St. Joseph A healing presence.

Three medical facilities.

One high standard of care.

St. Joseph

Health Center • Hospital West • Medical Park

Application for the 2005 Missouri Quality Award

CATEGORY 1 – LEADERSHIP

1.1 Senior Leadership

1.1a(1) SSM St. Joseph St. Charles (SJSC) is a Mission- and Values-driven organization. The organization is committed to providing exceptional health care services to every person who comes to SJSC in need of care. The culture is reflected in the Vision, Mission, Values and Quality Principles. The SSM Health Care (SSMHC) Board of Directors sets the organization's Vision Statement and affirms the Mission and Core Values statements developed with input from SJSC employees. The Board consists of nine members, both religious and laypersons, and meets four times a year. The SSMHC—St. Louis Regional Board operates under guidelines established by the SSMHC Board, and is responsible for medical staff credentialing and performance assessment and improvement. The Regional Board meets six times each year.

SJSC's senior leaders, called Administrative Council (AC) members, deploy the Mission, Vision and Values throughout the organization. They also set and deploy short- and long-term direction and standard performance expectations based on the Mission. This is accomplished through the use of department posters and employee Passports, new employee orientation, leadership meetings, Continuous Quality Improvement (CQI) teams, individual employee performance appraisals, quarterly Strategic and Financial Performance Improvement Process (SFPIP) reviews, daily in-process measures, and Town Hall meetings. Each SJSC employee develops a Passport – a card containing the SJSC Mission and Values, five key characteristics of Exceptional Health Care Services, key characteristics of National Patient Safety Goals, strategic initiatives and department and individual employee goals. The Passport links the individual employee's daily work to the department's goals and to the goals of SJSC.

The Passport is designed to generate two-way communication and align organizational initiatives with departmental and individual goals so that all personnel know the organizational direction and participate in the plan. It also sets the stage for employee development issues to be discussed between the leader and the Employee.

As part of the new employee orientation and ongoing use of Passports, employees receive training on:

- Mission, Vision, Values and discussion of SJSC Strategies
- Departmental goals and performance improvement link to Strategic Plan
- Passport
- Current organizational performance on key customer measures and implications
- ACES Customer Service Program
- Complaint Process (OFI)
- Confidentiality (HIPAA)
- Corporate Responsibility Plan (CRP)

AC members have identified and implemented additional means of communicating and deploying the Mission, Vision, goals, and performance expectations through annual in-service education, the *Spirit* newsletter, administrative rounds, and through medical staff, management and department meetings. SJSC uses the methods described above, and others, to communicate with staff and partners (Figure 1.1-1).

Leadership philosophy and performance expectations are fully deployed and published in the SSMHC Executive Leadership Handbook and guide the behavior of SJSC executive leaders. The expectations provide a standard for accountability and form the basis for learning through the Leadership Development Process. Senior leaders participate in a 360-degree evaluation process, receiving input regarding their behavior and management skills, and their commitment to the organizational values. The desired behaviors are based on the System's organizational values as well as the seven leadership expectations (Figure 1.1-2).

Seven Leadership Expectations
Superior results in clinical, operational and financial performance
Fact-based decision making
Involvement and shared accountability
Continuous quality improvement
Customer focus
Information sharing
Developing people

Figure 1.1-2 Leadership Behaviors and Expectations

Values, directions and expectations are communicated to key partners and suppliers. SJSC's physicians are key partners with some needs reflective of a customer, and communication occurs with Medical Executive Committee (MEC) members at meetings and with all physicians at department, house-wide and committee medical staff meetings. Communication with key suppliers occurs as part of the contract review process managed by SSMHC and SJSC, as well as through meetings.

1.1a(2) SJSC senior leaders promote an environment that fosters legal and ethical behavior by providing training during new employee orientation regarding 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 reporting approach is addressed in annual education, supported and discussed by department management at monthly department meetings and reinforced by Risk Management during the annual department visits. Annual education and discussions at monthly leadership and department meetings is used to continuously keep the issue of ethical and legal behavior in the forefront.

Key Communication Methods	Frequency	Audience
Site Visits by SSMHC President and Regional President	Annually	AC, Physicians, and Employees
SSMHC Link	Weekly	AC
Spirit newsletter	Biweekly	Employees, Physicians, Patients and Families
President/CEO Column published in *Spirit*	Biweekly	Employees, Physicians, Patients and Families
Making Rounds newsletter	Quarterly	Physicians
Executive Presentations at Orientations	Semimonthly	Employees
Mission Awareness Team	Monthly	Employees, Physicians
Showcase for Sharing Conference and Leadership Conference	Semiannually	Employees, Physicians, Suppliers
Ethics Committee	Quarterly	Employees, Physicians, Patients and Families
Medical Executive Committee (MEC)	Monthly	Physicians and Senior Leaders
Administrative Council (AC)	Monthly	Senior Leaders
Employee Councils	Monthly	Employees and Physicians
Town Hall Meetings	Semiannually	Employees and Physicians
Medical Staff Meetings	Monthly, Quarterly	Physicians
Leadership Meetings	Quarterly	Employees and Physicians
Department Meetings	Monthly	Employees and Physicians
Nursing Summit	Annually	Nurses
Clinical Collaborative Learning Sessions	Semiannually	Employees and Physicians
State of Safety Report, Risky Business, and Quality Tips	Quarterly	Employees and Physicians
Meetings in a Box or Toolkits	PRN	Employees and Physicians
Intranet and Intranet websites	Continuous	Employees, Physicians, Patients and Families, and Suppliers
Physician and Employee Satisfaction Surveys	Annually	Physicians and Employees
Patient Satisfaction Surveys	Continuous	Patients and Families
360-degree Performance Evaluations	Annually	Senior Leaders
Daily Ops Review	Daily	Senior Leaders and Leaders
Administrative Rounding	Daily	Senior Leaders and Employees
Supply Chain Communication User Meetings	Monthly	Suppliers, Leaders and Employees
Performance Appraisals	Annually	Leaders and Employees
Materiel Management Meetings	Annually	Leaders and Employees

Figure 1.1-1 Communication and Knowledge/Skill Sharing Methods

Senior leaders create a sustainable organization through various methods: strategic planning, which outlines and monitors the challenges, actions and measures; ensuring an environment for empowerment, innovation and organizational agility; a systematic, well-defined approach to process improvement; learning organization; well-defined organizational structure; collaboration with other health care organizations and identified best practices; and use of in-process and outcome measures to monitor performance.

1.1a(3) To create an environment for empowerment, innovation and organizational agility, senior leadership is focused on sharing authority, alignment and more formal processes for communication. These approaches include integrated leadership meetings, shared accountability, more emphasis on CQI and CRP, other quality collaboratives and benchmarking. For example, shared governance in the practice of nursing provides an organizational structure that gives nurses greater decision-making authority and overall accountability for nursing practice. It is an example of deploying decision-making to the immediate level of impact, and has contributed to a decrease in the nursing turnover rate.

SJSC's short– and long-term strategic directions and performance expectations are established through the annual Strategic, Financial and Human Resource Planning Process (SFHRPP) and deployed. Strategic initiatives are based on the Mission statement, and are consistent with SSMHC initiatives.

Maturity in understanding the Criteria for Performance Excellence as a business model — a focus on departmental measurement and empowerment of staff to make process improvements related to services that create value for patients and partners — has benefited SJSC in the improvement journey. As a result, SJSC has organized sharing of departmental in-process and outcome measures and customer satisfaction results, and sharing of information regarding the market and competitors. For example, the One Third/Two Thirds process, as well as identification of at least one best practice from the Learning Session approaches, allows SJSC to improve.

The culture also is characterized by an ongoing transformation to a learning organization and by inclusion and decision-making at the point of greatest impact. This is reflected in the organization's broad-based leadership system, which includes 13 executives from across the organization, making up the AC/senior leadership team. Since 1999, both the senior leadership team and leadership team (consisting of 109 directors, managers and supervisors from across the organization), have been following MQA/MBNQA criteria as a business model. Applying, receiving feedback and implementing improvements has been a driver in integration and standardization across all three facilities. SSMHC was awarded the first MBNQA in the health care category.

A well-defined organizational development structure is utilized to support leaders and senior leaders. This educational series includes values, customer service, diversity, empowerment, coaching, etc. It is tailored to the job function criteria and requires defined classes based on individual and position needs in order to foster an environment for organizational and personal learning. For example, diversity initiatives and learnings foster the organization's environment. Senior leaders personally participate in succession planning and development of future leaders through mentoring and coaching opportunities and serving as instructors in development sessions/classes.

SJSC is able to act with agility because both senior leadership and leadership fosters a culture of empowerment and departmental autonomy; invests in technology to provide timely information; and operates under a structure that allows decision-making at the level of greatest impact. SSMHC supports SJSC with various approaches that allow rapid change: Clinical Collaboratives; Information Systems/Decision Support; and the CQI/Plan-Do-Study-Act (PDSA) models. SJSC leaders model learning and innovation by being in the forefront of health care with the early introduction of CQI and systems thinking. In doing so, they have reinforced the organization's environment of empowerment, innovation, agility and learning. All levels of employees and leaders participate in CQI teams and require benchmarking against best practices. Those practices are adopted from within and outside the organization, and from health care and non-health care organizations.

In addition, SJSC collaborates with, and learns from, other health care organizations such as the Institute for Healthcare Improvement (IHI), and from other identified best practices such as the Glycemic Control Project. A SJSC physician initially identified this project in a national medical publication, and, after review, discussion and redesign, it was implemented at SJSC. Using CQI tools to drive incremental improvement, the project has resulted in reduced infection, complication and mortality rates. This practice was shared by SJSC at an annual SSMHC Sharing Conference at which 40-plus best practices across SSMHC were highlighted in breakout sessions. The practice now is being replicated throughout SSMHC. SJSC identifies and implements at least one best practice each year based on information shared at the annual Sharing Conference.

On an annual basis, each department director develops specific department goals and in-process and outcome measures to monitor department performance related to the SFHRPP, regulatory and accreditation requirements and other criteria. On a quarterly basis, the department directors formally report their data and improvement efforts to the SFPIP Team with representation from the Chief Operating Officer (COO), appropriate Vice Presidents (VP) and Quality Improvement (QI) Director. This allows SJSC to proactively anticipate changes in performances which may impact sustainability. Included

in this process is the directive to standardize and improve processes and performance across the organization. Key information from this process is shared at a quarterly Operations Meeting with the Regional VP, monthly Directors Meeting, AC and MEC. The purpose of this process is to share and promote organizational learning.

1.1b(1) Senior leaders use a variety of methods to communicate with, empower and motivate all staff throughout the organization. Various tools are used to facilitate communication as described in Figure 1.1-1. Employee satisfaction and physician surveys are an example of a formal method used by SJSC to understand the drivers of satisfaction. Annually, employees set their personal goals. Leadership focuses on empowerment by sharing authority through a shared accountability model which focuses on decisions being made at the point of greatest impact.

As AC members encourage frank, two-way communication with leadership, physicians and employees, emphasis is placed on creating value for patients, other customers and stakeholders (Figure 1.1-1). Two-way communication occurs at meetings such as Leadership, MEC, medical staff, Town Halls and during one-on-one conversations.

Senior leaders actively reward and recognize staff in Leadership Rounds, high-census free drinks, notes, employee of the month, annual pay increases and recognition of individual staff on a one-on-one basis. These rewards and recognitions reinforce high performance and supports an organizational focus on patients.

1.1b(2) A focus on the actions to accomplish SJSC's objectives, improve performance and attain vision is defined in the Strategic Financial Human Resource Planning Process (SFHRPP) and results are measured and monitored in SFPIP reviews. As part of this emphasis to create and balance customer/stakeholder value, the AC has focused on developing the organization's history and tradition, the long-term commitment to CQI, and current efforts to transform into a learning organization.

1.2 Governance and Social Responsibilities

1.2a(1) Senior leaders have established daily, weekly, monthly and quarterly reports to assess financials and organizational data. Senior leaders are held accountable to the Boards, Network, and System for operational and fiscal performance. Written reports, action plans and conference calls are used for reporting. If a greater than 5 percent year-to-date unfavorable variance occurs in any of the Key Characteristic Indicators, (Figure 4.1-1) a corrective action plan is developed and reviewed at the Monthly Operations Review.

