DPHC Web site (www.ssmdepaul.com), which provides health and services information, physician directory, photos of newborns and other information. Patients and other customers within the county service area receive a newsletter, "Well Informed," which describes services and current events at DPHC. Health information brochures on major diseases are available throughout the hospital. DPHC is proud of its educational local cable program, Health Quest, which airs 32 times each week on Charter Cable 20.

Group	Data/Information Availability
Patients, Families, Staff and Physicians	▪ Discussions with physicians/nursing ▪ Pastoral Care staff ▪ Health-information brochures ▪ Resources for nursing homes, home health and financial assistance ▪ DPHC web site ▪ "WellInformed" newsletter ▪ Health Quest cable program ▪ Robert Porter Learning Center ▪ Library online access to 300 medical reference books and 125 journals
Dept. Directors and Staff	▪ Clinical data through McKesson ▪ AC information in dept meetings ▪ Department stats printed and displayed with department goals ▪ Wireless phones, pagers, PDAs ▪ Meeting minutes ▪ "Spirit Speak" e-mail ▪ Monthly Leadership meetings ▪ Online insurance eligibility
Dept. Directors	▪ Online financial information ▪ Online time-keeping system ▪ Online productivity monitoring report (PMR)
Physician Partners	▪ Physician portal; via internet ▪ SSM Connect reports to offices ▪ Hard copy medical records ▪ Electronic ED record ▪ Medical staff meetings ▪ Medical departmental meetings ▪ Physician newsletters ▪ Hospital posters
Suppliers	▪ Electronic file transfer ▪ Faxing of purchase orders ▪ Conference calls ▪ Annual business reviews ▪ Meetings with supplier reps

Figure 4.2-1 Data and Information Availability

Patients receive DPHC information on admission and have access to public bulletin boards with DPHC key results posted. Leadership, patient rounds, and staff rounds are other sourcees of information. Community members receive information through a number of programs in the DPHC Community Health Program and through leadership participation in a number of community service organizations.

4.2a(2) Ensure Reliability, Security, User Friendly

To ensure reliability of hardware and software, DPHC is centrally supported by the SSM Information Center (SSMIC). The SSMIC has a technology management function that performs monitoring of information systems to ensure high availability and access of data and information. This is accomplished through the IC Operations Center, which performs real-time system monitoring, collects performance metrics for capacity planning, implements equipment and communications redundancy, firewalls and has installed protection against power fluctuation and viruses. Real-time monitoring is performed utilizing SSMIC's technology management function by the Operations Center, which is continuously staffed and utilizes system monitoring tools such as Spectrum and ITO. These data are used for forecasting and planning server, LAN and WAN upgrades. These tools identify computer software, hardware, LAN and WAN problems. In the event of a problem or potential problem, a systematic notification and response system is deployed. Performance metrics are collected on key systems and equipment and include disk, CPU and network utilization and uptimes. SSMIC is implementing redundancy for mission-critical systems. For the main hospital information system, redundant CPU technology has been installed at a second data center. DPHC in conjunction with the SSMIC has also developed and implemented a high integrity desktop. The high integrity desktop reduces security risks that lead to lost productivity and network downtime. Workstation issues are minimized and software applications and security patches are quickly implemented via the high integrity desktop.

The DPHC Network (LAN, WAN and Internet) Security Policy outlines the procedures and responsibilities of IS staff, and standards for safeguarding the system (hardware, software and internet). DPHC utilizes the SSMIC's Security Policies and Procedures that document DPHC's intentions and staff responsibilities regarding information confidentiality, privacy and security. The policies and procedures cover all employees, as well as all consultants, payors, contractors, contract physicians, external service providers, volunteers and suppliers/vendors who use DPHC's information or information processing services.

To ensure information security and confidentiality, the SSMIC has established a department for Compliance Administration and Security, which is responsible for ensuring appropriate authorized access to its computer systems.

HBOC is the primary hospital clinical information system and upgrades are introduced at least annually. A team of HBOC coordinators oversee the project implementation and also evaluate the user friendliness of the changes, including menu functionality, and screen flows. DPHC also provides detailed instructions, in-services, tips and shortcuts with significant changes to assist users. The SSMIC and DPHC site coordinators formally test software product enhancements prior to implementing to make certain they are reliable and user friendly. A Patch Management Team was formed to oversee the process of identifying, evaluating, prioritizing and deploying security patches in a timely manner. Feedback from the Customer Satisfaction Program and incorporation of user groups into the SSMIC SFHRP process helps ensure that hardware and software are reliable and user friendly. The application selection process depends on the end user to help define the criteria that will be required of an application and review the different vendor solutions to determine which best meets their needs, including user friendliness and ease of use. Project Beacon (electronic health record) and PACS (radiological Picture Archiving Communications Systems) are examples of systems to be implemented using customer input. Continuous monitoring of existing systems ensures expectations are met or discussion is raised to consider appropriate changes.

4.2a(3) Continued Availability in an Emergency
The SSMIC and DPHC have deployed uninterrupted power source (UPS) systems and are protected by a power generator to ensure reliability of hardware and software. Wherever possible, hardware systems are designed with built-in component redundancy. A Data Protection Team was created to integrate the protection of data and the IS continuity plan. A Business Impact Analysis was performed to identify the order of restoring the most time-critical systems first. This ranking is the foundation for the entire SSMIC disaster recovery plan. A key aspect of this plan is the development of the SSMIC backup data center which provides data replication and high-availability failover for select applications.

4.2a(4) Data & Information Availability Current
DPHC keeps data and information current with health care service needs and directions during the SFHRP and SSMHC IS Planning and Management Process (Figure 4.2-2). Technology needs are assessed through the internal and external assessment step of the SFHRP. The external emerging technologies analysis addresses the current situation in the industry and marketplace. The internal physical technology analysis assesses the technology needs of SSMHC's entities and networks to support achievement of goals and action plans. The System Information Management Council (IMC) uses the information collected through the SSMIC-sponsored IMC Education Day, the SFHRP and its own listening posts and learning tools to develop the Information Management (IM) Plan, which incorporates network and entity information system needs. Following approval by the IMC, the IM plan is incorporated into the SSMHC SFHRP. The SSMIC communicates its goals and objectives to each entity through an annual Service Letter Agreement that details the products and services which will be provided.

In conjunction with needs assessments and emerging technology analyses performed by SSMIC at the system level, the DPHC Information Management Council (IMC) uses a complementary Information Management Needs Assessment process using customer service feedback and technology assessment to determine the information management (IM), services (IS) and technology (IT) needs of the health center. The net result is the Information Management Plan. A short-term 90-day IS Plan also ensures hardware and software agility to meet the current and ongoing needs. DPHC's relationship with the SSMIC links these processes into the System IMC's IS Planning and Management Process. The DPHC and Network IMC act as listening posts and communicate entity IM/IS/IT needs to the System IMC, which is responsible for system-level initiatives. If a particular initiative does not meet the needs of DPHC, an Exception from Standardization can be submitted; pending its approval by the System IMC, DPHC is able to pursue initiatives that are more suited to its goals.

The SSMIC provides opportunities for DPHC to assess current directions in technology as they relate to health care by sharing information obtained through contracting and participating in external industry research groups. These include the Gartner and Meta Groups, Center of Applied Information Technology (Washington University), HIMSS, CHIME and Insight. Information is presented by the SMIC at annual National IS manager meetings, Functional Quality Team meetings, the annual Education Day and through special events/seminars sponsored by the SSMIC. Information from these meetings is posted on the Intranet.

4.2b Organizational Knowledge Management
The DPHC information system is a critical component of organizational knowledge management. With the collection of data and information, there is a focus on standardizing systems to ensure that standard data and information are available for reporting to DPHC, SSMSL and SSMHC. Once this information is reviewed, analyzed and validated, DPHC utilizes a wide variety of communication and knowledge sharing methods as identified in Figure 1.1-5 to disseminate this information throughout the organization. Examples of staff knowledge transfer methods include: orientation, town halls, annual

