2019

Malcolm Baldrige

National Quality Award Application

Mary Greeley
MEDICAL CENTER

Doing what's right.

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Mary Greeley MEDICAL CENTER
Doing what's right.

Organizational Chart

AD003 – 04/19

- **City of Ames**
  - **City Council**
- **Board of Trustees**
  - **Medical Staff**
- **PRESIDENT & CEO** Brian Dieter
  - **External Relations: Foundation/Older Adult Services/ Volunteer Services** Melissa McGarry

QUALITY
Karen Kiel Rosser

- **Community Relations** Steve Sullivan
- **Dietary** Matt Hart
- **Process Improvement/Lean** Ron Smith
- **Guest Services** Environment Services/Valet/Transportation Cathy Wright
- **Medical Staff Services** Sally Houser, Shaunda Calkins, RN
- **Supply Chain Management** Sue Draper
- **Quality Management** Darla Handsaker, RN (Compliance Officer)

NURSING
Cory Geffre, RN

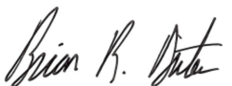
- **Inpatient Nursing Services/ House Managers** Matt Aitchison, RN
  - **Behavioral Health** Christy Krause
  - **ICCU** Sarah Heikens, RN (interim)
  - **Maternal/Child/Pediatrics** Amy Dagestad, RN
  - **Medical/Surgical & Nursing Support Team** Jo-el Sprecher, RN
  - **Medical/Telemetry** Amanda Lass, RN
  - **Oncology/Cancer Services Palliative Care** Sarah Heikens, RN
  - **Rehab Inpatient Hemodialysis** Joelle Schmidt, RN
- **Pharmacy** Doug Wetrich, RPh
- **Professional Development** Amy Stark, RN
- **Home Health/Hospice/ Public Health** Les White, RN
- **Emergency Services** Dieter Friton (Interim)
- **First Nurse** Jane Jackson, RN (Interim)
- **MICS/Security** Dieter Friton, MHA, NRP
- **Outpatient Nursing Services** Jane Jackson, RN
  - **Ambulatory Care** Bonnie Castro, RN
  - **Cath Lab/Cardiac Rehab** Cheryl Pietz,RN/Carrie Adams,RN
  - **Diabetes and Nutrition Education** Thyra Cox, RN
  - **GI Services** Donna Henderson, RN
  - **Pain Medicine Clinic** Jane Jackson, RN
  - **Wound Healing Clinic/ Wound Ostomy Care /Stroke Program** Jane Jackson, RN

FINANCE
Gary Botine (Privacy Officer)

- **Accounting** Lori Vander Werff
- **Business Office/ Patient Access Services** Heather Vandewater
- **Clinical Applications Systems** Evan Darnell
  - **Business Intelligence** AJ Smith
- **Health Information Management** Vicki Dunn
- **Information Systems** Scott Carlson
- **Security Officer** Nicole Pape

CLINICAL & SUPPORT SERVICES
Amber Deardorff, RN

- **Cardiopulmonary Services: Neurodiagnostics/Home Medical Equipment** Tammy Jamagin
- **Chaplaincy Services** Katherine Werner
- **Facilities** John Rodilosso
- **Human Resources: Education Management/ Medical Library** Penny Bellville
- **Laboratory** Connie Henderson
- **Radiation Oncology** Scott Cue
- **Radiology** Scott Cue
- **Rehab & Wellness: Hospital Services/OP Svcs: Ames & Story City/Lifetime Fitness Center** Matt Petersen
- **Surgical Services: Operating Room/Sterile Processing/ Anesthesia/Post Anesthesia Care** Brian Van Brocklin, RN



Brian R. Dieter, FACHE
President & CEO

Glossary of Terms and Abbreviations

A

AAHRMM ....American Association for Healthcare Resource & Materials Management

AAR ....After Action Report

ACTS ....Ambassadors, Communications, Teamwork, Safety

AHA ....American Hospital Association

AHRQ ....Agency for Healthcare Research and Quality

AIDET ....Acknowledge, Introduce, Duration, Explanation, Thank You

AMI ....Acute Myocardial Infarction

AMPT ....Web-based Employee Recognition Platform

ANCC ....American Nurses Credentialing Center

AOS ....Available on Site

A/R ....Accounts Receivable

ASC ....Ambulatory Surgery Center

AT ....Administrative Team

B

BOT ....Board of Trustees

BSN ....Bachelors of Science and Nursing

C

CA ....Cancer

CAH ....Critical Access Hospital

CAM ....Comprehensive Accreditation Manual

CAP ....College of American Pathologists

CARF ....Commission on Accreditation for Rehabilitation Facilities

CAS ....Clinical Applications Systems

CAT ....Computerized Axial Tomography, CAT Scan, a diagnostic test used to diagnose conditions and diseases