SJSC addresses fiscal accountability through a daily productivity monitoring system called Daily Ops Review. Daily Ops Review utilizes a standardized hour/department statistic definition, which allows each director to determine the productivity of their department on a daily basis, and reports the measure to the COO at a specific time each day. This process allows the organization to assess overall productivity for each given day, and to make necessary adjustments in real time. A monthly budget variance review process is utilized by each director to report the department's performance as it relates to the budget. 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.

Review of the 50 Performance Improvement Report (PIR) indicators on a monthly basis allows identification of favorable (green light) and unfavorable variance (red light) for any one of these indicators. A red light requires development of an action plan by the appropriate senior leader who presents at the Quarterly Operations Review for discussion and approval. On a quarterly basis, the department directors formally report their data and improvement efforts to the SFPIP Team. All the process owners related to fiscal accountability meet within the timeframes defined with representation from the COO, other appropriate senior leaders and other specific team members.

SJSC addresses independence in internal and external audits through SSMHC – St. Louis 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 SSMHC – St. Louis, as well as SJSC, on an annual basis.

Protection of stakeholder interest is addressed through discussions held at MEC, medical staff meetings, Advisory and Auxiliary board meetings and community groups where senior leaders hold membership or leadership roles. SJSC is actively involved in the communities it serves and strong community support of SJSC is evident.

As the AC reviews and analyzes progress toward short-term goals by using the PIR and a monthly update on all action plans for the SFHRPP, actions are taken to improve performance and better address changing health care needs. SJSC addresses management accountability for the organization's performance by reviewing measures as they relate to SFHRP short- and long-term goals, and in meeting the changing health care service needs. Senior leadership assesses the organization's volume and financial operational performance on a daily basis, using an electronically broadcasted worksheet, as well as on a monthly basis using a location specific PIR.

SJSC's approach to achieving breakthrough performance assesses results relative to other SSMHC facilities through the use of a process called the One-Third/Two-Thirds (Comparative Ranking Report). If SJSC ranks in the bottom two-thirds of the 16 SSMHC hospitals, a

Key Characteristic	2004 Results
Patient Satisfaction – Willingness to recommend – Inpatient	SJHC-84.3% SJHW-86.5%
Patient Satisfaction – Willingness to recommend – Outpatient Surgery	SJHC– 91.3% SJHW- 93.6%
Patient Satisfaction – Willingness to recommend – Emergency Department	SJHC- 84.6% SJHW- 84.9%
Physician Satisfaction	SJHC – 74.7% SJHW- 76.4%
Employee Satisfaction	SJHC- 81.0% SJHW– 68.0%
Operating Margin	SJHC– 1.3% SJHW – 3.0%
Composite Core Measures: • AMI	SJHC — 96.0% SJHW — 96.0%
• CHF	SJHC — 94.0% SJHW — 82.0%
• Pneumonia	SJHC — 91.0% SJHW — 80.0%

Figure 1.1-3 Key Characteristic Indicators and Performance Review Findings

System hospital in the top one-third is benchmarked to determine how they are achieving these results. If SJSC is in the top one-third, a business with excellent performance is identified. SJSC also searches for best in class performance, both internal and external to SSMHC and inside or outside of health care, using this process. SJSC participates in evidence-based clinical collaboratives both internally and externally with SSMHC and IHI. Clinical collaboratives are key, team-based approaches for creating and balancing value for patients/other customers and stakeholders. These collaboratives are designed to make rapid improvements in clinical areas that provide better outcomes for patients, and may reduce costs as well. SJSC has, and continues to, participate in a variety of clinical collaboratives since 1999 including Improving Prescribing Practices, Enhancing Patient Safety, Ischemic Heart Disease, Congestive Heart Failure, Community Acquired Pneumonia, Achieving Exceptional Patient Safety, Achieving Exceptional Patient Care, and Intensive Care Unit. These SFHRP priorities and opportunities are deployed using a specific sanctioning methodology for CQI teams and/or by leadership directive as applicable. Information is communicated to leadership, partners and suppliers (Figure 1.1-1). The review findings drive the development of priorities for growth in acute admissions, market share and operating margin. SJMP was designed, developed and then opened in the second half of 2003, based on the SFHRPP and utilizing the CQI model.

1.2a(2) SJSC systematically evaluates senior leadership performance utilizing a 360-degree evaluation process and receives input regarding behavior and management skills on a 1 to 3 scale. The results drive the annual senior leaders' personal development plan to further identify opportunities to develop leadership skills. Opportunities for development include participation in professional and community organizations, development seminars, mentoring, leadership conferences and other educational sessions. Each senior leader customizes the survey with one or more questions designed to measure his or her particular area of development.

Performance of senior leaders is also evaluated through daily productivity analysis, monthly PIR performance, quarterly SFPIP results, annual Employee and Physician Satisfaction Surveys, Patient Satisfaction Surveys, year-end PIR performance, and individual 360-degree evaluations. Senior leaders use these findings to understand performance and, when appropriate, perform root cause analysis and base action plans on the analysis. SSMHC and SSMHC–St. Louis staff ask for a 360-degree evaluation from appropriate senior leaders, as well as become involved in various SJSC initiatives and meetings where feedback can easily be shared. The Governing Boards perform an annual assessment which is shared with the Board and the organization to support improvement.

1.2b(1) SJSC addresses the impact of health care services and operations on society by assessing community needs through the use of data and focus groups, as well as participation on the Healthy Communities St. Charles County Advisory Board. In

addition, stakeholders' suggestions, regulatory compliance reviews and inspections also are used to assess how services and operations impact the communities served. They are submitted verbally or in writing, and are used by leaders and committees. Environmental and employee focused issues are reported and addressed by the Safety Council and patient safety related issues are addressed by the Achieving Exceptional Safety Collaborative Team. The Safety Council is an interdisciplinary team with membership that includes organizational leaders, physicians, employees, patients and key community representatives. Other issues are addressed by members of the AC. SJSC's key processes, requirements and measures are defined and goals are established (Figure 1.2-1).

SJSC addresses regulatory, legal, and accreditation requirements through participation in Joint Commission on Accreditation of Healthcare Organizations (JCAHO) survey process: Corporate Responsibility Process (CRP) to ensure ethical business practices; Health Insurance Portability and Accountability Act (HIPAA) process; contract review process; and risk management (RM). SJSC AC, MEC, and the 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 (Figure 1.1-1).

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 for improvements as defined in the Performance Improvement/Patient Safety Plan (PIPS). Trending data is shared monthly with leadership.

CRP identifies and investigates events that ethically or legally impact the organization. Key risk reduction strategies include risk management 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 SJSC 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. Most AC members subscribe to the *Health Care Advisory Board* publications and, when appropriate, attend the conferences and seminars related to changing health care trends and opportunities.

SJSC proactively addresses public concerns with current and future services and operations by conducting focus groups, holding meetings and discussions with the SJSC Advisory boards, participating in community organizations and holding leadership roles in the organizations, utilizing CQI teams, participating in clinical collaboratives

Requirements	Key Processes	Measures	Goals
Regulatory/Legal	• CRP • Regulatory Reviews/Inspections • HIPAA	• CHAN Audits • Visits by Regulators • HIPAA Complaints	• 0 Compliance Issues • 0 Regulatory Issues • 0 HIPAA Issues
Accreditation	• JCAHO Survey	• Survey Scores	• >93% with no Type 1s
Risk Management (RM)	• Employee Safety • Employee Safety (Incidents/Error Prevention)	• OSHA Reportable Incidents • Lost Time Injuries • Dangerous Abbreviations • Hand Hygiene	• 0 • 2.5 per 100 FTEs • 4 percent • 100 percent
Community Health	• Charity Care • Healthy Communities Programs	• Cost of Charity Care • Senior Services	

Figure 1.2-1 Key Requirements, Processes, Measures and Goals for Public Responsibility and Ethics

and re-viewing appropriate data and information. For example, in 2001, SJSC addressed compliance with the new privacy and security rules regulated under HIPAA. A baseline walk-through analysis was performed to understand the potential opportunities for improvement. A team was formed to lead each location, work plans were developed, standardized policies and procedures were implemented and initial education was conducted. On a continuing basis, standardized policies and procedures are revised and/or implemented, walk-throughs are conducted and standardized annual education is required to ensure continued compliance.

1.2b(2) SJSC fosters an atmosphere that creates a legal and ethical environment. All employees are required to participate in standardized education that addresses ethics, risk and CRP. This standardized education is provided at new employee orientation and then annually. In 1998, CRP was designed and implemented to address the requirements associated with regulatory, legal and ethical compliance in delivering health care services. Key elements of the process include standardized policies and procedures; ongoing legal opinions which are distributed electronically to the appropriate leaders; Help Line for reporting; training for employees, physicians, volunteers, and key vendors; formal reporting mechanisms to ensure policies are strictly followed; swift process for monitoring and responding to breaches; CRP contact person; annual conflict of interest procedure, corporate oversight and quarterly reports; Core CRP Team; and internal audit functions. Key processes and indicators of ethical behavior are defined (Figure 1.2-1).The CRP aligns with the elements of the national Office of Inspector General's (OIG) model compliance plan. KPMG conducted a System-wide audit in 2000, and identified SSMHC's CRP model as a best practice nationwide. The Catholic Healthcare Audit Network (CHAN) provides a staff person to routinely review process and procedures and provide independent feedback on the legal and ethical results of the organization.

SJSC'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. SJSC's contract review coordinator reviews 100 percent of all contracts. Those that deal with managed care or human resources are reviewed by staff specializing in those areas. The System contracts with a law firm that reviews 5 to 10 percent of high-risk contracts. Specialty Counsel Coordination Protocols assist in managing legal and regulatory compliance.

1.2c Consistent with the Vision, Mission, Values and culture, SJSC has identified improving the health of the community as an area of emphasis. The SFHRPP is used to identify goals and initiatives around the area of community health. In 2004, $8.6 million was provided to the community in the form of charity care. As one of the largest employers in the community, SJSC sponsors and/or participates in many community events such as the heart and cancer walks, wellness screenings and health fairs, as well as providing support groups for various illnesses and diseases. Events SJSC participated in were identified and selected based on criteria which includes demonstrated community need, as well as relativity to the Mission and the services provided. Senior leaders and staff are members and/or have assumed leadership roles in various community events or organizations.

Key communities are identified by a review of data regarding the primary and secondary service area and the needs of the residents. The emphasis for organizational involvement includes providing the *only* trauma services, *only* open-heart surgery service, *only* prenatal and pediatric clinics, *only* maternal fetal medical services, *only* senior services clinic, and *only* dental clinic in the three-county area. Data are monitored regarding these services. SJHC recently was recognized by a national health database reporting organization as the only performer in Missouri to be so recognized for Patient Safety and Clinical excellence, as well as for Cardiac Care. SJHW also was recognized for Pulmonary Care. The Senior Service Dental Clinic has received grants and awards for the services provided to a vastly underserved population.

CATEGORY 2 – STRATEGIC PLANNING

2.1 Strategy Development

2.1a(1-2) The SJSC planning process is aligned with the System SFHRPP. It combines direction setting, strategy development and deployment, human resources and financial planning. Through this process, SJSC is involved in a three year (long-term) planning horizon with annual updates (short-term) to the plan. The SFHRPP integrates quality principles and stresses planning as a way of learning and proactively anticipating patients' expectations, as well as market opportunities. The process ensures that strategic goals and objectives are clearly oriented toward performance improvement and alignment with the mission of SJSC.

Experience has taught SSMHC that three years provide optimal time to implement, fully deploy and realize the results of its strategic initiatives across the System. Because of the rapidly changing environment, each year SJSC and other SFHRPP participants across the System study and validate the focus on patients, other customers and markets, information and analysis, staff focus, measurement, analysis, knowledge management and process management. SFHRPP steps are summarized at the System, Network, entity and departmental levels. At times during the SFHRPP, these steps occur concurrently.

The SFHRPP begins in December at the System level when the Vision Statement, established by the SSMHC Board, is reviewed. The Vision and Mission statements serve as the foundation for the planning process. In February, the Innsbrook Group assesses key challenges, reviews comparative data and sets the System-

wide goals for the next three years, using the Vision and Mission Statements as a framework. To ensure alignment and integration between the System and campus, the Chief Executive Officer (CEO) of SJSC is a member of the Innsbrook Group.