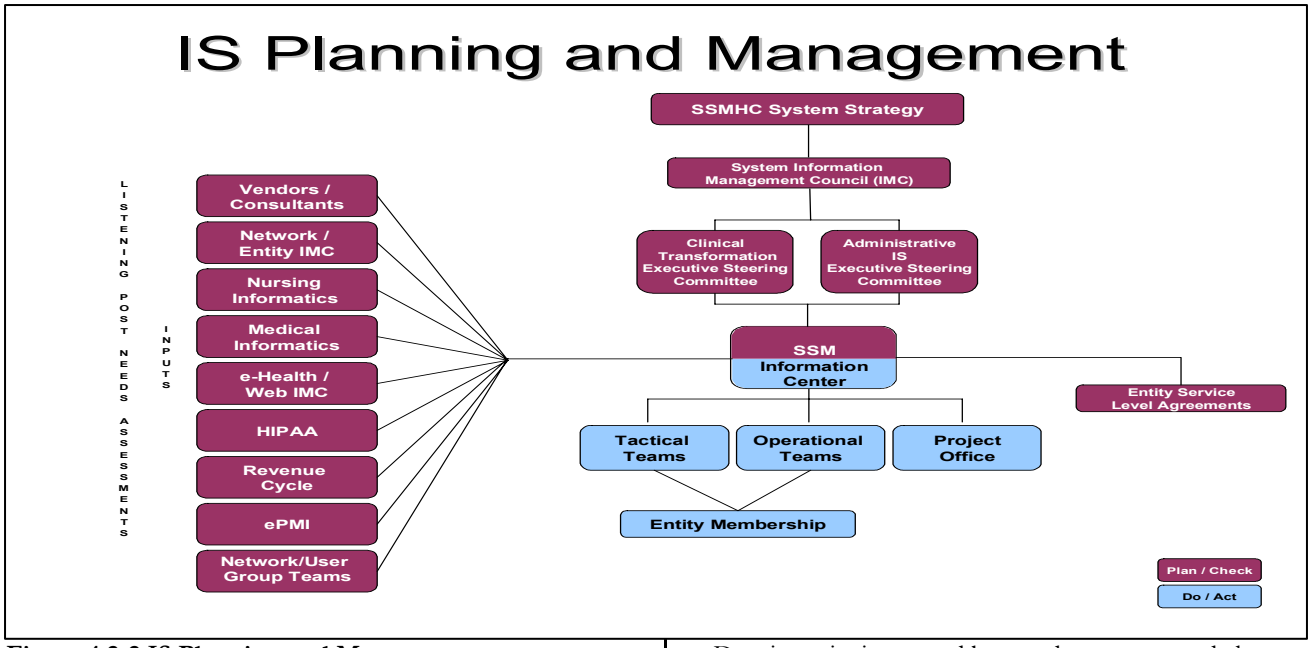


Figure 4.2-2 IS Planning and Management

skills days, department and team meetings, in-services, educational programs, Intranet applications, newsletters, preceptor program, and posting. Internal e-mail lists have been established to share information with groups who share a common interest. Transfer of relevant knowledge to patients, physicians and suppliers is accomplished through the methods described in Figure 1.1-5.

The rapid identification and sharing of best practices are accomplished in a variety of ways. DPHC has an annual Sharing Conference and also participates in the annual SSMHC Showcase for Sharing and the sharing component of the annual SSMHC Leadership Conference. Best practices are shared through participation in the SSMHC Collaboratives. Best practices are also identified through Exceptional Councils and the benchmarking process. The ECs are responsible for the assessment of best practices and the development of action plans for implementation.

4.2c Data, Information and Knowledge Quality

DPHC ensures integrity, accuracy and reliability of data in a number of ways. Standardized training is provided to all new and existing employees on an ongoing basis. Employees from the IS Department, as well as all other employees responsible for data entry, are included in the training process. The accuracy and reliability of data, information and knowledge is addressed in several ways. DPHC departments work with the SSMIC's Clinical Applications Department to complete Functional Utilization Assessments which help ensure that best practice models are being used for each application. DPHC also has Decision Support Services (DSS) and a Revenue Integrity Team as further measures for ensuring reliability and accuracy of information. DSS uses multiple systems to compare and cross check data. Audits of information systems and processes for integrity, reliability, accuracy, timeliness, security and confidentiality are performed by CHAN.

Data integrity is ensured by mandatory password changes, daily data backup to tapes, which are stored off-site and mandatory field entries to ensure completion of critical data fields. Coordinators and Super-Users are assigned and trained to provide immediate support for employees. The IC Security and DPHC IS are responsible for ensuring appropriate authorized access to its computer systems. DPHC uses SSMHC's formal electronic computer authorization process for granting access to systems, termination, and a process of routinely requiring passwords to be changed on computer systems meets HIPAA compliance. HIPAA training is required and monitored on an annual basis. DPHC uses an outside firm of CHAN auditors to assess processes and security.

Security and confidentiality are ensured via password protection, firewall protected Internet/Intranet and layered security levels within applications. The SSMIC Security Policy and Procedures documents DPHC's intentions and responsibilities regarding information confidentiality, privacy, and security. These policies and procedures cover all DPHC employees and partners who use DPHC information in their course of work. Privacy screens, alterations of physical space, and employee and partner behaviors are included in the policies and procedures to ensure confidentiality.

Timeliness of information is critical to performance. Timeliness expectations of many critical reports are established and performance is tracked (i.e. medical record reports, lab result availability, radiology report availability). The establishment of timeliness goals and result measures allows DPHC to better manage information quality. "Timeliness" is also determined based upon feedback from employees, partners and suppliers. Timeliness is also addressed by the automation of key reports so they are available to users when needed. DPHC schedules interfaces and updates to the various databases to ensure users have real time information. Many critical reports are scheduled to run automatically early in the morning so the information is available when staff and physicians arrive at work.

5.1 Work Systems

5.1a(1) Organize and Manage Work

DPHC organizes and manages health care services through an organizational structure designed to be flexible and responsive to the needs of staff, customers and partners. Work, jobs and skills are organized and managed according to functional responsibility, usually by departments and teams, to achieve high performance. Each department has a Scope of Service, which identifies services, customers and staffing requirements. The departmental posters which are linked to the Passport process, outline the goals, measurements and current progress of departments. Teams and Shared Accountability Councils are accountable to an EC and each has a charter (Figure 5.1.1).

The team charter identifies mission, goals, action plans, champion, target dates, quality measures and capital investment as appropriate. Key staff and patient satisfaction results are tracked and reported to the ESC, key clinical results to the ECOC and key business results to the EFC. These tools are updated on an annual basis to ensure alignment with the SFHRP.

In addition to department and team organization, work is organized by job and skill categories. Job descriptions at DPHC are written by managers with input from staff and approved by HR. The job description states the purpose of the position, competency, tasks and expectations. The human resource policies, standardized medical record documentation tools and standardized policies and procedures facilitate staff flexibility across locations. The SSMSL Staffing Service is utilized to temporarily fill professional positions when volume surges or time off cause shortages. DPHC also has an internal float pool to address nursing staffing needs. In both clinical and non-clinical areas, staff members are multi-skilled and cross-trained where applicable. These methods contribute to the agility of the organization.

5.1a(2) Work Systems Capitalize on Diversity

Diversity is an integral part of DPHC and is recognized as such in the SFHRP. As a result, the number of minority managers and professionals has increased over the past six years from 88 in 2000 to 227 in 2005. The management and professional staff is 16% minority. Overall, the staff is 82% female and 33% minority. DPHC capitalizes on the diverse ideas, cultures and thinking of its staff and its communities through its recruitment and orientation processes, SA, CQI culture and the Diversity Council.

In 2002, a Shared Accountability (SA) practice model was initially implemented in nursing and is being expanded to other departments to engage staff members in partnership and shared decision-making. SA is a professional practice model where accountability is understood to be the right and obligation to initiate and carry out an action or process. Interactions are relationship-based, rather than hierarchical. To a large extent, the work of SA takes place on the individual unit to promote service agility and to drive resource allocation based on patient-care needs.

Shared Accountability Council →	Exceptional Council
House-wide Patient Care Practice Council	ERC
House-wide Educational Council	ESC
House-wide Nursing Education Council	ESC
House-wide Nursing Quality Council	ECOC
Department Quality Councils	ECOC
Nursing Management Council	EFC
Department Management Councils	EFC

Figure 5.1-1 SA Council Reporting Links

Employees of diverse backgrounds and experience participate on multi-disciplinary teams, which facilitate diverse ideas and collaborative thinking. The membership of PI teams, EC and SA Councils are made up of a cross section of staff, physicians, managers and other staff as appropriate. An active Diversity Council works to define and implement strategies to embrace diversity and create an environment of cultural sensitivity, respect and workplace justice. Community diversity ideas are identified and integrated into the DPHC organization and management of work through the DPHC Community Advisory Board and senior leader participation in many community.

5.1a(3) Effective Communication and Skill Sharing

Effective communication is achieved through formal and informal communication channels (Figure 1.1-5). Formal communication channels include monthly AC, LT and Employee Council meetings, quarterly Town Hall meetings, monthly president lunches with 20 heterogeneous staff, monthly president's letter, "meetings in a box," leadership rounding and various general and focused newsletters. Regular department meetings are used by department managers to communicate information from AC and other departments. Informally, departments use regular staff meetings, SA team meetings and department communication books to share progress toward plans and to collect employee input on operational issues and employee satisfaction. The AC, LT and ECs have a meeting format designed to improve communication and discussion of issues related to the SFHRP. Management and staff participate on network and system teams and attend regular meetings for various functional groups, conferences, teleconferences and learning sessions where skill sharing is encouraged. CQI teams also present results and lessons learned to other departments and staff, informally and formally (DPHC and SSMHC Annual Showcase for Sharing Conferences and Blitz Days). Informal communication

occurs within departments and between internal customers and suppliers by face-to-face, two-way communication, conference calls, e-mails and the DPHC intranet.