CBES ....Computer Based Education System

CBL ....Computer Based Learning Modules

CDC ....Centers for Disease Control

CEO ....Chief Executive Officer

CFO ....Chief Financial Officer

CHF ....Congestive Heart Failure

CLIA ....Clinical Laboratory Improvement Amendments

CMS ....Centers for Medicare and Medicaid Services

CME ....Continuing Medical Education

CNA ....Certified Nursing Assistant

CPOE ....Computerized Prescriber Order Entry

CT ....Computerized Tomography

D

DART .... Days Away, Restricted or Transferred

DMACC .... Des Moines Area Community College

DNV .... Det Norske Veritas

DRG .... Diagnosis Related Group

E

e-Gram .... Electronic Employee Newsletter

e-Physician .... Electronic Physician Newsletter

EAP .... Employee Assistance Program

EOC .... Environment of Care

ED .... Emergency Department

EDI .... Electronic Data Interchange

EEOC .... Equal Employment Opportunity Commission

EHR .... Electronic Health Record

EMC .... Emergency Management Committee

EMP .... Emergency Management Plan

EMTALA .... Emergency Medical Treatment and Active Labor Act

EOS .... Employee Opinion Survey

ES .... Environmental Services

EPA ....Environmental Protection Agency

F

FMEA .... Failure Mode Effects Analysis

FMLA .... Family Medical Leave Act

FLSA .... Fair Labor Standards Act

FOCUS .... **F**ind a process to improve, **O**rganize a team, **C**larify current knowledge, **U**nderstand causes of process variation, **S**elect the process improvement tool

FQHC .... Federally Qualified Healthcare Center

FTE .... Full Time Equivalent

FY .... Fiscal Year

G

GPO .... Group Purchasing Organization

H

HAZMAT .... Hazardous Materials

HCAHPS .... Hospital Consumer Assessment of HealthCare Providers

HEAT .... Hear, Empathize, Apologize, Take Ownership

HeC .... Healthcare Enterprise Cooperative

HEN .... Hospital Engagement Network

HHQI .... Home Health Quality Improvement

HIMSS .... Healthcare Information and Management Systems Society

HIPAA .... Health Insurance Portability and Accountability Act

HR ....Human Resources

I

ICU ....Intensive Care Unit
IDHP ....Iowa Department of Public Health
IHA ....Iowa Hospital Association
IHC ....Iowa HealthCare Collaborative
IHI ....Institute for Healthcare Improvement
IMRT ....Intensity Modulated Radiation Therapy
IOE ....Indicator(s) of Excellence
IA DNR ....Iowa Department of Natural Resources
IP ....Inpatient

IRPE ....Iowa Recognition for Performance Excellence
IS ....Information Services
ISCO ....Information Security Compliance Officer
ISP ....Internet Services Provider
IT ....Information Technology

J

JC ....Joint Commission on Accreditation of Healthcare Organizations

K

KPMs ....Key Performance Measures

L

ERP ....Lawson Enterprise Resource Planning
LEM ....Leadership Evaluation Manager
LI ....Leadership Institute
LOS ....Length of Stay
LPN ....Licensed Practical Nurse
LSS ....Lean Six Sigma

M

MBNQA ....Malcolm Baldrige National Quality Award
McFC ....McFarland Clinic
MD ....Medical Doctor
MEC ....Medial Executive Committee
MGMC ....Mary Greeley Medical Center
MICS ....Mobile Intensive Care Services
MMIC ....Midwest Medical Insurance Company
MPA ....Masters of Public Administration
MRI ....Magnetic Resonance Imaging
MVV ....Mission, Vision, and Values

N

NEO ....New Employee Orientation
NDNQI .... National Database of Nursing Quality Indicators
NHSN .... National Healthcare Safety Network
NRC Health ..... National Research Corporation

O

OFI .... Opportunity for Improvement
OIG .... Office of the Inspector General
OIC .... Organizational Integrity Committee
OP .... Outpatient
OSHA .... Occupational Safety and Health Administration
OPSC .... Organizational Profile & Strategic Context
OR VAT .... Operating Room Value Analysis Team