In March, a Governance retreat is held for the System, Network and local board members to provide an opportunity for input into the three-year plan. As SJSC does not have a local board, the SSMHC–St. Louis board members represent the organization. At the System level, during April and May, Corporate Office departments such as finance and human resources, and divisions such as the SSMIC and Materials Management (which provide centralized services for the entities and networks), establish their plans and accompanying budgets. These department and division plans and budgets are consolidated in the Corporate Office and Information Center plan and determine the annual corporate fees to be paid by the entities.

In late May, the System provides SJSC with a submission packet with standardized forms and definitions to ensure a consistent format and alignment of network and entity plans with SSMHC goals.

Beginning in March and continuing through June, SJSC conducts an internal and external assessment based on the minimum data set requirements. This assessment is completed every three years as part of developing the SFHRP, and is validated annually. Data and information from a variety of internal and external sources are integrated to form the minimum data set. (Figure 2.1-1) The Area Director of Strategy & Business Development at SJSC coordinates the gathering of the information from various sources, such as patient, medical staff and employee satisfaction survey results, regulatory, suppliers, technology input, competitive data, state data on hospital utilization, market research, financial reports and the PIR. This information provides the assurance that a comprehensive analysis has been conducted of those key elements impacting SJSC.

In July, Corporate Planning distributes the Final Plan Assumption Guidelines to SJSC. These guidelines ensure the consistent use of financial and economic assumptions across the System in preparing the strategic plans. The assumption guidelines also contain information that affects SJSC, such as centralized service fees.

The AC utilizes the minimum data set to determine SJSC's strengths, weaknesses, opportunities and challenges relative to market position and growth in the market, as well as to identify gaps between current and desired performance levels. The dialogue occurs offsite as a strategic planning retreat. As part of this process, the AC establishes SJSC's three-year strategic plan or SFHRP to support the exceptional health care service goals defined by the System for SJSC.

This year, SJSC is in the first year of its 2005 – 2007 SFHRPP cycle. In 2004, SJSC participated in a 10-year strategic planning effort called the 2014 Project along with other SSMHC entities. The purpose of the 2014 Project was to evaluate long-term sustainability of each entity by modeling capital investment needs and financial projections for the next 10 years. This work established broad strategic positioning and a foundation for capital investment and financial performance expectations for SJSC for the next 10 years and served as the foundation upon which the 2005-2007 SFHRP was built.

2.1b(1-2) SJSC has identified strategic challenges, strategic objectives, examples of action plans, key indicators, and benchmarks as part of its SFHRPP. The strategic objectives are based on the characteristics of exceptional care. By defining exceptional health care characteristics, SSMHC has more explicitly linked its key strategic objectives to the Mission Statement and created goals which are explicitly tied to the Mission Statement. This has been a significant breakthrough for the organization. For each goal relating to the key indicators for the five characteristics of exceptional health care (inpatient satisfaction, physician satisfaction, employee satisfaction, unexpected readmission rates, and operating margin), SJSC compares its performance to that of other SSMHC hospitals systematically (Comparative Ranking Report).

As described earlier, strengths, weaknesses, opportunities and challenges are evaluated during the SFHRPP. Overall strategies and supporting action plans are designed to address the organization's key challenges.

SJSC divides its primary/secondary service area into five sub-markets. As part of its strategic planning process, the AC reviews demographic trends, utilization trends and competitor activities for these markets and defines market-specific strategies and priorities. For instance, the Central St. Charles County sub-market has the largest population base and has seen the largest absolute population growth. It is where SJSC's strongest St. Charles competitor is located. In addition, a large number of residents in this portion of the county seek care across the river because of ease of access to the I-40/64 corridor. In response, SJSC opened the 100,000-square-foot SJMP in 2003. SJMP is an ambulatory center with a full array of outpatient diagnostic and treatment modalities, in addition to primary and specialty care physician offices.

The second priority sub-market is Western St. Charles County, where SJHW is located, and which is seeing the greatest rate of growth. It is projected to exceed the Central sub-market in size in the next five years. Once the SJMP was funded, SJSC kicked off a master facility plan for the SJHW campus which included a new ED and a second MOB. Now under construction is a new patient tower which will expand surgery and inpatient beds. In an environment where patients, physician partners and

employee stakeholders have choices and increasing expectations, focus on their satisfaction and resulting loyalty is crucial. Declining reimbursement and ability to reinvest in the campus are addressed through specific revenue and expense action plans designed to drive the operating margin.

2.2 Strategy Deployment

2.2a(1) After setting goals and objectives, SJSC defines strategies and action plans with key clinical outcomes and safety measures, financial performance and satisfaction to support the three-year goals. The action plans include key milestones in implementation, champions, completion dates and capital requirements. These plans are approved by AC and tracked by the designated champion. The plans are finalized by allocating resources to support achievement of the goals and objectives. The Capital Allocation Process represents a system level approach to capital disbursement. The Operations Council (nine senior leaders, a subset of System Management), determines the maximum amount of available resources that may be spent on capital expenditures falling into the "over $500,000" category and falling into the "under $500,000" category.

For capital needs that exceed $500,000, SJSC completes a standardized Capital Project Application Form (CPAF) and submits it to Network leadership and the Corporate Office. For strategic projects, the CPAF includes an implementation timetable, strategic analysis, volume and market share projections as appropriate, financial projections and human resource requirements

External Sources	Internal Sources
Customer Information • Patient satisfaction survey results • Market share by product line and by sub-market • Patient origin analysis • Patient focus groups	**Medical Staff Analysis** • Medical Staff Satisfaction Survey results • Physician supply and demand assessments by specialty • Other physician listening and learnings
Demographic/ Socioeconomic • Population trends by sub-market • Population-based use rates • Major industries • Household income	**Product Line Analysis** • Profitability analysis • Market size projections • Consumer perception of key product lines • Health Care Advisory Board and SG-2 (consulting) product line trend analyses
Competitor Analysis • Inventory of competitors • Competitor market share trends • Competitor investments • Competitor intelligence	**Physical Plant/Technology** • Technology assessment • Facility assessment • Regulatory requirements • Department capital requests
Technologies/Trends/ Growth • Health Care Advisory Board and SG-2 technology analyses • Information Management (IMC) plan • Literature reviews	**Human Resources** • Employee satisfaction survey results • Market analysis of compensation and benefits • Turnover rates • Diversity of management and workforce • Employee council
Payor Analysis • Inventory of payors • Payment rates • Distribution of patients' utilization	**Financial Analysis** • Net revenue per APD • Expense per APD • Operating margin • Payor mix trends • Agency staff costs • Supply expense per APD • Utilization assumptions
Public Policy/ Accreditation • Federal and state legislative and reimbursement trends • JCAHO, state and other regulatory standards	**Clinical Quality Analysis** • Regulatory survey feedback • SSMHC Clinical Collaborative results • Department SFPIPs • Core Measures (public reporting)

Figure 2.1-1: Examples of External and Internal Data Collected for the Minimum Data Set

as appropriate. System finance and planning staff analyze CPAFs to ensure that the project is strategically and financially sound. The Council prioritizes projects based on the strategic and financial benefit to the system as a whole. Approved projects are communicated in an approval letter to SJSC's CEO. Based on the capital allocation, baseline volume and financial projections in the plan are adjusted, as appropriate.

SJSC allocates capital which is under $500,000 based on investments that are linked to the strategic plan, on routine replacement needs and on identification of patient safety or new regulatory requirements. Capital needs under $500,000 are identified and prioritized by department managers and submitted to SJSC Finance for compilation. Each month, the SJSC Capital Priorities Team, a subset of the AC, meets to allocate capital Campus-wide for the month.

Once SJSC finalizes the entity SFHRP, it is submitted to Network planning, finance, and HR staff for review. Once the plan is approved at the Network, it is submitted to Corporate Office for System Management final approval. The SSMHC Board reviews the System's overall financial plan and the entities' strategies for approval. The SFHRP is reviewed by the SSMHC Board in December and the SSMHC president/CEO communicates approval to SJSC's CEO via letter.

Once the SJSC SFHRP is completed, the SFHRP is deployed to the department level. SJSC has a systematic process for deploying its SFHRP, which has gone through many cycles of improvement. Leadership attends a special session to review the System and SJSC goals. This presentation includes guidelines on the establishment of measurable department goals and objectives that are tied to key SJSC objectives across all three locations. Each manager then develops a SFPIP, which includes department goals and objectives, action plans for achieving the objectives, completion dates and team leader assignments, as well as finalizes his/her annual operating budget. The department goals and objectives are visibly displayed on a poster within the department. To reinforce clarity and focus, each department posts graphs, which display trended monthly patient satisfaction results for the department on a "We Care" board, and other results quarterly on a Quality Board so that all employees in the department can see progress in achieving department goals and objectives.

Once departmental goals and objectives are established, SJSC uses its Passport program to deploy strategic goals and objectives and action plan goals to all employees. Department managers meet with their staff as individuals, or in a group setting, to establish personal, measurable goals which are aligned with the entity and department plans. For example, SJSC has an organizational goal related to Inpatient Willingness to Recommend. The key drivers of an inpatient's willingness to recommend include pain management and responsiveness. At a nursing unit level, for example, goals would define expectations of call light response or consistent use of the pain scale for pain assessment. A nurse on the unit, for example, would define personal goals as *Is there anything I can do for your before I leave the room* or *I will assess pain for every patient once per shift*. Passports are reviewed at each individual's performance evaluation and attached to the evaluation to promote accountability and linkage to performance expectations.

2.2a(2-5)b Sample short (one-year) and longer (three-year) term action plans, performance measures and available benchmarks are provided (Figure 2.2-1). The action plans are high-level descriptions. Detailed action plans are not provided due to space limitations. The campus action plans have assigned champions and provide key activities designed to achieve the goals. Departmental and individual goal alignment is achieved through department SFIPIPs, posters and the Passport program. The department goals are reviewed by AC members for alignment, measurability and approval. Further, as the Passports are signed by each individual's direct report, SJSC leadership knows that goal deployment and personal goal alignment is achieved. On an annual basis, the President/CEO of SSMHC and President/CEO of SSM Health Care–St. Louis visit the SJSC campus. During this visit, these leaders review the departmental goals/objectives with managers and their staff. They ask the staff members to explain their department and individual roles in fulfilling the campus' goals and Mission. Often both leaders will ask staff to share their Passport goals. Feedback from this site visit further confirms successful strategy deployment for the SJSC leadership.

As part of the SFHRPP, HR needs are determined as they relate to the action plans identified within the SFHRP. Increases and decreases in FTEs, skill mix, job reclassification and retraining requirements are assessed for each action plan. Costs associated with training and recruitment are accounted for within the budget process at the SJSC. As part of SJSC's efforts to improve nurse skill mix competencies, $150 per nurse was added to the 2005 operating budget to provide appropriate skills training and enhance shared accountability.