5.1b Employee Performance Management System
DPHC's primary performance management system is a 360-degree tool deployed at all levels and aligned with the SFHRP. This annual process of formal feedback and recognition throughout the year, along with AEPC, Passport Process and CQI help support high levels of performance and customer service focus. Executives are evaluated on the seven leadership expectations described in Figure 1.1-2. Managers and staff are evaluated on a similar 360-degree tool. The AEPC Exceptional Service Standards have been incorporated into the tool for 2006 and will comprise 50% of the evaluation. Approximately 98% of DPHC employees meet or exceed expectations on an annual basis. Employees not meeting expectations are placed on a performance improvement plan, which is designed to clearly identify steps to help employees meet expectations. Information regarding education and training needs are aggregated to identify trends and utilized by the Education Department for the development of the annual Education Plan. Upon hire, clinical and designated support employees are assessed using a performance-based development system. The results are used to create an assessment profile, orientation action plan, and to set expectations for high-performance work.

The Passport Process links personal performance goals to departmental and organizational goals to support a patient service focus and high performance around key organizational strategies [Section 2.1b(2)]. Participation on teams and the focus on CQI allow individual employees to exercise greater initiative and to assume more self-directed responsibility in their work. Managers motivate employees primarily through two non-monetary approaches: coaching and recognition. Employee recognition is accomplished through AEPC (including personal thank you notes and rounding), employee service awards, employee of the month, department/unit recognition for the highest patient satisfaction scores, 20+ club, birthday recognition, and the Mission Value Award. Teams are recognized for their performance improvement efforts at the annual DPHC and SSMHC sharing conferences. Staff and team achievements are highlighted in the president and staff newsletters. Formal coaching is built into the employee development process and informal coaching is an ongoing process at all levels.

In keeping with its MVV, DPHC develops compensation policies to be fair and equitable for all employees. Annual market surveys are conducted and pay ranges are adjusted as necessary to ensure competitive compensation for positions. DPHC demonstrates a compensation philosophy in which "internal equity" is very important. In determining salary offers for new hires, caution is taken not offer more to an external applicant than a current employee in the same job classification and with similar experience is receiving.

5.1c Hiring and Career Progression
5.1c(1) Identify Characteristics and Skills
Skills and characteristics needed by potential staff are identified through the use of the job description and competencies for the position. As each job description is created, the level of responsibility, qualifications, work experience and education requirements are determined by the department leader. Expectations of staff performance are listed on the job description/performance appraisal form, so that each employee is able to see performance standards for the specific position as well as standards relating to behaviors related to Mission and Values, CQI, safety, customer service and attendance. The job description and competencies are also reviewed and approved by DPHC and SSMHC HR to ensure consistency throughout the hospital and system as well as to be competitive within the market.

Applicants are selected based on a match to the job requirements and compatibility with mission and values. Pre-employment competency assessment includes qualification screening, skills, knowledge and ability to do the job. Verification is made of all licenses, registrations and certifications. Education, degrees and previous employment are verified, and security checks are performed before hire. Drug screening is completed for all staff.

5.1c(2) Recruit, Hire and Retain
DPHC acknowledges that identification, selection and retention of highly motivated and experienced employees are vital to sustaining a high-performance, customer-oriented culture. DPHC has numerous systematic approaches to recruit, hire and retain the best staff available (Figure 5.1-3). HR reports indicate the number, referral base and demographics of applicants for each position. These reports help ensure a diverse pool is considered when filling jobs. All open positions are posted internally on the DPHC and SSMHC intranet and the internet and a public bulletin board across from the HR office. Depending on the market for the position, human resources staff uses various methods to identify applicants, most of which are drawn from nearby communities. DPHC works cooperatively with local colleges to provide clinical training for students. Once qualified applicants are identified, screening is accomplished through the use of interviewing, skills checks, license and education verifications and reference checks. Once a job offer is made, additional screening is done by criminal background checks and drug screening. HR staff and department managers work cooperatively to choose new employees. As DPHC recruits for open positions, it goes to markets in the local community and across the two state areas of Missouri and Illinois.
DPHC values diversity in recruitment and is committed to diversity initiatives such as increasing the number of

minority management and professional staff. Information related to diversity in each segment of the staff is available to help identify opportunities for diversity initiatives for recruitment. DPHC also participates in the semi-annual SSMHC Diversity Forums. A two-day VOICE program was implemented to help entry-level staff gain skills necessary to become stable employees and better understand DPHC's Mission, Values and culture. DPHC has a higher retention rate for employees who complete this program versus those who do not. DPHC has also partnered with multiple nursing schools to train and hire student nurses. Many of these students remain at DPHC after graduation. Innovations to attract workers in a tight labor market have included: a summer intern program, preceptor program, sign-on and referral bonuses.

5.1c(3) Succession Planning and Career Progression
Succession planning is accomplished at the senior leader level through the SSMHC Executive Career Development Program. The program includes a leadership behavior assessment, a personal development plan, an executive orientation, CQI training and CRP training. Executive leaders have mentors available to them and are expected themselves to mentor others. Middle managers are assessed with the Caliper Profile for leadership qualities before employment. Each applicant is assessed to help determine a fit with the position and to identify areas for interview probes. This assessment helps the hiring leader to understand developmental needs for manager selection.

Organizational Development is a resource available from SSMSL to all management employees. This department offers educational classes and workshops on various topics for the benefit of new, as well as experienced, managers. In addition, new manager orientation is provided and covers specific managerial topics such as coaching, interviewing, conflict management and a review of policies and procedures. Employee education and career goals are also included in the annual evaluation process. Opportunities for all employees to develop skills for leadership positions are created through educational offerings; leading and participating on teams; involvement in the SA model; and through lead, preceptor and care team coordinator (CTC) roles.

Employees are supported in their learning goals through help with identifying and accessing materials and programs for professional development. Education and training are offered within the department and hospital. Seminars and college courses are supported by tuition assistance. Many classes are also offered in the work place.

Approaches to Recruit, Hire and Retain staff		
Recruit	▪ Job fairs ▪ Recruitment events ▪ Sign-on bonuses ▪ Explorer Club ▪ Bulletin boards ▪ Job shadowing	▪ Employee Referral Program ▪ School-business partnership ▪ RN pampering parties ▪ Junior Doctor Days ▪ Intranet/Internet
Hire	▪ Apply online or in person ▪ SSM transfers given priority ▪ Coordination with clinical programs	▪ Offer within 48 hours for critical positions ▪ HR reports track applicants ▪ Internship programs ▪ Group interview events
Retain	▪ Compensation reviews ▪ Market pay assessments ▪ Rewards and recognition	▪ Self-scheduling ▪ Paid education and training ▪ Shared Accountability ▪ Preferential PTO picks ▪ Loan Repayment Program

Figure 5.1-3 Approaches to Recruit, Hire and Retain Staff

5.2a Employee Training and Development
5.2a(1) Employee Education and Training Contribute to Action Plans
DPHC identifies and addresses staff developmental needs on a hospital-wide, department and individual level to support the SFHRP using the Education Planning Process (Figure 5.2-1). This process addresses training needs in four key areas: regulatory and compliance standards, performance improvement, employee skill development and new products and technology. Recognizing that continuous learning is essential for employees to keep current with changing health care technology, industry trends and government regulations education is prioritized depending on employee and DPHC needs. The Education Planning Process provides for ongoing planning and implementation of training as action plans change.

Education and training is designed to support DPHC goals and action plans. The Education Department and Education Councils develop goals for house wide staff education. Departments develop annual education goals consistent with specific services provided and staff needs. Short-term goals are met primarily through continuing education classes, department based training, skill labs and on-line learning. Longer term goals are typically addressed through the development of department resource staff, opportunities for on the job and cross training, tuition reimbursement for college level coursework, leadership development and clinical internship programs. Staff development needs for licensing and re-credentialing requirements are defined and planned for annually. The Value Analysis Team (VAT) addresses training needs associated with new products and equipment and coordinates training delivery in work areas. Career

progression occurs through internal opportunities for on the job or cross training facilitated by the manager. Advancement through formal education is supported by loan forgiveness, tuition reimbursement and scholarship programs.

5.2a(2) Address Key Organizational Needs
Staff education and training are linked to the key organizational needs identified in the SFHRP through the Education Planning Process (Figure 5.2-1). Education and training are also linked to the ESC and the House-wide Nursing Education Council (Figure 5.1-1). These links allow the process to address needs associated with new staff orientation, diversity, ethical health care, business/management practices and leadership development. Safety education and training needs are also identified by the Education Planning Process in collaboration with the CRP Plan, ERC, Worker Safety Team and Risk Management Department. The CRP Plan

identifies training requirements for educating staff on ethical business practices. The plan initiates training in orientation and includes a list of modules, both general and job specific, with timelines for completion. SSM Organizational Development (OD) supports leadership development at DPHC. Staff, workplace and safety training approaches are identified in Figure 5.2-3.

5.2a(3) Seek and Use Input
DPHC collects input from staff and managers about training needs and from a variety of patient and customer sources, which are summarized in Figure 5.2-2, to determine education, training and development needs for the Education Planning Process. The employee and manager identify individual training needs at the time of the annual performance review. Needs assessment results are aggregated and input is used for planning house-wide and department-based staff education.