P

PC .... Personal Computer
PCI .... Percutaneous Coronary Intervention(s)
PDCA .... Plan-Do-Check-Act
PET .... Position Emission Tomograph
PFAC .... Patient & Family Advisory Council
PG .... Press Ganey
PHi .... Preventable Harm Index
PI .... Performance Improvement
PIT .... Product Improvement Team
PMS .... Performance Measurement System
PN .... Pneumonia
PP .... Performance Plan
PRC .... Professional Research Consultants
PRIDE .... People, Respectful, Innovative, Dedicated, Effective
PSC .... Patient Satisfaction Committee
PTCA .... Percutaneous Transluminal Coronary Angioplasty
PTO .... Paid Time Off

Q

QIP .... Quality Indicator Project
QPSC .... Quality & Patient Safety Council

R

RIE .... Rapid Improvement Event
REAP .... Rewards for Employee Achievement Program
RFP .... Request for Proposal
RN .... Registered Nurse
ROI .... Return on Investment

S

SAN .... Storage Area Network

SCIP ....Surgical Care Improvement Project

SCM ....Supply Chain Management

SLA(s) ....Service Level Agreement(s)

SMART..............Specific, Measureable, Achievable, Relevant, and Time-bound

SNAP ....Supplemental Nutrition Assistance Program

SNF ....Skilled Nursing Facility

SPTF ....Strategic Planning Task Force

SWOT ....Strengths, Weaknesses, Opportunities, Threats

SP ....Strategic Plan

SPP ....Strategic Planning Process

5s ....Sort, Straighten, Sweep, Standardize, Sustain

T

TAT ....Turn Around Time

TCU ....Transitional Care Unit

TJC ....The Joint Commission on Accreditation of Healthcare Organizations

U - V

UIU ....Upper Iowa University

UTI ....Urinary Tract Infection

VAT ....Value Analysis Team

VBP ....Value Based Purchasing

VSM ....Value Stream Mapping

VOC ....Voice of the Customer

VOM ………..Vector of Measures

VP ....Vice President

W - Z

PREFACE: ORGANIZATIONAL PROFILE

P.1 ORGANIZATIONAL DESCRIPTION

P.1a Organizational Environment

For more than a century, Mary Greeley Medical Center has provided quality patient care for central Iowans. The hospital, which opened in 1916, was built by Captain Wallace Greeley and given to the city of Ames, Iowa, in memory of his beloved wife, Mary, who died in 1914. Captain Greeley was a former Union Army officer during the Civil War. He and Mary settled in Ames, where he went on to become a prominent businessman, mayor and state legislator. Captain Greeley and Mary also helped establish the city's public library. In July 1915, six months after Mary's death, Captain Greeley announced his vision for the city's first hospital. Prior to 1916, Ames had no hospital facilities for its citizens. Captain Greeley consulted a group of local physicians about where to locate the new hospital and what to include in the building. He also brought in a medical specialist from Chicago who was nationally known as a consultant in the design and construction of hospitals. On Dec. 29, 1915, construction began on Mary Greeley Memorial Hospital. A local newspaper referred to the project as "*a most magnificent gift*" to the city. The original cost of the hospital was $80,000 and Captain Greeley provided an additional $3,000 for equipment and furnishings. The original building had 30 patient rooms. At the hospital's dedication on Sept. 24, 1916, which was attended by more than 2,000 people, Captain Greeley said, "It affords me great pleasure, more than words can express, that I contribute something towards the welfare of not only those now in need, but also for those who will be here long after we have passed away."

Today, Captain Greeley's vision to improve the quality of life in this community and honor the memory of Mary, lives on. Mary Greeley has grown with the region it serves and plays a vital role in the health of Ames and surrounding communities.

P.1a(1) Health Care Service Offerings MGMC is a public, not-for profit, 220-bed hospital. **Main health care services offered** include inpatient (IP), outpatient (OP), emergency department (ED), and home healthcare (HH) services (see also Figure P.1-**1**). A workforce of approximately 1,300 non-union, patient care and support staff, and a medical staff of over 200 providers **deliver health care services to** those in need. **Figure P.1-1 highlights the relative importance of each service to the organization's success.** MGMC's long-term organizational success and financial viability are supported by its focus on delivering health care services both efficiently and effectively (Figures 7.1b(1)) and with a patient centered focus (Figures 7.2a).