Key indicator progress is monitored through daily review of in-process measures, through monthly review of PIR and quarterly review of department SFPIPs. Examples of daily in-process measures include the reporting of 1) worked hours per day to monitor productivity, admissions, average daily census, ED visits, outpatient visits and gross revenue, which are key drivers of operating margin, and 2) percent of time ED patients have treatment initiated within 30 minutes, a key driver of patient satisfaction. Each quarter the SJSC AC meets with the Executive VP of Network Operations to review the PIR and to discuss action plans related to SFHRP implementation. AC meets quarterly to discuss critical success factors in implementing the SFHRP. Department

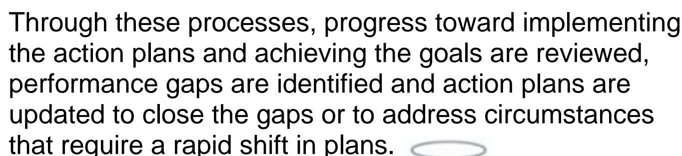
Strategic Challenges	Strategic Objectives	Examples of Action Plan Focus	2004 Actual	2005 Goals	2006 Goals	2007 Goals	Benchmarks
Growing consumer, payor and regulatory emphasis on patient safety and clinical outcomes	Exceptional Clinical Outcomes - • AMI • CHF • Pneumonia Core Measure Composite Scores	• AMI: Increase ACEI for LVSD to 93%	SJHC: 96.0% SJHW: 96.0%	SJHC: 96.10% SJHW: 96.43%	SJHC: 96.10% SJHW: 96.43%	SJHC: 96.10% SJHW: 96.43%	All are CMS Premier Demonstration Project best practices: AMI—96.04% CHF—99.84% Pneumonia—96.01% (external benchmark)
		• CHF: Increase LVF assessments to 97.1%	SJHC: 94.0% SJHW: 82.0%	SJHC: 99.87% SJHW: 84.98%	SJHC: 99.87% SJHW: 95.50%	SJHC: 99.87% SJHW: 86.0%	
		• Pneumonia: Increase pneumococal screening and/or vaccine to 73%	SJHC: 91.0% SJHW: 96.0%	SJHC: 96.03% SJHW: 96.16%	SJHC: 96.03% SJHW: 96.16%	SJHC: 96.03% SJHW: 96.16%	
Growing Customer and Stakeholder Expectations Nursing and Other Health Care Professional Shortage	Exceptional Patient Satisfaction (Willingness to Recommend Score)	• Increase IP satisfaction with responsiveness • Increase IP satisfaction with pain control	SJHC: 84.3% SJHW: 86.5%	SJHC: 87.6% SJHW: 87.8%	SJHC: 90.6% SJHW: 90.7%	SJHC: 93.5% SJHW: 93.5%	93.5% is Press-Ganey Means & Ranks 99th percentile (external benchmark
	Exceptional Physician Satisfaction (Physician Satisfaction Score)	Implement fast-track teams to improve: • Scheduling • Pre-cert • Registration • Facility Access • Test Reporting	SJHC: 74.7% SJHW: 76.4%	SJHC: 78.8% SJHW: 78.8%	SJHC: 82.4% SJHW: 82.4%	SJHC: 83.7% SJHW: 83.7%	86.4% is high score for the SSMHC entities (internal benchmark)
	Exceptional Employee Satisfaction (Employee Satisfaction Score)	• Increase retention and recruitment with emphasis on shortage groups; implement shared accountability model	SJHC: 81% SJHW: 68%	SJHC: 83% SJHW: 74%	SJHC: 86% SJHW: 78%	SJHC: 89% SJHW: 83%	89% is HR Solutions National normative Data 99th Percentile best in class performance (external benchmark)
Increasing financial pressures, including capital investment requirements and declining reimbursement	Exceptional Financial Performance (Operating Margin)	• Increase volume by implementing ambulatory development and MD recruitment plans	SJHC: 1.3% SJHW: 3.0%	SJHC: 2.75% SJHW: 3.96%	SJHC: 4.50% SJHW: 5.48%	SJHC: 4.95% SJHW: 6.19%	2.8% is 2004 Composite "AA" Midpoint (external benchmark)

Figure 2.2-1: Strategic Challenges, Objectives, Examples of Action Plans, Key Indicators and Benchmarks (Excerpted from SJSC 2005-2007 SFHRP)

managers review their SFPIP's quarterly with an AC member and the Director of QI.

Performance against competitors is monitored through various qualitative and quantitative methods and then action plans are developed as appropriate to address. For example, in 2004, we experienced a decline in outpatient diagnostic service volumes. Through qualitative feedback from physicians and staff focus groups, as well as from our physician satisfaction survey, we identified gaps in services, especially compared to freestanding providers. As a result, an Exceptional Growth Initiative (EGI) was undertaken with teams developed around identified issues.

Through these processes, progress toward implementing the action plans and achieving the goals are reviewed, performance gaps are identified and action plans are updated to close the gaps or to address circumstances that require a rapid shift in plans.



CATEGORY 3 - FOCUS ON PATIENTS, OTHER CUSTOMERS AND MARKETS

3.1 Patient, Other Customer and Health Care Market Knowledge

3.1a(1) SJSC has defined patients and their families as its key customer group. SJSC further delineates this customer group into categories based on site of care: IP, OP and ED. Physicians are SJSC's key partner group with some needs reflective of a customer. Customer groups and their associated requirements, expectations and preferences are determined through surveys, "We Care" feedback, OFI's, focus groups and other listening and learnings. The SFHRPP uses environmental scanning to identify potential customers, customers of competitors and future markets. The minimum data set (Figure 2.1-1) 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 monitor data from Medical Staff surveys and physician contacts, and conduct web-based and literature searches. Collaboration with area nursing homes, participation in civic and community activities by employees and staff, focus groups, and a hotline for patients and visitors provide additional opportunities to learn of potential customers. This data is shared with the AC and included in the SFHRPP.

SJSC determines market segments primarily by patient type (IP, ED, ASC vs. OP) and product line. Gender, age, DRG (see Glossary), primary payor and physician also are analyzed. During the SFHRPP, market segments that are prioritized for growth and improvement are determined. The SFHRPP includes an internal, as well as an environmental and market, assessment.

3.1a(2) Multiple tools (Figure 3.1-1) are used to differentiate the requirements, expectations and preferences of customers. One tool SJSC utilizes to identify customer requirements is patient satisfaction surveys. Data from these surveys is aggregated and analyzed against factors most closely correlated with patient loyalty. The tool used to analyze these requirements is called the Impact Analysis and the results are updated biannually. Other methods to determine individual requirements include comment cards, complaints and patient call-backs. SJSC refined its ability to identify inpatient priorities and preferences in 2000 through the use of Di-Diver™ software, which facilitates detailed segmentation of patient satisfaction data. This data is merged with patient Trendstar data which provides segmentation by race, gender, age, DRG, primary payor and physician.

Patient and other satisfaction results are utilized in determining strategic initiatives and in setting performance improvement efforts at an organizational and departmental level. On a semiannual basis, the Corporate planning staff provides correlation analysis of key system-level indicators to further define which indicators strongly correlate, positively or negatively with IP loyalty. The key measures have been stated consistently as Pain Management and Nurses Respond Quickly.

Other listening and learning tools are used to determine, as well as define and differentiate, the requirements, expectations and preferences of former, current and potential customers (Figure 3.1-1). To ensure that customer needs are addressed in the design of new services, and management of existing services, teams utilize the CQI model. In the Process Design Approach, the second step of the process requires Customer Needs Analysis (CNA). The CNA serves as the foundation upon which the newly designed process will be based. The Process Improvement (PI) approach of the CQI model assesses whether customer needs are being met.

3.1a(3) To keep listening and learning methods current with changing health care needs including changes in the health care marketplace and directions, the Corporate planning and SJSC QI and strategic planning departments evaluate the patient satisfaction surveys and assess and improve the robustness of other listening and learning methods as a part of PDSA on an annual basis through:

- validation of survey questions for relevancy and validity via SSMHC Corporate Planning
- web-based research
- monitoring regulatory guidelines
- input from directors and staff
- assessment of effectiveness of customer needs determination processes by matching benchmark processes with current performance.

Effective with the discharges of April 2005, our survey vendor was changed to Press Ganey to allow more timely reporting of results, ease of reports, and ability to identify a benchmark comparison peer group to facilitate identification of improvement opportunities. The selection process involved a systematic review of various vendors, and using our CQI process, Press Ganey was selected.

3.2 Customer Relationships and Satisfaction

3.2a(1) SJSC recognizes that physician referrals are the primary source of patient customers. Physicians also have an essential role in meeting the key customer requirements of patients and in improving clinical outcomes. The physician/partner relationship, therefore, is considered critical to the organization's success. SJSC has identified that physicians are partners with customer-like requirements. The Exceptional Growth Initiative (EGI) is based on listening and learnings from focus groups of physicians and office staff. More than 100 opportunities have been identified and using a very systematic, well-defined process, the issues are being addressed by appropriate subteams with a defined measurement and communication process. To date, our physicians are recognizing these efforts with volume growth.

Physician relationships are a critical factor of all five key characteristics. Physicians serve in leadership roles in the organization, are involved in process improvement teams, are communicated with regularly, are involved in the SFHRPP, lead and participate in clinical collaboratives, and are involved in marketing plans.

SJSC's key customer requirements are those factors determined by Impact (regression) Analysis of patient satisfaction data to most strongly impact patient loyalty as measured by willingness to recommend. The SSMHC planning staff provides monthly reports that depict trends and gaps between current performance and inpatient loyalty goals for each entity. To build patient relationships, SJSC continuously monitors customer requirements and our performance, and takes action to improve areas of dissatisfaction identified through listening and learning tools (Figure 3.1-1).

SJSC relationship building initiatives include: ACES (Attitude + Commitment = Exceptional Satisfaction); Community health education classes; customer service recovery by employee empowerment at the point of contact; mission outreach efforts such as "Adopt a Family" at Christmas; support groups; e-health information; health fairs; individual patient care and education; follow up phone calls to patients; health tips shared with the community via television, radio and newspaper; opportunity to communicate with Leadership; AC rounds; manager rounds; access to necessary health care regardless of ability to pay; web site; patient ambassador program; senior service initiatives; and Ethics Committee. On a monthly basis, all appropriate directors receive a report of their department performance in order to make improvements to better meet patient expectations.

Informal methods for surveying and assessing customer needs include discussions with staff who interact with patients and their families; executive leader visits with patients; participation in community organizations; input from volunteers and advisory board members; and suggestions from medical staff members on behalf of their patients.

Patients and Families	Key Requirements
• Inpatients	• Responsiveness, Pain Management
• Outpatients	• Wait times, Pain Relief
• Emergency Department	• Wait Times, Pain Management

Figure 3.1-2 Customer Requirements & Service Standards

3.2a(2) Customer requirements for contact are determined through various methods (Figure 3.2-3). The 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 said that the wait time from time of arrival to initiation of care was a dissatisfier for them. Based on that input and using the CQI model, the ED Steering Team developed and deployed the Excellence in Response, or 30/30, program, which has resulted in improved patient satisfaction and volume growth for both SJHC and SJHW. The organization's ability to manage and meet customer requirements is deployed and measured using each department's annual SFPIP. There is a minimum of one customer service metric required in each department's plan. In addition, the Customer Service Team evaluates opportunities and takes action using CQI Models. Deployment of customer service requirements is performed through the utilization of the SJSC Passport, ongoing mandatory customer service training for all employees, and the annual performance appraisal process where employees are annually evaluated against the Customer Requirements.

3.2a(3) SJSC has a systematic, integrated complaint management process called Opportunity for Improvement (OFI), (Figure 3.2-1). Included within SJSC's OFI process is an established mechanism to respond to complaints within 30 days, to notify the individual about the resolution of the issue, and to initiate service recovery (Figure 3.2-2). Employees are empowered to utilize customer service recovery mechanisms at the point of customer contact and at the time of the complaint.

An automated system is used for tracking the complaints and other customer feedback and then aggregating the data for review. Data is analyzed to determine if systemic problems exist, or if adverse trends are developing. The information generated from this process is reported quarterly to the AC and Leadership by the QI Department in order to identify and initiate improvement

priorities. The annual OFI report defines improvements by specific department or issues that have resulted from the OFI process.

3.2a(4) SJSC keeps abreast of changing customer health care needs utilizing an evaluation process within the SFHRPP, ongoing Patient Satisfaction Survey impact analysis via DI Diver™, and annual evaluation of SJSC's key indicators. Internet research and literature searches, roundtable or focus group discussions with key stakeholders, participation in SSMHC's identification and sharing of best practices, participation in IHI and SSMHC clinical collaboratives, all help to keep SJSC's hand on the pulse of health care's ever-changing environment.

Local Community Relationship**:** The external demographic/socio-economic analysis asks: Who is SJSC currently serving? What are the needs of the customers being served? What changes are necessary over the next three years to meet those needs? The external public policy/legislative analysis asks: How will emerging legislative issues impact SJSC as a provider?

Patient Access**:** The external consumer information analysis asks: What do consumers think about the products and services compared to those of competitors? What do customers expect? What do market trends identify as consumer behavior? Exploratory research on unmet consumer needs (for example, outmigration) is conducted as part of this analysis. If factors are detected that require a change in a relationship-building approach, these changes are incorporated into the SFHRPP strategies and/or other action plans as appropriate. Focus groups and complaint data are utilized when more detailed analysis of external and internal changes are needed.