Focus groups and surveys solicit input for education and training from identified groups such as graduate nurses, entry-level staff through VOICE, educators and preceptors. Feedback from these groups resulted in revisions of the graduate nurse internship program, preceptor refresher course, VOICE manager training and nursing orientation. Lessons learned and newly created knowledge from teams is factored into training and education by the House-wide SA Education Councils in the fifth step of the Education Planning process Figure 5.2-1. The EC and SA structures are the framework for learning to be communicated across the organization and for best practices to be replicated and standardized.

These processes develop employee-specific education with feedback from educators, preceptors, staff, and department directors who assess and provide input on specific training needs through the use of surveys, observations of performance and two-way communication. Employee specific education aligns with the employee's individual passport goals.

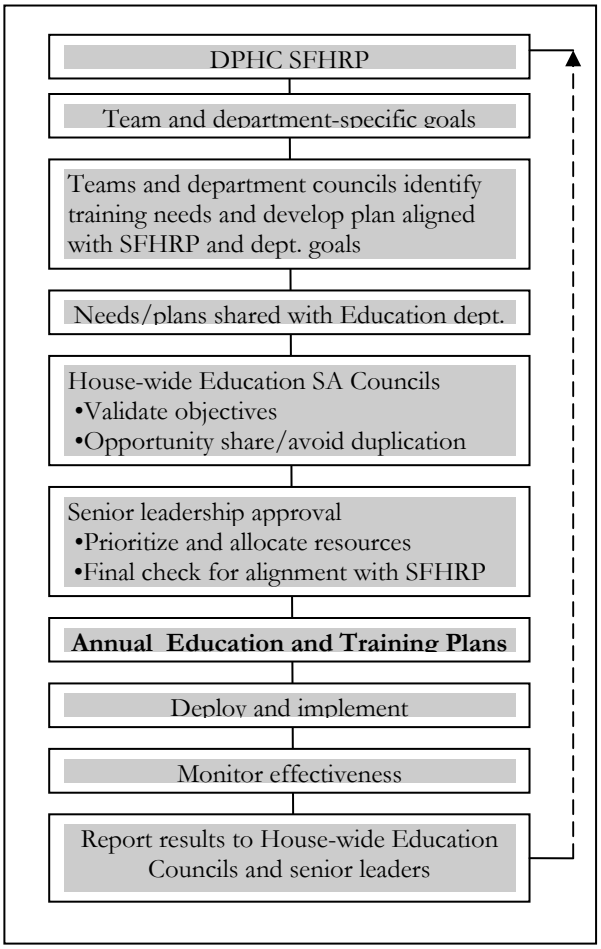


Figure 5.2-1 Education Planning Process

Input Methods for Determining Training Needs	
▪ Competency assessments	▪ Regulatory agencies
▪ CQI teams and staff meetings	▪ Environmental rounds
▪ Observation of performance	▪ Risk management data
▪ Employee, patient and physician surveys	▪ EC and SA education councils
▪ Focus Groups	▪ Value Analysis Team

Figure 5.2-2 Input Methods for Determining Training Needs

Staff, Workplace & Safety Training Approaches	
▪ Patient safety/ EOC education	▪ Ergonomic and back safety programs
▪ Environmental rounds with staff	▪ Crisis prevention certification
▪ State of Safety and Medication Safety newsletters	▪ Dangerous abbreviation screen savers
▪ OSHA training	▪ Annual safety fair
▪ Nursing blitz days	

Figure 5.2-3 Staff, Workplace & Safety Training Approaches

5.2a(4) Deliver Education and Training
Education and training are delivered formally and informally through a variety of approaches and coordinated by the House-wide Education Council. Department-based educators provide specialized training specific to patient populations and healthcare disciplines. Education and training delivery methods include: classroom lecture, video, discussion, demonstration, simulation, computer assisted, case studies, self learning packets, role modeling, games and problem solving exercises, cross training on the job, and one-to-one coaching. Educators determine delivery methods by interviewing staff and taking into consideration the learner needs, as well as, options conducive to reaching all shifts and PRN staff. Skill-based training, such as CPR, requires hands-on learning and competency assessment through return demonstrations. Methods vary from formal classes to preceptor demonstration and mentoring at the workgroup level, to sharing of articles and materials at departmental meetings depending on staff needs and preferences.

Initial education and training are delivered through organization-wide and department-specific orientation programs. New employees participate in a general orientation program which involves senior leaders who welcome new employees and share the Mission, Values, and goals of DPHC. Orientation also includes patient rights, AEPC, HIPAA, CRP, Intro to CQI, diversity, patient safety, safety and security, disaster plan, OSHA, infection control, employee benefits, EAP and HR policies. Department-specific orientation is systematic and validates key job skills. It is coordinated by department managers and educators, and often includes preceptor guidance based on competency assessment. Initial training is reinforced through annual training for employees.

DPHC's preceptor program provides trained preceptors to coach new employees, validate performance and serve as role models. Originally designed for nursing, the program was adapted for additional job roles in transportation, registration, housekeeping, unit secretaries and clinical partners. The program has been identified as a best practice for replication in SSMSL entities. Internships are made available at DPHC for graduate nurses and student nurses in the final phase of their education. These internships, designed to increase recruitment and retention of new nurses, provide a longer term mentoring relationship.

5.2a(5) Reinforce New Knowledge and Skills
New knowledge and skills are reinforced on the job through observation of performance by educators, preceptors, managers, peers, physicians, patients and families. Preceptors provide continuous and immediate reinforcement to staff following training. Educators reinforce training and job skills by providing informal follow-up with managers and assessing whether training programs have met departmental objectives and employee performance has improved. Directors assure that employees achieve expected levels of performance through on-going competency assessments of patient care staff and through the annual evaluation process. Observation and coaching is provided with documentation of validation of skills. Checklists and written procedures outline criteria for successful performance. Annually, skills and processes recently introduced and problem prone are identified for house-wide or department review through the competency blitz program or department education plans. Auditing processes evaluate change in practice following training related to performance improvement initiatives. Retraining is completed to address gaps.

DPHC's policy of notice requirement for resignations allows departing or retiring staff to transfer knowledge and work through transition plans. This transition plan is the responsibility of the department/unit director. Also the ability of staff to cross-train functions allows for coverage of employees who have left or are out of work temporarily. DPHC also utilizes an exit interview process to systematically transfer knowledge from departing or retiring staff. The HR Department performs the interviews and key information is shared with the unit/department director.

5.2a(6) Evaluate Effectiveness
Education and training programs are routinely evaluated and improved through the Education Council. Methods and tools for evaluation follow criteria described in the Kirkpatrick and Abruzzese models. Four levels of evaluation are defined: process, content, outcome and impact. Educators follow up with managers to assess whether training programs met objectives and if staff performance and work system performance improved. Staff members evaluate the content and presentation after formal educational programs through completion of formal evaluations. Findings are tabulated, summarized and used for improvement in program design and delivery. Performance indicators and risk management monitors are made available to teams through the CQI process providing the opportunity for evaluation at the level of impact. Performance improvement teams are linked to an EC to ensure training leads to improved performance. An example of how training and education are effective is

illustrated by improvements in skin care outcomes following the implementation of a training program.

5.2b Motivation and Career Development

Through AEPC, Passport Process, CQI, Shared Accountability and a faith-based culture, DPHC motivates staff to develop and use their full potential. AEPC rewards and recognizes performance related to achieving exceptional patient satisfaction. The passport process motivates the staff related to their specific department and individual goals. The empowerment associated with Shared Accountability and the teamwork with CQI are also motivating factors. The faith-based culture, the source of the core values, is another motivating factor for staff. Managers help staff attain job and career-related development and learning objectives through the annual evaluation process [Section 5.1c(3)]. Other formal mechanisms in place to help staff with job and career development include: DPHC budget for staff education, scholarships, tuition reimbursement, loan forgiveness and the clinical stipend program. The stipend program offers entry-level staff the opportunity to attend nursing or radiology school with financial aid and tuition reimbursement.

5.3a Work Environment

5.3a(1) Ensure and Improve Workplace Health, Safety, Security, and Ergonomics

DPHC maintains a work environment and a staff support climate that contribute directly to the safety, well-being, satisfaction and motivation of all staff through the ESC and the ERC. Workplace health, safety, security, and ergonomics are managed through the ERC and the Safety Committee. The Safety Committee is a multi-disciplinary committee that meets monthly to provide oversight for safety and risk management efforts that are vital to the protection and welfare of employees and patients. Their efforts reflect the seven Environment of Care areas established by the JCAHO. The key measures for staff safety, security and ergonomics are listed in Figure 5.3.1.

Workplace health and ergonomics are monitored and measured by employee health and infection control nurses, who also aggregate and review data related to employee health, including exposures and infections. The employee health nurse tracks and reports employee safety measures that include: reportable accidents, lost time injuries, back injury cases, needle sticks/sharps cases and workers compensation claims. Ergonomic assessments are completed upon request and when trended data indicates the need. For example, as a proactive measure, the Workers Compensation Coordinator has coordinated employee workstation ergonomic evaluations to help minimize potential lost time injuries.Other processes include: annual safety survey, Environment of Care Rounds, new employee orientation, additional assessments as needed, annual safety fair and a monthly safety newsletter. A safety survey is conducted annually to aggregate input from staff. All findings are reported to the Safety Committee and action plans are developed. Environment of Care rounds are conducted in each department. Training sessions for staff on gait belt use, proper body mechanics, and patient handling and transfers are offered twice per month.