Figure P.1-1 MGMC Service Offerings

Service	Volume	Revenue	%
Inpatient	8,510 admissions	$245,524,399	43%
Outpatient	125,169 visits	$286,892,886	50%
Emergency Department	28,059 visits	$34,623,860	6%
Home Health/Hospice	17,260 visits	$6,933,428	1%

Mechanisms used to deliver health care services include direct and indirect patient care and support services provided by a workforce described in P.1a(3) and Figure P.1-3.

P.1a(2) Mission, Vision, Values, and Culture. The **mission, vision, and values (P.1-2)** are the foundation of MGMC's culture and as such, are the basis for the Indicators of Excellence (IOE), long-term and short-term goals, and Annual Action Plans within the strategic plan.

P.1-2 MGMC Mission, Vision, Values, Core Competencies
Mission
To advance health through specialized care and personal touch.
Vision
To be the best.
Values
P – People Oriented, **R** – Respectful, **I** – Innovative **D** – Dedicated, **E** – Effective (PRIDE)
Core Competencies
Quality, Safety, Patient Experience

The organization's tag line *Doing What's Right* captures a **key characteristic of its culture** and a unique element of MGMC's environment. This tag line, developed in part by employees, patients, and stakeholders during the re-branding process (1.1a(1)), reinforces the MVV and guides decision making, planning and engagement. It supports a culture where employees are empowered to continuously improve their work and to do what's right.

Through the SPP MGMC **identifies and establishes core competencies** (2.1a(4)) of high *quality*, *safe* care that is delivered by an engaged workforce which, in turn, results in an exceptional *patient experience*. These three core competencies support the MVV, and are central to the strategic plan and its Indicators of Excellence (IOE).

P.1a(3) Workforce Profile MGMC's **workforce profile** is detailed in Figure P.1-3 and describes employee, physician and volunteer **educational requirements, workforce groups and segments**. The employed workforce is defined by two segments: 1) patient care and 2) support services. The non-employed workforce is segmented by physicians and volunteers. Students are not included in our workforce numbers per the Baldrige definition as they do not do the work of the organization.

Figure P.1-3 Workforce Profile, Segments and Key Requirements

	Workforce Groups	Percent of Workforce	Educational Requirements	Key Requirements
MGMC Employed	EMPLOYEES 1,310			
	Patient Care	70%	RN/BSN, MSN, PhD, AD, Technical	Respect and Communication (7.3-17; 7.4-1)
	Support Services	30%	High school diploma, AD, Technical	
Non-Employed	PHYSICIANS 200			
	Physicians	Post-Graduate, MD, DO		Efficiency (7.1b(1)) Communication (7.4-4)
	VOLUNTEERS 500			
	Volunteers	Non-specific; must complete orientation and competencies associated with volunteer opportunity		Purposeful Work (7.3-22; 7.4-3)

Recent changes to MGMC's workforce composition include the need for adequate capability and capacity of the workforce to support our vision. Ames, Iowa has one of the lowest unemployment rates in the country (Ames = 1.2%; Iowa = 2.7%, and national = 4.1%), and must compete with other businesses for staff (capacity). **Changes in workforce needs** continue to be related to our employed workforce, specifically, our drive to increase the percentage of BSN prepared nurses. Research proves that patients experience fewer complications when the *majority* of nurses providing their care are prepared at the baccalaureate level. To date, more than 50% of our nurses are BSN prepared (from 30% in 2011; Figure 7.3-7).**Key drivers that engage the workforce in achieving MGMC's mission and vision** are listed in Figure P.1-5 and were determined as described in 5.2a(2). MGMC does not have any **organized bargaining units**. **Workforce special health and safety** requirements are described in 5.1b(1) and Figure 5.1-3 and 6.2c(1).

P.1a(4) Assets **MGMC's main site** is in Ames, Iowa, and has over 570,000 square feet of building space on the main campus. In 2012, MGMC began a multi-phased construction project that included a new, six-story patient care tower, new power plant and data center, a covered sky walk, and an expanded emergency department and ambulance garage. Phase 1 (new inpatient tower) was completed in April, 2014, and phase 2 (lobby, skywalk, ED and ambulance garage) was completed late 2016. MGMC is committed to its mission of advancing health and as such, in 2008 decided to collaborate with partner McFarland Clinic in the purchase of a shared Electronic Health Record (EHR). This integrated EHR operates a full complement of applications to support the delivery of patient care services for both inpatient and outpatient/ambulatory care and provides MGMC with a competitive advantage in the care coordination process (Figure P.2-3, SA1). MGMC does not have any patents.