3.2b(1) Patients are surveyed for satisfaction, dissatisfaction and opportunities for improvement using

Customer Groups	Listening and Learning Tools and Frequency	Primary Owners
Former and Current Patients and Families	• Satisfaction Surveys: IP, OP, ED, ASC (Continuous) • Senior Services Liaison (Continuous) • Patient Ambassadors (Continuous) • Physician Offices Focus Groups (Continuous) • Physician Focus Groups (Continuous) • Home Care (Continuous) • Call-Backs (Continuous) • Comment Cards (Continuous) • Complaint System & Informal Feedback (Continuous) • Ethics Committee (Continuous) • Web Page Response System (Continuous) • Administrative Rounds (Continuous)	• Department Leaders • Senior Services • Volunteer Office • Management • Teams and staff • We Care Team • Quality • VPMA • Marketing • AC
Potential Patients and Future Markets	• Survey Research (Annual & as needed) • Published Studies (Annual & as needed) • Community Contact (Board of Advisors) • Internet • Web Pages Response System (Continuous) • Professional Associations, Courses, Journals, and E-mail Newsletter (Continuous) • Subscriptions & News Abstract Services (Continuous)	• SSM Planning/Quality • Planning/ Marketing • AC • PR/Marketing

Figure 3.1-1 Customer Listening and Learning Tools

ASC patients and other patient groups, as defined by criteria, receive follow-up telephone calls to assess their recovery and evaluate their satisfaction.

3.2b(3) SJSC gathers information on customer satisfaction relative to competitors and other health care organizations by using surveys and focus groups (Figure 3.1-1). Patient satisfaction surveys are tailored to patient group and service type. Comparison data and benchmarks are sought and obtained for patient customer groups whenever possible. The physician satisfaction survey contains specific questions regarding care related activities to elicit feedback on the performance of SJSC as compared to other hospitals in the area where the physician also practices.

SJSC, as a part of SSMHC, obtains benchmark data from the National Research Corporation's Health Care Market Guide (HCMG) for the IP, ED, and ASC patient satisfaction surveys. The HCMG is an ongoing tracking study that focuses on the key drivers of patient satisfaction for more than 2,500 hospitals. SJSC also is utilizing certain Press Ganey data for benchmarking. Privately and publicly produced studies that compare all health care providers in our geographic area are used on issues relative to patient satisfaction and performance. All of this information is analyzed and used to identify needed improvements, and to develop goals and action plans.

3.2b(4) SJSC closely collaborates with the SSMHC Corporate planning staff on an ongoing basis to evaluate and improve the content of the patient satisfaction surveys. SJSC annually evaluates the satisfaction surveys to keep them current with health care service needs through regular internet research and literature reviews, networking with research vendors and external benchmarking with other health systems and companies.

Questions on the written surveys are evaluated and improved on an ongoing basis by SSMHC using feedback from patient satisfaction coordinators including SJSC's and the owners of health care processes that are included in the survey(s).

In early 2000, the process of reporting patient satisfaction information was improved to be more timely and less costly. Monthly reports now are posted on SSMHC's intranet rather than published in printed reports. The QI department staff downloaded the data for analysis and development of action plans using Di-Diver™. Timely and actionable data also is being provided through monthly executive summaries sent to all AC members and Leadership.

In 2001, SJSC took this process improvement one step further by disseminating the departmental specific patient satisfaction results to the director of each department via a written report each month. This data is reported to staff and included in the department's SFPIP report. The data is posted in a public location in each care area on the department's "We Care" board. The department's SFPIP report outlines strategies for improvement of patient satisfaction.

Obtain Services

- SJSC Internet Site and Physician Search
- Speakers and newsletters
- Clinics (Women's and Children's, Maternal Fetal High Risk, Senior Services and Dental)
- Participation in health plans
- Policy of access regardless of ability to pay

Seek Assistance & Information

- SJSC caregivers and Patient Handbook (patient's rights and responsibilities)
- 800 phone number
- Internet Web site
- Ethics committee
- Educational programs and support groups
- Speakers bureau

Make Complaints

- SJSC complaint process (OFI)
- Grievance Committee
- CRP and HIPAA Help line
- Patient Satisfaction surveys and comment cards
- Patient Ambassadors
- Manager rounding
- Direct contact with employees, senior leaders and physicians
- State Abuse/Neglect Hotline (customers and employees)

Figure 3.2-3 Key Access Mechanisms

The SJSC QI department, along with AC, MEC and others, have established specific strategic objectives and action plans to improve organizational performance. In addition, as part of the leadership system redesign, the approaches and teams used to manage these processes have undergone multiple cycles of refinement.

CATEGORY 4 – MEASUREMENT, ANALYSIS, AND KNOWLEDGE MANAGEMENT

4.1 Measurement, Analysis, and Review of Organizational Performance

4.1a(1) There are 50 indicators that align and monitor operational and strategic performance of the five characteristics of exceptional health care, plus patient safety. These indicators are assessed annually for appropriateness and revised, as necessary, using an SSMHC CQI team. SJSC has adopted a standard set of definitions for these 50 indicators that are combined on the PIR, published monthly and distributed electronically to the AC members (Figure 4.1-1). These indicators were selected through SSMHC's and SJSC's SFHRPP. They are further subdivided into areas that measure clinical quality, customer service, employee and physician satisfaction, expense, growth, profitability, productivity, reimbursement and safety. Additional reports, such as departmental finances, Solucient Action, customer satisfaction and ad-hoc reports from Decision Support may be used to identify variances.

In addition to monthly reports, departments use departmental daily "in process" and "outcome" indicators to track daily operations and progress toward mutually agreed upon goals. Departmental goals are aligned with SJSC, Network and System goals using the SFHRPP. Each hospital department must identify at least two in-process measures and additional outcome measures around the five key characteristics (Figure 1.1-3) to monitor department performance. Each of these measures should be SMART: specific, measurable, achievable, realistic and timely.

Daily OPS is a process and a SJSC best practice which measures productivity of departments within each entity. On a daily basis, managers report their departmental paid hours and productivity statistics to administration. If the budgeted and actual paid hours, and productivity statistics for any given day are not aligned, corrective action is taken immediately to align the department. Staffing levels are adjusted so that alignment can be made.

SJSC's approach to collecting and integrating data and information to measure its performance is driven by a robust information system based on common platforms that are deployed across SJSC and SSMHC. These tools are used to develop and support innovation such as blood sugar control.

4.1a(2) Operational and strategic decision making is supported through the use of key comparative data and information. These are selected through the SFHRPP and include the five key characteristics and patient safety (Figure 4.1-1). Comparative data are obtained locally through patient and employee surveys, within the System through the monthly executive summary, clinical collaboratives (Figure 4.1-3), Network medical management reports and nationally by using the top 10th or 25th percentiles as appropriate benchmarks for clinical/operational processes. Benchmarks are taken from external sources (ORYX, Fathom, NRMI, etc.), when available.

System or hospital best practices are used where external sources are unavailable. Internally, SJSC uses a mandatory process called One-Third/Two Thirds for benchmarking the key characteristics, productivity comparisons and other opportunities. Comparative process data and information identification is an element of the CQI models. For example, the clinical collaboratives are a key benchmarking tool.

4.1a(3) SJSC keeps the performance measurement system current with the health care service needs and directions through the SFHRPP and Information

Performance Improvement Report Categories	Indicators
Service and Quality	AMI, CHF, Pneumonia Composite Scores
Physician Satisfaction	Physician Satisfaction
Patient Safety	Dangerous Abbreviations
Service and Growth	Inpatient Loyalty Index
Growth	Admissions
Productivity/Expense	Operating Expense Per AEA
Reimbursement	Patient Revenue Per AEA
Liquidity	Net Days in Accounts Receivable
Profitability	Consolidated Operating Margin %
Note: PIR contains 50 indicators. These nine are listed due to space constraints.	

Figure 4.1-1 Performance Improvement Report Indicators

Area	Method of Collection
Employee Satisfaction	• HR Solutions employee surveys • Manager Report Cards • Department Surveys • Performance Reviews • Mentor/Mentoree Sessions • Daily Interactions
Customer Satisfaction	• Patient Surveys (I/P, O/P, and ED) • Comment Cards • OFI • Manager Rounding • Ambassador Rounds • Daily 30/30 Report
Physician Satisfaction	• Annual Physician Survey • Physician Meetings • Daily Interactions
Financial Performance	• SAP – Budget Variance Reports • PIR • Daily Ops • Daily Report
Clinical Excellence	• Solucient Explore • JCAHO • CMS • Clinical Collaboratives
Patient Safety	• Chart Review • AES • Collaboratives • JCAHO readiness

Figure 4.1-2 Information Gathering Methods

Management Council (IMC) review process. During the SFHRPP, health care service needs and directions are reassessed, evaluated and prioritized. If, through this reassessment, any modifications to the directions or needs of SJSC are identified, the performance measurement system is updated after discussion with senior leaders. SJSC has an annual two-day planning meeting as part of the SFHRPP process. The Director of Strategy & Business Development conducts regular reviews of health care service needs using Advisory Board Roundtable, Hospital Utilization Summary and other sources.

4.1b(1-2) Senior leaders review the following reports as part of the organizational performance review: monthly PIR (financial), quarterly Quality Report to the Board (quality and safety), annual employee and physician (satisfaction) and monthly Customer Satisfaction Executive Summary (satisfaction). As a result of these reviews, senior leaders identify issues that require further analysis. Depending upon the type of indicator that requires analysis, the senior leader may request assistance from decision support, QI, finance, other senior leaders and/or department directors. Trending, decision matrices, pareto and control charts are the most commonly used analyses tools.

SJSC utilizes a well-defined, deployed and mature Performance Management Process comprised of the PIR, Quality Report to the Board, Opportunity for Improvements (OFIs) and Daily Ops processes. This practice reviews and assesses organizational performance as well as performance by competitors or high performing organizations; progress in achieving Strategic, Financial and Human Resource Plan (SFHRP) short– and long-term goals; and achievement in meeting constantly changing health care needs. The process improves accountability and monitoring of performance at all levels of the organization. The most significant improvement is the development of common definitions to ensure consistent and accurate measurement of performance across the organization. The Performance Management Process defines the roles and responsibilities of senior leadership in managing the performance of SJSC, defines a consistent set of performance reporting tools that are used, and establishes standardized definitions and indicators to ensure consistency in the measurement and evaluation of performance. SJSC addresses management accountability for the organization's performance by reviewing measures as they relate to the changing health care service needs. Senior leadership assesses the organization's volume and financial operational performance on a daily basis using an electronically broadcasted worksheet, and on a monthly basis using a location-specific PIR, also known as the Red light/Green Light Report, which contains 50 indicators. Clinical performance is assessed by senior leaders and leaders on a daily or monthly basis through the use of in-process measures or outcome measures. The balanced PIR, which has undergone several cycles of refinement, covers performance in the following areas: growth, reimbursement, productivity/ expense, liquidity, service and quality, patient safety and profitability.

Communication of the results of organizational-level analyses is accomplished in a variety of methods using various communication tools. These consist of meetings, such as quarterly Advisory Boards, monthly MEC, monthly Performance Improvement Councils (PIC), monthly AC, quarterly leadership meetings, monthly department meetings, and monthly directors' luncheons. Information flow throughout SJSC is achieved via AC and MEC meetings, followed by leadership and directors' luncheon meetings, followed by monthly departmental meetings with employees. In addition, this information is communicated through a variety of other mechanisms including Medical Staff Committee Meetings, Town Hall meetings, e-mail, interoffice mail, intranet, SJSC *Spirit* newsletter, bulletin boards and We Care Boards (Figure 1.1-1).

4.2 Information and Knowledge Management

4.2a(1) Data and information are made available to staff, physicians, suppliers, partners and other customers via online applications accessed from PCs, automatic report distribution to network printers, electronic data interchange (EDI), hard copy reports delivered via interoffice mail, committee and team meetings, pagers and fax

machines. The SJSC computer networks are connected to the SSMHC wide area network (WAN) allowing staff with access to almost any application, independent of where they are geographically located. 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.

Medical staff partners and caregivers have access to the medical information necessary to provide patient care. For example, HBOC laboratory, radiology, pathology and medical transcription reports are distributed automatically to the appropriate departmental printer where the data and information is needed. This information also is employees, physicians, patients and families to see. The hospital-based e-mail system also is used to make announcements.