Factors	Measures	Figures
Employee Safety	-Back Injury Cases -Lost Time Injuries -Workers Comp Claims	7.4-2 7.4-2 7.4-2
Staff Well-Being	-Employee Satisfaction Score - Timeliness of Evaluations	7.4-7 7.4-9
Employee Satisfaction and Motivation	-Employee Satisfaction Score -Employee Turnover -Tuition and Loan Reimbursement $	7.4-7 7.4-3 7.4-5
Diversity	-Number of Minorities in Management -Overall % Minorities	7.4-4 7.4-4

Figure 5.3-1 Measures of Staff Safety, Well-Being, Satisfaction and Diversity

5.3a(2) Ensure Workplace Preparedness

The DPHC Safety Officer and Safety Committee are responsible for emergency preparedness. The Safety Officer coordinates DPHC staff preparation for emergencies. DPHC also has physician and nurse representation on local, state and federal organizations including CEMA, SEMA and FEMA. The Emergency Preparedness Manual, located in each department, contains plans for disasters, emergency water, fire safety and the procedures needed in the event of a bomb threat. At a minimum, two drills are performed each year. These include communication of the effectiveness of the drills and are designed to identify opportunities for improvement in ensuring health care services and business continuity for patients, customers and staff. DPHC also participates in community emergency preparedness drills. All leaders accountable for administrator on-call duties are trained in hospital emergency incident command system (HEICS).

5.3b Employee Support and Satisfaction

5.3b(1) Determine Key Factors

DPHC utilizes an employee opinion survey to determine the key factors affecting employee satisfaction, motivation and well-being. Results are analyzed based upon normative differential score and best-in-class performance, which compares DPHC's scores in several dimensions with the National Healthcare Normative, Press Ganey (beginning 2006), SSMHC best practice and prior DPHC results. Survey data is initially segmented into work group results. Department managers share these results with staff and complete departmental feedback sessions to validate those

results. The surveys and department feedback sessions allow for action plans to be developed in order to quickly address areas for improvement. Data is further segmented by job category, age, gender, national origin, tenure of employment with DPHC and pay status (hourly or salary).

DPHC also employs an HR IS Coordinator, responsible for identifying and addressing problem areas. The HR IS Coordinator completes new employee surveys within 30 days of employment as well as exit interviews with outgoing employees. Other means of determining employee satisfaction and well-being include annual manager report cards, quarterly Town Hall meetings with the President and AC, monthly staff lunches with the President, employee complaint resolution process, Shared Accountability Councils, Employee Council and the Employee Satisfaction Team. The results and processes are accountable to the Employee Satisfaction Team, ESC and AC. Senior leadership utilizes this information in the SFHRP process. The identified key measures for employee well-being, satisfaction, motivation and diversity are listed in Figure 5.3.1.

5.3b(2) Services, Benefits and Policies
DPHC provides services, benefits and policies to support staff and to contribute to staff well-being and satisfaction including:

- Various categories of employment (including full time, part time, per diem, weekend option and on-call)
- Support for transfers within DPHC and SSMHC
- Work at home options for certain jobs
- Varying Schedules within 72 hours every two week pay period considered full time with benefits
- Posting open positions for internal recruitment

DPHC recognizes diversity in the workforce by offering a flexible benefits program that permits employees to select or opt out of benefits that most closely meet their individual or family needs. Flexible benefits include: medical benefits (either managed care or indemnity), prescription drug coverage, two levels of dental coverage, two levels of vision coverage, varying levels of employee life insurance and dependent term life insurance, two levels of accidental death and dismemberment coverage, Legally Domiciled Adult (LDA) coverage, short- and long-term disability, Long Term Care insurance for employees, health and dependent care pre-tax spending accounts, and 403(b) matched tax deferred savings plans tailored to the employee's desired risk level.

DPHC also provides a defined benefit pension plan for employees; tuition reimbursement and loan repayment; multiple leave of absence programs for employee, family, personal, educational and military reasons; direct deposit; ability to participate in MOST; adoption assistance; cafeteria and gift shop discounts; Mission Retreat Day participation; Employee Relief Fund to aid employees during a financial crisis, and Employee Assistance Program (EAP). In 2001 DPHC amended its retirement program to allow employees age 60 or older who have five years of vesting service to receive pension benefits while continuing to work for DPHC full or part time. The DPHC Employee Emergency Relief Fund is funded by employee donations and fundraisers with an average of $55,000 distributed annually. DPHC also employs a staff outreach social worker, who has helped more than 300 employees with crisis situations such as caregiver conflicts, stressors and health-related issues. A Learning Center for all employees provides programs designed to help employees meet the challenges of personal and work development, and work/life balance.

5.3b(3) Employee Well-Being and Satisfaction
The employee survey is the primary method used to determine staff well-being, satisfaction and motivation. Results are analyzed by job category, age, gender, national origin, tenure of employment with DPHC and pay status (hourly or salaried). Follow-up feedback sessions are conducted with employee groups to clarify and validate survey results. An interim abbreviated written survey is used to evaluate improvements made in response to employee feedback. Another formal method utilized is the monthly HR Scorecard. This tool was initially implemented in 2003 and is provided to senior leaders and managers with measurements including: turnover and reasons for turn over, number of positions filled, number of vacancies, number of grievances, participation in 403(b) plans, department/unit specific patient satisfaction, tuition reimbursement and loan repayments, and terminations within 30 days or one year of employment.

In addition to the HR Scorecard and annual employee survey, measurements include monthly turnover reports aggregated by departments, number of performance appraisals completed in a timely manner, and number of employees performing at various levels of performance. Informal methods of determining staff satisfaction include skip-level meetings, HR interviews of employees in areas with staff dissatisfaction, and specific group sessions and surveys from town hall meetings. New Graduate Nurse Roundtables are held to discuss the challenges of a new role. Key measures used to track staff safety, well-being, satisfaction and motivation (Figure 5.3-1) are reported to AC, leadership, ESC and the Board.

5.3b(4) Assessment Findings to Business Results
Employee satisfaction is a key indicator in the SFHRP. This enables senior leaders to correlate the affects of changes in staff satisfaction with the other key Exceptional Goals (including; patient satisfaction, clinical outcomes, physician satisfaction and financial performance) through the formal annual strategic planning process and concurrently through the EC structure. The HR Scorecard is utilized to correlate staff satisfaction measures to other key organizational results. Review and analysis of these results allows senior leaders to identify potential staff problems prioritize action plans to improve the work environment.

6.1 Health Care Processes

6.1a(1) Determine Key Health Care Services

All hospital services and processes are driven by Mission, Vision, Values, SFHRP and regulatory requirements. On an annual basis through the SFHRP process, key health care services and delivery processes (Figure 6.1-1) are reviewed and re-designed as necessary. This annual review is important in view of changing customer needs, environment and regulatory requirements. Some hospital services and processes are mandated by State and CMS licensing regulations and accreditation agencies (JCAHO). The need for services is also based upon customer focused studies, stakeholder input and community assessment data. The SFHRP has defined the key patient/customer segments as inpatient, outpatient and emergency services and five key health care processes:

ADMIT-ASSESS-TREAT-EDUCATE-DISCHARGE

These key processes apply to all of the identified patient segments. These processes contribute to improved health care service outcomes by organizing workflow that encourages a standardized, scientific approach to patient care. As a result, the patients routinely recover from an acute episode, learn about their illness and are prepared for discharge and out-patient follow-up. Although there is structure, the human, material and educational resources of the hospital have the agility to accommodate the special needs of patients. These processes also have measures (in-process and outcome) to ensure improvement of health care service outcomes. Finally, DPHC publicly reports in-process quality measures for the treatment of patients with acute myocardial infarction (AMI), congestive heart failure (CHF) and pneumonia (CAP). These three medical conditions are included in the top ten volume DRGs. Key service lines identified in the SFHRP are: cardiac, surgical services and oncology. Key health care services are determined in the Step 1-Identify Opportunity of the CQI Model (Figure 6.1-2).

6.1a(2) Determine Health Care Process Requirement

Key health care process requirements are determined from a variety of sources including: patient (key customer) feedback, community patient perception studies, regulations, accreditation standards, professional guidelines, medical literature and reimbursement mandates from insurers. Systematic feedback from patients and their families includes: focus groups, leadership rounding, survey responses and complaints (Figure 3.1-2). Survey responses are analyzed so that hospital leaders can identify and prioritize key requirements. Suppliers continually provide new technology and medicines that in turn necessitate revisions in service delivery methods and monitoring. In addition, every patient has a physician who orders the treatment and monitoring of his/her care. Therefore, the treating physicians establish process requirements for every patient in the hospital. The physician and supplier requirements are communicated through the methods identified in Figure 1.1-5.