P.1a(5) Regulatory Environment **MGMC adheres to the Iowa Code as well as all local, state and federal standards, regulations, and licensures** as noted in Figure P.1-4.

Figure P.1-4 Key Regulatory Agencies and Accreditations

Legal / Regulatory	
HIPAA	Privacy and security of health information (Figure 7.4-10)
EEOC	Non-discrimination of employees (Figure 7.3-3)
FLSA	Fair and equitable labor practices (Figure 7.3-3)
Occupational Health and Safety	
OSHA	Workplace safety (Figures 7.3-9; 7.3-11)
CDC	Standards for disease and infection control (Figure 7.3-12)
Accreditation and Licensure	
TJC	Standards for business, clinical, and facility safety and accreditation (Figure 7.4-8)
DNV	Standards for business, clinical and facility safety and accreditation. (Figure 7.1-31)
Financial and Environmental	
CMS	Medicare/Medicaid billing (Figure 7.4-8)
EPA	Environmental impact (Figures 7.4-11; 7.4-12)

P.1b Organizational Relationships

P.1b(1) Organizational Structure **MGMC is governed by a five-member elected** Board of Trustees (BOT). The MGMC BOT oversees and supports the strategic direction for the organization as well as provides oversight of quality outcomes and physician credentialing and privileging. **The President & Chief Executive Officer (CEO) reports to the BOT. Senior leaders** reporting to the President include the Chief Financial Officer (CFO), the Chief Nursing Officer (CNO), the Vice President of Clinical and Support Services, and the Vice President and Quality Improvement Officer. **Leaders** at MGMC are defined as department directors, supervisors/managers and they report to their 'one-up' (i.e. directors report to VP's, supervisors/managers' report to directors). The structure of MGMC's leadership system (Figure 1.1-1) is rooted in the PDCA methodology and the philosophy of managing for daily improvements (1.1c(1)).

P.1b(2) Patients, Other Customers and Stakeholders **Key health care market segments** include a primary market (Story County) and secondary market (Boone, Hamilton, Hardin, Marshall, and Greene counties). Patients are the **key customers** and are segmented as noted in Figure P.1-5. The key stakeholder is the community. **Key requirements** and expectations are listed in Figure P.1-5.

Figure P.1-5 Key Customer and Stakeholder Groups

Key Groups (and Segments)		Key Requirements and Expectations	Results
Patients (Customer)	**IP**	Quality/Safety	Figures 7.1(a)
		Communication	Figures 7.2-2; 7.2-3
	OP	Timely	Figures 7.2-6; 7.2-7; 7.2-8
		Communication	
	ED	Timely	Figure 7.2-10
		Care Coordination	
	Home Health	Care of the Patient (care coordination)	Figure 7.2-12
		Communication	Figure 7.2-14
Stake-holder	**Community**	Improved outcomes	Figures 7.1a
		Cost effective	Figures 7.4-14; 7.5-5

P.1b(3) Suppliers, Partners, and Collaborators **Key suppliers, partners, and collaborators and the role they play in the organization** are described in Figure P.1-6.

Figure P.1-6 Key Suppliers, Partners and Collaborators

	Type and Role in Work System	Role in Enhancing Competitiveness	Mechanism of Two-Way Communication	Role in Innovation	Key Supply Network Requirements
Suppliers	Supplier of medical and non-medical supplies,equipment, service	Provide cost effective supplies (SA1, SA2) Group purchasing power; cost effective (SA1)	Quarterly business/SLA review; on-site meetings; national vendor meetings; board member	Identify waste reduction; standardize inventory; negotiate new and improved pricing	**Timeliness, availability, cost effectiveness, expense reduction** Figures 7.1c
Partners	Formal contract with clinic (McFC) to deliver direct patient care	Provide superior care to achieve excellent clincial outcomes; enhance care coordination (SA1, SA3)	Medical staff directorship meetings; SLA review; member of SPTF	Support improvement efforts through RIE & VSM; support use of best practices through protocol driven care	**Effective and efficient** clinical care delivered; Figures 7.1a,b
Collaborators	Business leaders providing intermittent support to those who provide care	Recruiting businesses to area; support for local health care	Member, chamber board; economic development member; community collaboration	Collaborate on plan design to create steerage to MGMC to reduce overall healthcare costs	**Cost effective** pricing; Figures 7.4-14; 7.5-5
	Local colleges and universities providing intermittent support for educational priorities of the workforce	Student nursing pool; evaluate student nurses during practicum; expose MGMC to new graduate nurses	Ongoing support for student learning during practicum & preceptorships; nurse residency; on-site RN to BSN program	Use of technology to support on-site experience; collaborate on identifying creative solutions to increase RN to BSN	**Safe and effective care** through increased nursing education; Figures 7.3-6, 7.3-7, 7.3-8