Suppliers and other partners obtain information by use of various methods including electronic file transfer, faxing, mail and e-mail. Admitting clerks and billers check eligibility and claim status electronically via Medifax and payor web sites. Third party payors' claims are processed electronically through the SSI clearinghouse. SJSC shares electronic information with organizations such as: Hospital Industry Data Institute (HIDI), State Trauma, Cancer Registry, and Centers for Medicare and Medicaid Services (CMS). This information is shared with other hospitals for comparisons and benchmarking.

Clinical Collaboratives	Indicators
Achieving Exceptional Safety (AES)	• Reduce Falls • Reduce Dangerous Abbreviations • Improve compliant hand washing • Surgical Site Markings
Congestive Heart Failure (CHF)	• Left Ventricular Function Assessment • Use of ACE Inhibitors on Left Ventricular Systolic Dysfunction (LVSD) • Smoking Cessation
Acute Myocardial Infarction (AMI)	• Aspirin at arrival and discharge • Beta Blocker at arrival and discharge • Use of Angiotensin Converting Enzyme (ACE) inhibitor in LVSD • Smoking Cessation • Reduce Mortality
Community Acquired Pneumonia (CAP)	• Timeliness of Antibiotics • Oxygenation Assessment • Smoking Cessation • Pneumococcal screening/immunization
Adult Intensive Care (Diabetes)	• Elevated head-of-bed for mechanical ventilator • Deep Venous Thrombosis Prevention • Normalization of blood sugar

Figure 4.1-3 Clinical Collaboratives (List not all-inclusive)

available online via the PC. Physicians and their office staff have the option of accessing patient information for their patients online via the Physician Portal. SSM Connect will print or fax electronic reports directly to physician offices. Physicians and appropriate caregivers have access to the written medical record in the hospital, when needed. Order sets and protocols are available real-time via the intranet for physicians and caregivers. Department directors can access up-to-the-minute financial information through SAP™ via their PC. The results of customer service surveys for the IP, ED, and ASC are distributed via e-mail to the management team. The appropriate areas print and post these results for all

Patients and other customers can access health information, a listing of available SJSC services, photos of newborns and more on the SJSC website (www.ssmstjoseph.com). Patients and other customers within the service area receive the quarterly newsletters “Healthy Connections” and “Well Informed,” which describe services and current events at SJSC. Health information brochures are available throughout SJSC via display racks. In addition, patients and payors may access their medical records upon request and with proper release. SJSC partners with physicians in offering educational sessions to their patients, families and community through the Speakers Bureau program.

Nursing provides inpatients with information regarding their medications and disease state. Case Management provides inpatients with appropriate information on resources, such as nursing homes, home health, durable medical equipment providers, etc., for use upon discharge.

4.2a(2-3) To ensure reliability of hardware and software, SJSC 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 system monitoring is performed utilizing SSMIC's technology management function, which includes an Operations Center that is continuously staffed, and system monitoring tools such as Spectrum and ITO. This data is used for forecasting and planning server, LAN, and WAN upgrades.

Through the assistance of SSMIC, real-time monitoring is performed via system monitoring tools such as Spectrum and ITO. These tools automatically identify computer software, hardware, LAN and WAN problems. In the event of a problem or potential problem, personnel are notified, via visible alarms or by automatic paging, to the appropriate staff member. Performance metrics are collected on key systems and equipment and include disk CPU, network utilization and system uptimes. This data is used for forecasting and planning server, LAN and WAN upgrades, when needed. SSMIC is implementing redundancy for mission-critical systems. For the main Hospital Information System, redundant CPU technology is being installed at a second data center located off-site from the primary system at SSMIC. A Businesss Impact Analysis (BIA) is being performed to identify the order of restoring the most time-critical systems first. This ranking is the foundation for the entire disaster recovery plan for the SSM information systems.

SJSC Recognized Best Practice Programs
• Daily Ops Process
• ED Excellence in Response or 30/30
• Glycemic Control (Blood Sugar)
• Near Miss Program

Figure 4.2-1 SJSC Recognized Best Practices

The SSMHC and SJSC network (LAN, WAN, & internet) security policy outlines the procedures, responsibilities of IS staff, and standards for safeguarding the hardware, software and the internet. SJSC utilizes SSMIC's Security Policies and Procedures that document SJSC'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 and resident physicians, external service providers, volunteers and suppliers/vendors who use SJSC's information or information processing services. To ensure data and 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 oversees the project implementation. As a part of the implementation, the coordinators evaluate the user friendliness of the changes, including menu functionality and screen flows. In cases where SJSC cannot make changes to make an application as user friendly as they would like, tips are sent out and shortcuts, outlines, and detailed instructions are provided to assist the user.

4.2a(4) SSMHC and SJSC keep their data and information current with health care service needs and directions during the SFHRPP and the SSMHC IS Planning and Management Process. Technology needs are assessed through the internal and external assessment step of the SFHRPP. 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 an SSMIC-sponsored IMC Education Day, the SFHRPP, and its own listening posts and learning tools to develop the Information Management (IM) Plan, which incorporates Network and entity information systems needs. Following approval by the IMC, the IM plan is incorporated into the System's SFHRPP. The SSMIC communicates its goals and objectives to each entity and to the Network through an annual Service Letter Agreement that details the products and services the SSMIC will provide to that entity and to the Network during the year.

SSMIC, representing all of SSMHC, contracts with and participates in, external industry research and educational groups, including the Gartner Group, Meta Group, Washington University's CAIT program, HIMMS/CHIME and INSIGHT to keep current with health care service needs and directions.

4.2b The collection and transfer of staff knowledge is accomplished utilizing the information systems provided by SSMHC and SJSC. There is a focus on standardizing systems within SSMHC to ensure that standard data and information are available for reporting at a Network and System level (Figure 4.1-2). The knowledge collected from this approach is transferred to staff, physicians, vendors, supplier/partners and patients/customers through multiple delivery processes including, but not limited to, reports (standardized and custom developed), entity participation on standardization teams, internet and intranet applications, PC workstations, publications such as the *Spirit* newsletter and monthly departmental

teams present results and lessons learned to other departments and staff, when and where appropriate. In addition, skill sharing is encouraged at annual meetings and conferences, as well as at the annual corporate Showcase for Sharing. Informal communication occurs within departments and between internal customers and suppliers by face-to-face, two-way communication, conference calls and e-mails. In meetings where information is shared, problems are solved and processes improved in response to customer and other shareholder's feedback.

5.1b SJSC's performance management system supports a focus on high levels of performance and a patient/customer and health service focus. All employees are evaluated on at least an annual basis. Having two specific due dates for evaluations is a process improvement implemented to address timely evaluations and managing staff feedback on smoothing the workforce. The performance appraisal instrument includes nine areas for assessment. This annual process of formal coaching and feedback, as well as informal recognition throughout the year, helps support high levels of performance and customer service focus.

Within the SJSC culture, it is understood that the primary motivation of staff members comes from the fundamental desire to perform well in their work. Therefore, an environment has been created to support employees in many ways; not only by providing the information and tools they need to do their work, but also by soliciting feedback in various ways in order to remove barriers to staff motivation. Employee satisfaction surveys, routine feedback to department managers in daily work and staff meetings, exit interviews, on-boarding surveys and Town Hall meetings are designed to provide employees with the opportunity to provide valuable input into their work environment. The agenda for Town Hall meetings provides updates on current initiatives, financial reports and responses to employee questions.

Participation of teams and the focus on quality principles permits 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. Formal coaching is built into the employee development process, and informal coaching is an ongoing process at all levels.

Employee recognition is accomplished through formal programs, such as: employee service awards, 20+ Club, Christmas dinner, birthday card with free meal, holiday bonus, "We Care Program," and Foundress Day. Additionally, several informal activities recognize employees and reward them for their efforts, including ice cream socials, free pizza, free beverages during high census and notes to employees from all levels of leadership recognizing exceptional contributions.

Teams are recognized for their performance improvement efforts at annual local and corporate sharing conferences. Staff and team achievements are highlighted in the bimonthly newsletter and departments are honored for their work during annual celebration weeks.

In keeping with its Mission and Values, SJSC 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. SJSC demonstrates a compensation philosophy in which "internal equity" is very important. In determining salary offers for new hires, extreme caution is taken to not offer more to the external applicant than a current employee in the same job classification and with similar experience.

5.1c(1) Skills and characteristics needed by potential staff are identified through 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 around Mission and Values, CQI, attendance, safety and customer service.

5.1c(2) All open positions are posted internally on the Corporate intranet and on the internet. Depending on the market for the position, human resources staff uses various methods to identify applicants, most of whom are drawn from nearby communities. SJSC works cooperatively with local colleges to provide clinical training for students. Four directors serve as instructors in nursing and health information management programs to address staffing shortages. Three of the positions are financed by SJSC. Once qualified applicants are identified, screening is accomplished through 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. Human Resources staff and department managers work cooperatively to choose new employees.

As SJSC recruits for open positions, it goes to markets as small as the local community and as large as the two-state areas of Missouri and Illinois. Department director-level applicants are assessed with a battery of tests, including a Caliper Profile, which identify personality characteristics relevant to management and measure key skill areas needed. SJSC values the diversity of individuals in this recruitment area, and it is committed to diversity initiatives such as increasing the number of minority management and professional staff. SJSC participates in the semiannual SSMHC Diversity Forums. Employees are a diverse group of individuals with a variety of cultural, as well as occupational, backgrounds. Innovations to attract workers in a tight labor market have included a summer intern program for nursing students,

a preceptor program, extended orientation and sign-on and referral bonuses.

5.1c(3) Succession planning is accomplished at the System through the Executive Career Development Program. The program includes a leadership behavior assessment, a personal development plan, an executive orientation, CQI and corporate responsibility process training. Some executive leaders serve as mentors to others in the leadership development process.

Organizational Development (OD) is a resource available at the Network level 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.

Employees are supported in their learning goals through help with identifying and accessing materials and programs for professional development. Education and training offered within the department, within the hospital and through seminars and college courses are supported by tuition assistance. In 2004, 216 employees took advantage of tuition assistance with SJSC providing $365,710 in assistance. Also, 88 employees received $165,512 in loan payment reimbursement. Many classes are offered in the workplace.

5.2 Staff Learning and Motivation

5.2a(1) Continuous learning is essential for employees to keep up with changing health care technology, industry trends and governmental regulations. Education and training is designed to support SJSC goals and action plans. Learning needs are addressed through System-wide training, leadership development and entity and department-specific training. A needs assessment collects information from many sources, including competency reports, occurrence reports, annual employee performance evaluations, System-wide initiatives, employee satisfaction, exit interview results and safety monitors. From all of these sources, educators and managers identify training needs and design appropriate learning interventions around long- and short-term needs. Education is prioritized depending on employee and SJSC needs. For example, employee satisfaction survey scores resulted in the initiative to develop and provide education on conflict management and diversity for employees.

Long-term goals typically are addressed through programs such as tuition reimbursement for college-level coursework, leadership development and clinical internship programs. Short-term goals are met primarily through continuing education classes, department-based training, and training on new equipment from vendors. Staff development needs for licensure and recertification are met through internal and external continuing education programs.

5.2a(2) Initial education and training are delivered through organization-wide and department-specific orientation programs. Employees participate in a general orientation program welcoming new employees and sharing the Mission of SJSC. Examples of topics covered include the Passport program, ethics, CRP policies, CQI, safety, infection control, lifting techniques, patient rights and HR policies. Department orientation follows, is systematic, and often includes preceptor guidance based on initial PBDS competency assessment. Initial training is reinforced through annual training for employees and addresses: the Mission and Passports, safety, infection control, HIPAA, CRP, diversity and sexual harassment (Figure 5.2-1).

5.2a(3-4) Input from staff and managers comes from a variety of sources including annual individual staff development plans and departmental training needs assessments. These plans and assessments are used to 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. In addition, a review of employee performance evaluations identifies training needs, as well as comments from evaluation forms from other educational offerings.

Educators, including preceptors, address various learning styles by offering lectures, skill demonstrations, videotapes, self-learning modules, online training, individual instruction and group learning activities. 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.

5.2a(5) 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, assessing whether training programs have met departmental objectives and employee performance has improved. Directors assure that employees achieve expected levels of performance through ongoing competency assessments of patient care staff, with competency summaries reported to the AC and Board annually.