The key requirements of all processes are that they be timely, effective, efficient, safe and patient centered (Figure 6.1-1). Effective health care is that which is accessible to all patients. Efficient health care focuses on waste reduction, including wait times. Safety includes expectations for practitioner competence defined in all job descriptions. In addition, safety includes an expectation that employees consistently deliver care according to policies, procedures and acceptable standards of practice. Finally, patient centered care is care directed at patient requirements and delivered with compassion and respect. These requirements are consistent with the 2001 Institute of Medicine's recommendations for improving health care quality. Identification of customer needs and expectations is addressed in Step 2-Current Situation of the CQI Model (Figure 6.1-2)

6.1a(3) Design Processes to Meet Requirements

When hospital leaders identify an opportunity to launch a new or modified health care process, the AC determines if this proposal meets organizational requirements and may apply the prioritization tool [Section 4.1b(2)] as appropriate. The proposal is then referred to the appropriate EC. The EC then appoints a new multidisciplinary PI team to obtain further information and develop a formal proposal for a new process or assign the task to an appropriate existing PI team for modification of a current process. Guided by the five quality principles (Figure P.1-1), ECs create teams to design health-care services and related delivery processes. A new team would need to submit a charter to the EC for approval (Step 1 of the CQI Model- Figure 6.1-2). All new services are required to link to the strategic goals and Mission.

PI teams incorporate the CQI/PDSA cycle and include sub-steps or questions that serve as checkpoints to ensure teams consider various requirements. The core of the CQI model is the Plan-Do-Study-Act (PDSA) cycle (Figure 6.1-2). This basic approach was modified by SSMHC in 1999 using a model from a MBNQA winner (Florida Power and Light.). This approach includes sub-steps or questions that serve as checkpoints to ensure process design or improvement teams consider, at a minimum, requirements such as customer expectations, safety, regulatory requirements, best practices, payor requirements, potential design problems and measurement systems. Outcomes, cycle time, productivity, cost control, efficiency and effectiveness are incorporated into the design of key processes through the team charter process and with feedback from the ECs, team leaders and key stakeholders.

New technology and organizational knowledge drive changes in current processes and creation of new service delivery models. Both physicians and staff are regularly updated about new treatments and devices as a result of membership in professional associations, medical publications, vendor contacts, conferences and best practice site visits. DPHC is part of a dynamic and competitive health care environment and therefore, also receives information from a variety of sources about technology at competitors. DPHC also benefits from experience of other SSMHC hospitals through active participation in

Health Care Processes	Measures		Key Requirements					Segment		
			Timely	Effective	Efficient	Safe/Accurate	Customer Focus	IP	OP	ED
Admission	Time to Transcribe H&P	(Figure 7.5-1)	X	X	X	X	X	X	X	X
	Registration Accuracy	(Figure 7.5-2)	X	X	X	X	X	X	X	X
	Time to Register Patient	(Figure 7.5-3)	X	X	X	X	X	X	X	X
	Total Admissions	(Figure 7.3-5)		X	X	X	X	X	X	X
Assess	Door to Doctor Treatment Time in ED	(Figure 7.5-6)	X		X		X			X
	Lab Turnaround Time	(Figure 7.5-4)	X	X	X	X	X	X	X	X
	Diversion Hours	(Figure 7.5-5)	X	X	X		X	X		X
Treat	Core Measure Scores	(Figure 7.1-1-4)		X	X	X	X	X	X	X
	Patient Satisfaction	(Figure 7.2-1)	X	X	X	X	X	X	X	X
	Inpatient Mortality	(Figure 7.1-5)		X		X	X	X		
	Patient Satisfaction with Pain Control	(Figure 7.2-2)	X	X	X	X	X	X	X	X
	Blood Utilization	(Figure 7.5-7)		X		X	X	X		
Educate	Smoking Education	(Figure 7.5-8)		X	X	X	X	X		
Discharge	Medication Discharge Instructions Completed	(Figure 7.5-9)	X		X		X	X	X	X
	Medicare Length of Stay	(Figure 7.5-10)	X				X	X		

Figure 6.1-1 Key Health Care Processes, Measures and Requirements

collaboratives, SSMSL committees, and telephone/in-person conferences. DPHC also participates in the nation-wide "Saving 100,000 Lives" Campaign sponsored by the Institute for Healthcare Improvement (IHI) which began early in 2005. This campaign provides recommendations for reducing inpatient mortality associated with several high risk conditions.

6.1a(4) Address/Consider Patient Expectations

Customer requirement expectations and priorities are integral to both the design and provision of services. During Step 2 of the CQI Model, customer needs and expectations are identified and addressed to ensure that requirements are incorporated into the new or modified service (Figure 6.1-2). This is accomplished by reviewing the sources of customer listening and learning tools (Figure 3.1-2). DPHC has patient ambassador volunteers who provide comfort measures in the ED, ICU, surgery waiting room and admitting area. When issues arise, they bring the patient's concerns directly to the clinical staff and unit director to address immediately. As a result of the Priority Index, DPHC has focused its bedside patient service efforts on the top two priorities: timely responsiveness to patient requests and pain control. These drivers are incorporated into the department goals and individual Passports on units that provide patient care.

On a daily basis, during the health care service delivery experience, a variety of methods are used to address patients' expectations and preferences, involve them in decision making and explain anticipated outcomes. These methods include:

- Patient rounds by staff and unit managers
- Patient is informed of likely risks and outcomes by the physician through one-on-one conversations and an informed consent process.
- Patient and family have input into the treatment plan and setting of goals.
- Initial and ongoing patient assessment determines patient preferences regarding spirituality, education, nutrition and pain management, as well as needs relating to other aspects of care.
- Clinical guidelines and standardized order sets "map" the plan of care, based on practice standards for specific diagnoses, procedures or patient types.
- Information about the operation of the organization is published on the DPHC website and in the patient admission handbook.
- Case management staff coordinate patient care across the continuum of care to facilitate timely delivery of appropriate services.

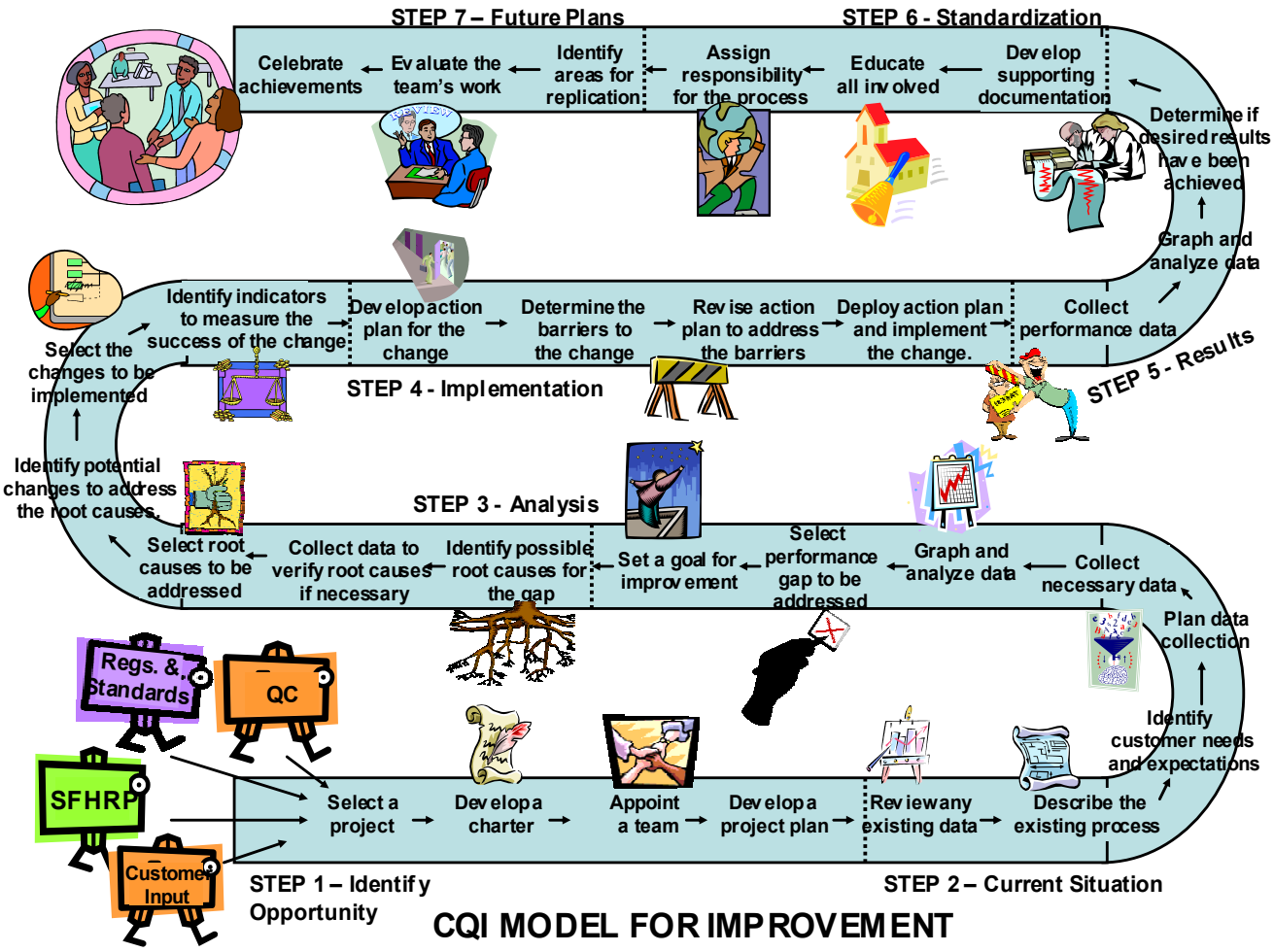


Figure 6.1-2 CQI Model for Improvement

6.1a(5) Key Performance Measures/Indicators

Key performance measures for health-care service delivery processes are listed in Figure 6.1-1. Additional measures are included in the DPHC PIR and the EC PIRs related to clinical outcomes, regulatory requirements, financial performance, patient/employee/physician satisfaction. These PIRs include a combination of in-process and outcomes measures. Departments also utilize in-process measures to manage healthcare delivery processes.