5.2a(6) Education and training programs routinely are evaluated and improved. Educators follow up with managers to assess whether training programs have met objectives, and if staff performance and work system performance have improved. Staff members evaluate the content and presentation after formal educational programs through completion of formal evaluations.

Area	Purpose	Examples	Area Sponsor
Administrative	• Enhance position specific competencies • Support mission, vision, values, SFHRP	• Orientation • Passport • CRP • HIPAA • Diversity • CQI • Ethics • Safety • IS Systems	• HR • QI • RM • IS • Senior Leaders • System
Clinical Education	• Enhance clinical competencies • Continuing education • Promote professional development	• Inservice Training • Nursing Orientation • Dept. Orientation • Grand Rounds • Tumor Boards • Cancer Series • Patient Safety • Leadership Training • JCAHO Prep	• Clinical Education Specialists • Nursing Education • SSMHC—St. Louis Org. Development • System • QI • Leadership

Figure 5.2-1 SJSC Education, Training, and Development

Findings are tabulated, summarized and used for improvement in program design and delivery. Examples of how training and education have been effective are illustrated by reductions in medication errors, needle sticks and nosocomial infection rates. In addition, training effectiveness has resulted in improved documentation audits, decrease in number of restraints of Skilled Nursing Facility (SNF) patients and improved pain management documentation.

5.2b SJSC's CQI culture motivates staff to develop and use their full potential. The goal of increasing staff empowerment leads to increasing emphasis in formal learning objectives for operating in an environment where more decisions are made at the level of greatest expertise. Formal mechanisms in place to help staff with job and career development include departmental budgets for staff education, both internal and external. Tuition reimbursement and loan forgiveness are available to eligible staff. Managers help staff attain job and career-related development and learning objectives by maintaining a staff member specific file to develop a plan, monitor progress and follow up.

5.3 Staff Well-Being and Satisfaction

5.3a(1) SJSC maintains a work environment and staff support climate that contribute directly to the well-being, satisfaction and motivation of all staff through programs applied consistently across the three campuses and measured for effectiveness. Workplace health and ergonomics are monitored and measured by employee health and infection control nurses that amass and aggregate data related to employee health, exposures and infection. The employee health nurse tracks and reports on several Employee Safety Monitors that include reportable accidents, lost time injuries, back injury cases, needlesticks/sharps cases and workers compensation claims. Results then are compared to averages obtained from the Department of Labor and SSMHC best practices, and are reviewed to discover areas for improvement and needs for additional training. For example, as a proactive measure, Employee Health has coordinated employee workstation ergonomic evaluations to help minimize potential lost time injuries. As a proactive approach, within general orientation, which is a requirement for all staff, particular focus is given to infection control, back safety, radiation, electrical safety and Material Safety Data Sheets.

The Safety Council is a multidisciplinary team 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 as established by JCAHO. The Safety Council has created Safety First, an anonymous process for employees to make suggestions to report unsafe conditions existing at SJSC. Trended, segmented data is reported at the Safety Council meetings by the Safety Director. Department managers are required to complete environment of care checklists at least twice a year as a mechanism for the Safety Council to monitor and measure safety compliance and allow for variances in work environments.

5.3a(2) The Safety Council also is responsible for emergency preparedness. The Emergency Preparedness Manual, located in each department, contains plans for disasters, emergency water, fire safety and the procedures in the event of a bomb threat. At a minimum, two drills are performed each year that include communication on the effectiveness of the drills designed to identify opportunities for improvement in ensuring health care services and business continuity for patients, customers and staff. SJSC also participates in community emergency preparedness drills.

Factors	Measures
Employee Safety Monitors	• Lost time injuries • Back Injury Cases • Blood Borne Pathogen Exposures • Workers Compensation Claims
Staff Well-being	• Employee Satisfaction • Dollars Spent for Health Care
Employee Satisfaction/Motivation	• Employee Satisfaction • Employee Turnover • Work it Self • Team Work
Diversity	• Number of minorities in professional and management positions

5.3-1 Key Measures for Staff Safety, Well-Being, and Satisfaction and Motivation

5.3b(1) SJSC utilizes an employee survey to determine the key factors affecting employee satisfaction, motivation and well-being. All staff members are invited to participate in the comprehensive survey that contains 26 questions. Results are analyzed based on a normative differential score and best-in-class performance, which compares SJSC's scores in several highlighted dimensions with the National Healthcare Normative, the SSMHC best-in-class benchmark, as well as previous SJSC survey 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. Further data is segmented by job category, age, gender, national origin, tenure of employment with SJSC and pay status (hourly or salaried).

SJSC also employs a Retention Coordinator whose role is designed to quickly identify and address problem areas. The Retention Coordinator completes "on boarding surveys" with staff after 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, where employees provide feedback on their supervisor; semi-annual Town Hall meetings where the President of SJSC and other members of the leadership team address staff concerns; the SJSC employee complaint resolution process; and department unit councils, a result of shared governance and employee council, whose responsibility it is to serve as a liaison between staff and leadership.

5.3b(2) SJSC has enhanced its work environment to facilitate retention and recruitment by providing:

- various categories of employment including full time, part time, per diem, weekend option and on call to allow flexibility to staff and to meet the needs of the organization based on changing patient volumes;
- posting open positions for internal recruitment;
- support for transfers to different departments within SJSC as well as different entities within SSMHC;
- work at home options;
- and, varying schedules with 72 hours every two-week pay period being considered full-time with full-time benefits.

SJSC recognizes the diversity of the workforce by offering a flexible benefits program that permits employees to select or opt out of benefits that most closely meet their individual and family needs. Flexible benefits include medical benefits that consist of either managed care or indemnity plans with prescription drug coverage that also contains an out-of-area provision for students attending an out-of-area school or university; two levels of dental insurance coverage; two levels of vision insurance 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 to provide coverage for times of extended care offered for employees and family members; health and dependent care pre-tax spending accounts; and 403(b) matched tax deferred savings plans tailored to the employee's desired risk level.

SJSC also provides: extended medical benefits to employees who have exhausted Family Medical Leave Act (FMLA) eligibility; defined benefit pension plan for employees; tuition reimbursement and loan repayment; multiple leave of absence programs for employees, family, personal, educational and military reasons; direct deposit; ability to participate in MOST; adoption assistance; cafeteria and gift shop discounts; FOCUS days (one day to reflect on the Mission); Employee Relief Fund to aid employees in a time of financial crisis; and Employee Assistance Program (EAP). In 2001, SJSC 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 SJSC full or part time.

5.3b(3) The employee survey is the primary method used to determine staff well-being, satisfaction and motivation. Results are analyzed by job category, age, gender,

IP	SP	Process	Measures	Key Requirements					Market Segment		
				Timely	Effective	Efficient	Safe/Accurate	Patient-Centered	In-Patient	Emergency Dept.	Ambulatory
X		Admission	Time to register patient (Figure 7.5-1)	X		X			X	X	X
X		Assessment/ Diagnosis	Time to transcribe H&P following dictation (Figure 7.5-2)	X		X	X		X		
X			Percent lab test results within 30 minutes for ED patients (Figure 7.5-3)	X		X	X	X		X	
X			Radiology report turn-around time (Figure 7.5-4)	X		X	X	X	X	X	
X	X	Treatment	Core Measure Composite Scores (Figure 7.1-4)	X	X	X	X	X	X	X	
X			Patient loyalty (willingness to recommend) (Figure 7.2-1)	X	X	X	X	X	X	X	X
			In-hospital mortality rate (Figure 7.1-1)		X		X	X	X		
			Patient admissions (Figure 7.6-1)		X		X	X	X	X	X
X			Patient satisfaction with pain control (Figure 7.2-4)	X	X	X	X	X	X	X	X
X	X		Use of Dangerous Abbreviations (Figure 7.1-12)				X		X	X	X
X		Discharge & Education	Recovered Enough for Discharge (Figure 7.5-5)	X	X	X	X	X	X	X	X

Figure 6.1-1 Key Healthcare Processes Indicators or Key Measures (IP = In-Process Measure, SP= Part of the Strategic Plan (SFHRP))

6.1a(3) When hospital leaders identify an opportunity to launch a new or modified health care process, the AC appoints a multidisciplinary team to determine the feasibility of offering the new service. The team conducts that feasibility study by using methods consistent with CQI principles. Introduced in 1990, CQI has become embedded in the SJSC culture. The core of the CQI model includes the Plan-Do-Study-Act (PDSA) cycle. This approach includes substeps or questions that serve as checkpoints to ensure process design teams consider, at minimum, requirements such as customer expectations, safety, accreditation/regulatory requirements, best practices, payer requirements, potential design problems, measurement systems, etc. Any employee, team or partner can request that the AC commission a specific process team. All proposed team charters are reviewed, revised and/or approved by the AC. All new services are required to link to the strategic goals and Mission.

In accordance with the principle rule of medicine, "First, do no harm," the key touchstone for all processes is patient safety. In addition, a trial or "pilot" testing of new procedures in a limited environment is standard practice prior to considering organization-wide implementation. Key partners, specifically physicians, lead multidisciplinary committees that oversee the design, implementation and monitoring of key process requirements.

SJSC employs experts who are trained in CQI methods and regulatory/accreditation requirements, and who serve as team facilitators or active participants. Finally, regulatory and accreditation oversight is monitored by the JCAHO Steering Team which meets monthly.

New technology and organizational knowledge drive changes in current processes and creation of new service delivery models. Both staff and physicians are regularly updated about new treatments and devices as a result of membership in professional associations, medical publications, vendor contacts and travel. Process agility occurs through systematic review of order sets and care pathways as well as both in-process and outcomes data that are overseen by the various multidisciplinary committees. SJSC is part of a dynamic and competitive healthcare environment. Therefore SJSC is routinely exposed to policies, procedures and devices used at competing hospitals via in the local media, through networking opportunities, and first-hand accounts from patients and physicians who have been in those hospitals. At a System level, SJSC benefits from the experience of other hospitals within SSMHC through active participation during regularly scheduled telephone, video and in-person conferences. The hospital participates and provides a leadership role for several System-wide collaboratives. Finally, SJSC participates with the nationwide collaborative from the Institute for Healthcare Improvement (IHI) known as "Saving 100,000 Lives" campaign, which began in early 2005. This campaign provides additional recommendations for reducing mortality associated with several high-risk conditions. A scorecard is used to communicate progress toward goals.

When leaders identify an opportunity to launch a new or modified health care service, a team is appointed to determine the feasibility of offering the new service. One of the first steps is to contact other facilities in SSMHC, or outside of SSMHC, to determine if they have worked on a similar issue. If so, the storybook is obtained and reviewed for potential replication. A team charter is used to define the project and seek AC approval. In-process and outcomes measures are designed into the pilot prior to implementation through research and benchmarking. Once it is determined that implementation is feasible, the process or design is rolled out across the organization. If the proposed process poses a high risk to patient safety, the team conducts a Failure Mode and Effects Criticality Analysis (FMEA) and incorporates preventive measures in the process design in order to promote a more error-free process and trouble-free implementation. Routine progress reports are provided to the AC and MEC.

6.1a(4) Customer requirement expectations and priorities are integral to both the design and provision of services. During the Planning phase of the CQI Model – Conceptual Design Step – the team addresses the question "What are the customers' expected outcomes from the process?" to ensure that requirements are incorporated into the new or modified service. This is accomplished by reviewing many sources of existing patient/customer feedback data including surveys and comment cards, conducting specialized surveys or focus groups and including customers on the design team. SJSC has patient ambassador volunteers who provide non-clinical comfort measures in the ED and selected patient care areas. When issues arise, they bring the patient's concerns directly to the clinical staff. Customer needs are validated during the Study phase of the CQI system.

As a result of the Impact Analyses, SJSC has focused its bedside patient service efforts on the top two drivers: timely responsiveness to patient requests and pain control. These drivers are incorporated into the SFPIP of every department that provides patient care. Patient perceptions of physician behaviors are obtained via the survey and are shared quarterly with the Physician Performance Improvement Councils (PIC).

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. They are as follows:

- Prior to any procedure, each patient is informed of likely risks, benefits and alternative treatments by the physician through one-on-one conversations using a process known as "informed consent." Documentation of informed consent is required prior to the start of any procedure and is part of pre-procedure checklists.
- The patient and family have input into the treatment plan and setting of goals.
- The initial and ongoing patient assessment includes determining patient preferences regarding spiritual, educational, nutritional and pain management needs, as well as needs relating to other aspects of care.
- Standardized order sets "map" the plan of care based on evidence-based practice standards for specific diagnoses, procedures or patient types.
- Information about the operation of the organization is published on SJSC website and in the patient admission handbook. These approaches are used to establish expectations.

6.1a(5) All processes have data-gathering requirements that are aggregated at two different levels. The first, and most important, level is that of the patient's response to treatment. Data obtained throughout the patient's stay are placed into the medical record. Forms and checklists in the medical 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 partner input is sought through continuous interaction between the patient/family, caregiver staff and physicians 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 during multidisciplinary meetings, department meetings, SFPIP reviews and operational review meetings that are conducted as frequently as twice per day in the case of nursing bed board meetings. Regulatory and accreditation requirements are used in the design of new services and to modify/improve existing ones. These requirements are identified in the SJSC annual Performance Improvement and Patient Safety plan (PIPS), which is reviewed and approved by AC and MEC, and is distributed to department leaders annually. Key performance indicators are identified as a part of the PIPS. Department or area managers collect the data as often as daily and various department-level or multidisciplinary committees review monthly or quarterly. In addition, these data are reviewed quarterly during SFPIP meetings. Other key indicators are listed on the monthly PIR.

In-process measures are defined at multiple levels. At the hospital level, managers report during a process known as "Daily Ops." In addition, the ED provides daily reports on the percent of patients seen by a physician within 30 seconds for a life-threatening emergency and within 30 minutes for all other conditions. This program is known as Excellence in Response or 30/30. All key process departments participate in these endeavors, which were initially developed, pilot tested and deployed at SJSC. Excellence in Response data is broadcasted to hospital managers via email each day. Specific in-process measures related to both efforts have been developed and are refined annually as part of the SFPIP. In addition, the System has facilitated meetings of department managers from hospitals across the System who have defined standard in-process measures. Finally, all departments or areas have in-process measures that connect directly to the strategic goals in the SFHRP.

All of these data are reviewed during the SFPIP, and are contained on one of two forms: a performance improvement form or a quality assurance form. If the data reveal that key requirements are not being met, an action plan is required for correction. That action plan is incorporated into the SFPIP documents. In addition, both in-process and outcomes data and plans are displayed on quality boards located in staff lounge areas and meeting rooms in every department within SJSC.

A "data architecture" has been developed at SJSC, and approved by AC, which depicts a linkage of the strategic goals of organization with the process flow of data. The architecture reveals which departments or areas produce the data, who reviews the data and the frequency of that review.

6.1a(6) SJSC minimizes costs associated with inspections, tests and audits by designing key measurement indicators into the process itself, having systematic sampling processes, and by using data stored electronically in information management systems. The measurement of quality service begins with the employees and key stakeholders who provide services directly to the patient. Employees are routinely involved in auditing a predetermined sample of medical records within a clearly established timeframe. Errors and rework are prevented through the use of templates, checklists, pre-approved printed order sets and standardized policies and procedures that are developed or approved by multidisciplinary teams. These are communicated to the staff via routine communication that reaches all levels of SJSC. Policies, procedures and order sets are electronically stored on the SJSC intranet and can be accessed by computer. Medical Staff Bylaws and Rules and Regulations govern physician practices. Each facility has a PIC that oversees physician practices and processes in the hospital that impact physicians. The PIC teams report their findings to the MEC. Each facility has a Safety Council that meets monthly to review data related to promoting a safe environment. Each facility has a Medication Error Reduction Team (MERT) that meets monthly and focuses on medication delivery systems that account for up to 70 percent of errors in hospitals. The MERT concept was developed and deployed at SJHW, and since has been identified across SSMHC as a best practice. Every quarter, both MERT groups meet as a single team in order to share information and standardize practices. Each facility has a Sentinel Event Team that reviews unexpected adverse events involving patients. An intensive assessment, including a root cause analysis (RCA), is promptly initiated when adverse events occur or when statistical analysis detects undesirable variation in patient safety or clinical outcomes. SJSC annually selects at least one high-risk process, medication delivery process and infection process for FMEA and subsequent improvement. Recommendations from all of these teams are incorporated in the SFPIP for specific departments or areas, and are monitored quarterly by the SFPIP team to ensure that the conditions are in place to prevent errors.

6.1a(7) Process improvements begin with redesign by multidisciplinary teams that are commissioned by the AC. All redesign teams use the CQI model for improvement, which has a built-in focus on improving the design process, transfer of team learnings and such factors as quality, cycle time, cost control, new technology and efficiency/effectiveness. Team charters clearly define both in-process and outcome measures of success. Project reports indicate obstacles encountered and recommended next steps. When data indicate that the redesigned process is sustaining its predetermined performance goals for at least one year, then the redesign team transfers the action plan and data-reporting requirement to the area or department manager.

The Director of QI prepares an annual report regarding performance improvements based upon the information in the SFPIP forms. Similar reports are produced regarding performance improvements subsequent to patient complaints, medication safety efforts, environment of care and physician peer review.

Meeting minutes, project reports, emails, newsletter articles, posters, storyboards, monthly leadership meetings and presentations at staff meetings historically have been the most common approaches for the transfer for learning. In addition, best practices that are adopted by the AC are assigned to special project teams to drive organizational learning and innovation. For example, the ACES customer service initiative was piloted at SJHW and assigned to an implementation team at SJHC. That team was responsible for implementing the same program at SJHC in the spring of 2005.

A critical component of the SFPIP review is the participation of the VPs. They approve and promote performance improvements that can be spread to other areas in the organization based upon the success incurred by one or more of their departments. Where the hospitals have separate multidisciplinary committees, executive physician leaders attend the meetings at both hospitals. Therefore, they bring the experience and learnings from one group to the other and promote standardization at both hospitals. Recommended changes in practice from outside organizations such as the Institute for Safe Medication Practice, IHI and JCAHO are routinely routed through SJSC via email address books.

6.2 Support Processes and Operational Planning

6.2a(1) With the exception of physicians, support services are those that do not provide key health care services directly to patients or their families. The Mission, Vision, Values, SFHRP, customer and operational need drive the need for support service processes. SJSC uses the CQI Design model to initially establish service processes and the CQI Improvement model to both manage and improve them.

Name of Support Service	Site Manager at SJSC	Manager Reports to St. Louis Regional Network Leadership	SSM System-Level Integration
Information Systems	X	X	X
Clinical Engineering (Biomed)	X	X	X
Materials 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 (Physicians)	X		

Figure 6.2-1 Key Support and Business Processes

Since physicians are key partners with needs reflective of a customer, SJSC employs full-time physician leaders in key areas such as the ED, and has two physician executive leaders, a Vice President for Medical Affairs and a Vice President for Clinical Affairs. Therefore, the physician perspective is well represented both at the AC and leadership. SJSC also employs a physician liaison who markets services and recruits new physicians. This role provides invaluable feedback from physicians in the community about their expectations of SJSC and reports findings to the AC. The key requirements of all support processes are that they be timely, effective, efficient, accurate and customer-centered as listed in Figure 6.2-2.

6.2a(3) Business and other support processes are designed to meet requirements using the same approaches as the health care delivery processes – through multidisciplinary teams using the CQI Model. Key stakeholders are always design team members.

Process design begins with the recruitment of competent process owners, specifically employees, physicians and vendors, when appropriate. During the recruiting process, SJSC seeks to attract employees and physicians who meet service line needs, and who are qualified to provide exceptional health care. Once they become members of the organization, SJSC integrates employees and physicians into the key processes through orientation, strategic communications, meetings and education and development opportunities. These new members continually introduce new technology and knowledge into the organization. In addition, all support groups actively participate with their peers in other hospitals through collaboratives coordinated by the System. Organizational knowledge is facilitated by information technology, sharing in meetings and displays of data. Organizational agility to rapidly respond to changes in our environment is supported by routine meetings, email, journal subscriptions, process indicator review at quarterly SFPIP, and active participation at both the Network and System level conferences. SJSC developed a CQI checklist in 2004 based upon the CQI model which is used to assist design teams and facilitate rapid-cycle CQI.

Physicians can access patient diagnostic reports (laboratory and radiology reports) electronically through the Physician Intranet Portal, use electronic signature (Esign) to complete reports, generate patient lists, access MD Consult, etc. This system allows the physician to review data and recommend treatment plans from their office, which greatly increases the speed of changes in treatment. In addition, all leaders are connected to one another by email, which facilitates sharing ideas, performance data and communicating decisions.

Inclusion of our material management suppliers is also 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 a significant economic benefit from this relationship with a 6 to 15 percent savings over prevailing market prices. SJSCs supply chain management processes are established and monitored by SSMHC at least annually. SSMHC's materials management process is designed to achieve economies of scale and reduced prices by consolidating purchasing and contracting with preferred suppliers and partners. This supplier partnership enables SSMHC, SJSC and its suppliers to align their strategic goals. Formal contracts, and at least quarterly business reviews, define supplier requirements.

SSMHC Materials Management sets goals to support the System'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 Processes is managed through a multilevel 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 issues 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 and present future business opportunities.

Newly designed support and business processes are according to the CQI Design Model. The design teams oversee the implementation, and the daily operations are transferred to leadership once the new processes meet performance expectations and stabilize.

6.2a(4) Key performance measures/indicators, including in-process measures, are monitored to manage the key business and other support processes (Figure 6.2-2). The CQI Improvement Model is used to measure, manage/control and improve the key business and other support processes. 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 used to determine if business and support processes meet the key customer and operational requirements are subjected to the same SFHRPP review process as the Health Care Processes. 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 assurance activities, customer satisfaction, benchmarking data and employee suggestions also are used to guide performance improvement efforts in support services. These results are shared with staff, reported and then used by leaders to guide ongoing improvement efforts.

Physicians chair 80% of multidisciplinary committees. This structure requires physicians to play a very active role in not only determining policies and procedures, but in being an advocate for patient needs as processes are designed and improved.

6.2a(5) SJSC has minimized costs and increased efficiency in the Physician Partnering process through a retention strategy based on integrating physicians into the organization and satisfying their requirements. In the Supply Chain Management Process, user groups give management support for standardization and product deployment, which controls consistency of the process. By standardizing and consolidating distribution, the benefits are: delivery according to user needs, just in time inventory, vendor managed inventory, and often vendor consignment. In addition, prevention-based methods are used within SJSC to minimize costs associated with inspections, errors and rework 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.

The System likewise oversees SSMIC and related technology. All IS hospital managers report to the Chief Information Officer at the Information Center. Requests for computer and related information technology needs are part of the hospital annual budgeting process. By coordinating IS at a System level, SJSC derives the same benefit from economies of scale for its information technology needs as it does for its supply management processes. Errors and rework also are reduced because practices are standardized across the entire System.

6.2a(6) SJSC evaluates and improves business/support processes by developing measurement tools and responding to performance results. The PIR contains established thresholds of performance for multiple indicators at the System, Network and hospital level. At the department level, in-process measures are monitored based on established performance thresholds and reviewed during the SFPIP. A negative variance from these thresholds activates the formation of teams and/or other corrective action plans to make improvements using the CQI Improvement model. Benchmarking data provided by Solucient products such as Action O-I and Explore, as well as employee suggestions, are other activities for improving support services. Results are shared with staff through the transfer of learning methods such as newsletters, revised policies and procedures and department meetings.

6.2b(1) Financial support of operations is ensured via the SFHRPP described in detail in Category 2 which employs the PDSA cycle of the CQI model. SJSC's fiscal 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 (Step 10D of the SFHRPP) in June. Budgets are divided into capital and operational expenses accordingly to criteria established by Financial Services. Operational revenues fund operational expenses whereas capital expenses and new business investments are occasionally supported by loans from external financial organizations. Budgets are historically based upon previous year's activity and adjusted for new business opportunities or expenses. Financial modeling software facilitates decision-making with regards to patient volumes, which drive both revenue and expenses. Department leaders submit goals and action plans beginning in May which contain both proposals for new business opportunities and next year's anticipated expenses to the AC for review. The AC and Network Leaders balance the requests for funding