DPHC uses an organizational daily report that includes volume and revenue indicators to track daily operations. These measures selected by AC and EFC and tracked by the COO and department managers. These measures are aligned with the SFHRP and DPHC goals. Daily OPS is a process which measures productivity of departments on a daily basis with managers reporting departmental worked hours per unit of service (WHPUOS) to the COO. If budgeted and actual WHPUOS for any given day are not aligned, corrective action is taken immediately to adjust staffing levels and align the department by the end of the week. Daily hospital and ED capacity information is also distributed to leadership to better manage health care processes. This information helps managers identify opportunities to correct staffing inefficiencies on "real-time" basis. Since DPHC is consistently near its capacity on a daily basis, bed capacity status is communicated through an electronic paging system at several intervals throughout the day allowing managers to respond quickly to changes.

DPHC uses JCAHO's National Patient Safety Standards and CMS Core Measures to ensure patient safety and compliance with regulatory and accreditation requirements. The Risk Management OFI process also addresses these issues on a daily basis. Payor requirements are addressed by the Case Management Department and their processes with daily contact with payors. These in-process and outcome key measures are tracked by the ERC. Input is obtained from patients, physicians, suppliers and collaborators through the listening and learning tools listed in Figure 1.1-5. This information is reviewed by the ECs and AC and utilized to manage health care processes.

All processes have data gathering requirements that are aggregated at two levels. The first, and most important, level is the patient's response to treatment. Data obtained throughout the patient's stay are placed in the medical record. Forms and checklists in the record have been developed by multidisciplinary committees to ensure that key process requirements, including patient safety, regulatory, accreditation and payor requirements are routinely met. Real time patient, family and physician input is sought through continuous interaction with the staff and leadership throughout the patient's admission. The second level of review includes indicator data that is aggregated by department, area or diagnosis. These data are examined by the appropriate EC, department or AC. Regulatory and accreditation requirements are used in the design of new services and to modify existing services. These requirements are identified in the annual DPHC Performance Improvement and Safety Plan (PIPS).

6.1a(6) Minimize Costs of Inspections, Tests, Audits
DPHC minimizes costs associated with inspections, tests and audits by designing key measurement indicators into the process itself and by using standardized order sets, protocols and pathways; key indicators; and electronic data management. Validation processes are also included in key data collection processes such as the CMS Core Measures for AMI, CHF and pneumonia. Errors and re-work are prevented through the use of templates, checklists, standardized order sets and pathways. Policies and procedures are also utilized to reduce errors and costs of inspections, test and audits. These are stored electronically and can easily be accessed on-line. A number of committees also track safety processes and measures including the Medication Safety Team, Patient Safety Team, Risk Management and Sentinel Event Committee and the ERC.

DPHC employs comprehensive near-miss and sentinel event processes to expand prevention-based processes and approaches. Aligned with the core value that errors occur primarily because of a breakdown in processes, the near-miss process is a blame-free and allows staff to address process breakdowns in a collaborative fashion. In addition, DPHC is part of the SSMHC Achieving Exceptional Safety (AES) clinical collaborative, which focuses on implementing evidence-based processes to reduce medical errors and improve patient safety. To further prevent errors and rework, DPHC participates in the Catholic Health Audit Network (CHAN), which serves as an external audit function to ensure that the health center has effective processes in place to ensure regulatory compliance and to minimize risk.

6.1a(7) Improve Health Care Processes
CQI/PDSA is the methodology used to improve health care processes (Figure 6.1-2). Data driven decision making is a key component utilizing comparative information. Tracking of key measures relative to goals or benchmarks allows DPHC to identify opportunities for improvement. The ECs are responsible for commissioning new performance improvement teams or engaging current teams to address these opportunities. Utilizing benchmarks and best practices allows DPHC to keep current with health service directions. By continuously comparing and measuring work processes, DPHC gains valuable comparative and benchmarking information to improve performance. A list of key comparative data sources utilized are identified in Figure P.2-1.

DPHC keeps the performance measurement system current with the health care service needs and directions through the SFHRP, EC structure and data driven decision making with frequent reporting of PIR results. Continuous customer listening and learning strategies (Figure 3.1-2) also allow DPHC's performance management processes to change with changing customer needs. Other resources utilized to ensure DPHC sensitivity to unexpected organizational or external changes include the SSMHC Clincial Collaboratives, SSMSL Clinical Performance Improvement Center, the SSMHC Quality Resource Center and SG2. [Section 4.1.a(3)]. During the SFHRP, health care service needs and directions are reassessed, evaluated and prioritized. If, through this assessment, any modifications to the directions or needs of DPHC are identified, the performance measurement system is updated after discussion with senior leaders.

Reports from the DPHC PIR and the EC PIRs are reviewed by senior leaders and leadership monthly. Health care processes can be modified to achieve better performance and adjust to changing needs or directions. Meeting minutes, project reports, emails, department bulletin boards, public bulletin boards, monthly leadership meetings and staff meetings have been the most common approaches for transfer of learning. Data and information are made available to staff, partners, suppliers and patients through online applications accessed from desktop computers, automatic report distribution to network printers, electronic data interchange (EDI), hard copy reports delivered via interoffice mail, committee and team meetings, PDAs, pagers, fax machines and hard copy records (Figure 4.2-1). The annual DPHC Sharing Conference and annual staff Blitz days also provide sharing of lessons learned and innovation across the organization.

6.2 Support Processes
6.2a(1) Determine Key Support Processes
Support services are those that do not provide key health care services directly to patients and their families, yet are critical to organizational success. The Mission, Values, SFHRP, regulatory, key customer and operational requirements determine DPHC's support and business processes. Key business and other support processes and requirements are determined in the same manner as the key health-care delivery processes [6.1a(1)]. DPHC uses the CQI Improvement Model to manage and improve these processes.

Figure 6.2-2 identifies key business and support processes and the associated key measures. Figure 6.2-1 displays the Key Business and Support Process Management Matrix. Many of these processes are managed by leaders with reporting to DPHC, SSMSL or SSMHC. These services were integrated over ten years ago in order to reduce administrative costs and standardize services to entities within SSMSL or SSMHC. However, DPHC employees provide the day-to-day service to internal customers.

Support services routinely solicit feedback from their health care process customers in the form of direct telephone or written communication, focus groups as well as formal and informal surveys. In addition, AC and SSMSL/SSMHC senior leaders have direct input into both the provision of a support service and setting performance expectations to meet operational challenges. DPHC considers its physician partnerships and supply chain management processes essential to its business growth and achievement of strategies.

6.2a(2) Determine Key Support Process Requirements
Key business and support process requirements are determined by the AC, ECs and departments through CQI methodology that incorporates the key customer, partner and supplier listening and learning methods (Figure 3.1-2) and the organizational communication and knowledge sharing methods identified in Figure 1.1-5. including: customer surveys, reviews of accreditation standards, regulatory requirements, literature about best practices and performance relative to benchmarks. Written surveys are used annually to gather opinions and needs of key customers, stakeholders, business partners, physicians, suppliers and staff. The results are analyzed and goals are established to meet the ever-changing organizational and customer needs. A benefit of the dual-reporting of certain leaders is routine interaction with DPHC customers, SSMSL and SSMHC creating better effectiveness and alignment.

Since physicians are key partners, DPHC employees full-time and part-time physician leaders to manage medical staff functions. This includes are fulltime Vice President of Medical Affairs, part-time department chairpersons and multiple program medical directors. The physician perspective is well represented at AC and MEC. The Physician Services Department serves as a liaison for the medical staff and administration and also helps in physician recruitment and obtaining market information. This department provides invaluable feedback from physicians in the community about their expectations of DPHC with reports to senior leadership and to the ESC. The key requirements of all support processes are that they be timely, effective, efficient, accurate and customer-focused as listed in Figure 6.2-2.

6.2a(3) Design Support Processes
Business and support processes are designed and improved

Support Service	DPHC Manager	SSMSL Manager	SSMHC Integration
Information Systems	X	X	X
Clinical Engineering (Biomed)	X	X	X
Materiel Management	X	X	X
Credentials Verification		X	
Human Resources	X	X	
Occupational Medicine	X	X	
Financial Management	X	X	
Environmental Services	X		
Engineering Services	X		
Medical Staff	X		

Figure 6.2-1 Key Business and Support Process Management Matrix

to meet requirements using the same models and approaches as the health care delivery processes through multidisciplinary teams using the CQI Model. Process design begins with the recruitment of appropriate process owners, specifically employees, physicians and vendors, as appropriate. Key stakeholders are included in design teams as appropriate. See Section 6.1a(3) for the methods used to design and implement new processes, including the incorporation of new technology, organizational knowledge, improved cycle time, productivity, cost control, and other efficiency and effectiveness factors. New technology is introduced into the processes through vendors bringing new technology, SG2 participation, and site visits to best practices. Organizational knowledge is made available and kept current through the methods discussed in Sections 4.2a(1) and 4.2a(4) with information systems and business/support process leaders regular meetings with DPHC senior leadership. These processes address the potential need for agility through the SFHRP, Passport Process and department goals.

Inclusion of material management suppliers is critical to our Mission. SSMHC is an owner and participating member of Premier, Inc., one of the two largest health care group purchasing organizations in the nation. SSMHC derives significant economic benefit from this relationship with a 6-15% savings over prevailing market prices. DPHC's supply chain management process is designed to achieve economies of scale and reduced prices by consolidating purchasing and contracting with preferred suppliers. This supplier partnership enables SSMHC, DPHC and suppliers

Support/ Business Process	Measures		Key Requirements					Segment		
			Timely	Effective	Efficient	Accurate	Customer Focus	IP	OP	ED
Human Resources	Overall Turnover	(Figure 7.4-3)		X	X	X		X	X	X
	RN Employee Turnover	(Figure 7.4-3)		X	X		X	X	X	X
	Employee Satisfaction	(Figure 7.4-7)		X	X	X	X	X	X	X
	Performance Appraisal Timeliness	(Figure 7.4-9)	X	X	X	X	X	X	X	X
	Paid Hours per Adjusted Patient Day	(Figure 7.4 -1)		X	X	X	X	X	X	X
Physician Partnering	Medical Staff Growth	(Figure 7.2-9)		X	X	X	X	X	X	X
	Physician Satisfaction	(Figure 7.2-7)		X	X	X	X	X	X	X
Facilities Management	Patient Satisfaction with Cleanliness	(Figure 7.5-11)		X	X		X	X	X	X
	% Preventative maintenance completed as scheduled	(Figure 7.5-12)	X	X	X	X	X	X	X	X
Supply Management	Surgery Inventory Turns	(Figure 7.5-13)	X	X	X	X	X	X	X	
	Blocked POS in less than 45 days	(Figure 7.5-14)	X	X	X	X	X	X	X	X
Financial Management	Supply Expense per APD	(Figure 7.5-15)		X	X	X	X	X	X	X
	Discharged and Not Final Billed (DNFB)	(Figure 7.5-16)	X	X	X	X	X	X	X	X

Figure 6.2-2 Key Support and Business Processes, Measures and Requirements

to align their strategic goals. Formal contracts and quarterly business reviews define supplier requirements. SSMHC Materials Management sets goals to support SSMHC's strategic initiatives via an annual planning process. System-wide user groups, composed primarily of leadership, have been formed to provide customer input on supply needs, consensus on preferred products and clinical acceptability. The Supply Chain Management Process is managed through a multi-level materials management organization that coordinates SSMHC system-wide purchasing and maintains effective ongoing communication with internal customers as well as suppliers. SSMHC's materials managers meet every two weeks by video/teleconferencing to brainstorm new ideas, discuss strategy, review contract offerings, participate in supplier presentations, discuss distribution ideas and review supplier performance. Entity supplier contacts meet quarterly with SSMHC to conduct formal business reviews and planning sessions. The purpose of these sessions is to review performance; discuss reciprocal goals, requests and unresolved issues; and identify future business opportunities.

6.2a(4) Key Performance Measures/Indicators
Key performance measures and indicators are utilized to manage the key business and support processes (Figure 6.2-1) Performance measures include both outcome and in-process measures that are used by process owners to manage day-to-day process performance and to assess results. Performance measures are used to determine if business and support processes meet the key customer and operational requirements. Both are subjected to the SFHRP review process. Process owners use internal customer feedback from daily interactions as well as the annual employee and physician satisfaction survey results to evaluate and improve support processes. Patient care services, strategic initiatives, mission, quality improvement activities, customer satisfaction, benchmarking data and employee suggestions are also used to guide performance improvement efforts in support services. These results are shared with staff and used by leaders to guide ongoing improvement efforts.

6.2a(5) Minimize Cost of Inspections, Tests, Audits
DPHC minimizes overall costs associated with inspections, tests, and performance audits utilizing methods similar to health care processes as described in 6.1a(6), including standardization of processes and by consolidating distribution. Benefits achieved by standardizing and consolidating distribution include: delivery according to user needs, just in time inventory, vendor managed inventory and often vendor consignment. In addition, prevention-

based methods are utilized within DPHC to minimize costs associated with inspections, errors and re-work in key support processes. Methods include computerized edit/validation checks for billing, accounting and human resources; extensive preventive maintenance for clinical equipment; and proactive safety programs. By coordinating IS at a system level, DPHC derives the benefits of economies of scale and standardization, which help improve efficiencies, reduce errors and reduce rework.

6.2a(6) Improve Support Processes

The CQI Improvement Model is used to measure, manage, control and improve key business and support processes. Implementation of these processes is achieved utilizing the same methods as described for health care delivery processes in 6.1a(3) including action plans. Business and support process implementation also incorporates contracts, data performance reviews, department goals to ensure design requirements are being achieved. Variances are addressed utilizing a standardized action plan format.

DPHC evaluates, improves and keeps current business and support processes by developing measurement tools and responding to performance results. The DPHC and EC PIRs contain established thresholds of performance for multiple indicators. In-process measures are monitored based on established performance thresholds. A negative variance activates corrective action plans to the appropriate senior leader or EC using CQI methodology. Improvements and lessons learned are shared with other organizational units to drive learning and innovation through the same processes and communication strategies as identified for health care processes in Section 6.1a(7).

Premier provides an annual scorecard detailing performance and comparison to peers within the group purchasing organization. A scorecard was also developed by Cardinal, and SSMHC provides input from internal customers to measure the performance of Cardinal Distribution, Pyxis, Allegiance and SSMHC. Scorecards are reviewed at each quarterly network business review and planning session and with other key suppliers. Aramark performance is addressed through the appropriate DPHC department management processes.

6.2b Operational Planning

6.2b(1) Financial Resource Availability

Financial support of operations is ensured through the SFHRP described in Section 2.2a(1). DPHC's financial year begins in January. Strategic planning begins at the Board level every January and culminates in the development of preliminary goals, action plans and budget in June. Budgets are divided into capital and operational expenses according to the criteria established by Financial Services. Operational revenues fund operational expenses, whereas capital expenses and new business investments are funded by SSMHC. The AC and SSMSL balance the requests for funding operational and new business expenses against the projected revenue for the coming year. Budgets are finalized in November. Therefore, the budgeting process ensures that adequate resources are available to support expenses and any new business ventures for the coming year. Because DPHC is part of an integrated system of hospitals, both risk and financial gains are pooled within the system.

Once capital is allocated to DPHC, the funds are available for covering operational expenses according to the Financial Services policies and procedures and the CRP program. Those procedures allow for movement of funds within a cost center at the discretion of the leaders. Therefore, agility is provided even at the department level to meet changes in operations encountered during the current fiscal year. Any manager can make off-budget expenditure requests to the AC in the event of an unforeseen need that arises. Financial risks associated with new business investments are assessed by the operational leaders, EFC, AC and Financial Services in a series of meetings which always includes historical experience of other hospitals, product vendors (if applicable), and physician partners. The EFC ensures the adequate assessment of current business operations and risks and reports to the AC. This council is responsible for monitoring of department financial related goals, monitors the progress of PI teams, participates in the development of the SFHRP, approves/commissions financial improvement teams, and monitors the Budget Gap Rectification Plans.

6.2b(2) Continuity of Operations

In the event of an emergency, the continuity of operations is ensured by structured internal and external disaster plans. Disaster plans are required as a condition of participation for JCAHO accreditation and by State licensing regulations. Environmental hazard vulnerability analysis (HVA) are annually prepared and integrated into the disaster plan for the hospital. The results of the HVA lead to proactive contingency plans that focus on the most likely threats to operations. The changes to the plans and reminders are shared with the staff via routine newsletters, meetings and annual competency training.

In addition, DPHC has developed a Hospital Emergency Incident Command System (HEICS) as a supplement to the internal and external emergency plans. The HEICS system employs a resource guide, action plans and checklists for incident commanders (AC members) to use in the event of mass casualty incidents. AC members have had HEICS training. This system includes contact names and numbers for DPHC leaders, local community resources (fire, ambulance and law enforcement), SSM entity contacts and SSMSL senior leaders. Finally, DPHC is an active participant with forty-four other area hospitals who form the St. Louis Area Regional Response System (STARRS). Therefore, continuity of operations is assured not only for DPHC, but for all other hospitals in the immediate region.