P.2 ORGANIZATIONAL SITUATION

P.2a Competitive Environment

P.2a(1) Competitive Position **MGMC is the largest independent medical center** in its primary and secondary markets and has established itself as the market leader through effective strategic deployment of its mission and vision, a commitment to performance excellence, and successful workforce management. Based on the 2018 Iowa Hospital Association database (the most current, available data), MGMC's size and market share compared to its **key competitors** is listed in Figure P.2-1. **Growth** of MGMC compared to market segments is noted in Figures 7.5a(2).

Figure P.2-1 Market Share

Provider	Number Beds	Primary + Secondary Market (6 counties)	
		IP	OP
MGMC	220	42.8%	48.3%
[redacted] Des Moines (DSM)	802	9.5%	4.0%
[redacted] Des Moines (DSM)	779	9.1%	3.7%
[redacted]	125	9.7%	15.4%

Key competitors within a 35-mile radius of MGMC.

MGMC collaborates with local and state leaders and organizations to further its mission and to address its strategic challenges and opportunities. MGMC's commitment to a learning environment coupled with the requirement for baccalaureate-prepared nurses resulted in a collaborative arrangement with Iowa State University to offer a new RN-to-BSN program on their campus. To support efforts to increase BSN-prepared nurses by 2020, MGMC's Foundation provides scholarships to students in need. To date, MGMC has increased the percent of BSN prepared nurses (Figure7.3-7) which exceeds its goal.

P.2a(2) Competitiveness Changes **Key changes taking place that affect MGMC's competitive situation** include increased pressure to efficiently and effectively coordinate care and manage outcomes. MGMC's SP incorporates the goals and objectives of the Value Based Purchasing (VBP) program (Figures 7.1a and 7.2a(1)) so that alignment of these efforts is achieved. Additionally, changes in the way healthcare is being delivered (shift from IP to OP) and reimbursed which will present both strategic challenges (Figure P.2-4) and strategic opportunities (also 2.1a(2)) for MGMC.

P.2a(3) Comparative Data **Key sources of comparative and competitive data, including those from within the healthcare industry and those outside the healthcare industry** are listed in P.2-2

Figure P.2-2 Comparative and Competitive Data

Data Source	Measure	Example Results
CMS/HCAHPS (HC)	Patient engagement and clinical quality metrics	7.2-20; 7.2-24
IHA (HC)	Market share; Cost for services	7.5-5 through 7.5-9
Press Ganey (HC)	Core measures for process of care	7.1a
Premier Operations Advisor (HC)	Full Time Equivalent (FTE) and operational effectiveness	Leader Business Reviews (1.1c(2))
OSHA (HC + NHC)	Workforce safety	7.3-8; 7.3-9
NDNQI (HC)	Nursing practice measures	7.1-26; 7.3-6; 7.3-7
NHSN (HC)	Hospital Acquired Infections	7.1-9 and 7.1-10
IHC (HC)	Hospital Engagement Network	7.3-12
Moody's & Poor (HC + NHC)	Financial metrics	7.5-1 through 7.5-4
NRC (HC + NHC)	Patient engagement	7.2-3 through 7.2-11
	Provider engagement	7.3-23; 7.3-24
	Employee engagement	7.3-17; 7.3-18

*HC=healthcare; NHC=other industry/non-healthcare **cycle of learning to the process*

During the 2019 SPP, MGMC defined what being the best means and determined this to be 'incremental and sustainable improvements in our performance.' For MGMC, its vision *To*

Be the Best does not necessarily set the expectation that all results will be at the national top decile. Rather, the vision frames benchmark selection to focus the organization on continually striving to get better every day. Where appropriate, MGMC compares metrics to its key competitors. **The most pressing limitations to these data sources** include timeliness of reporting (i.e.: CMS, TJC, and IHA lag 9-18 months), access to historical competitor data for trending purposes, limited (if any) comparisons for segmentation with MGMC hospital groups, and lack of outpatient comparison data. Additionally, many benchmark sources provide only averages. While comparisons may be non-existent for some important metrics (i.e.; Preventable Harm Index), MGMC continues to monitor these and compares them to its historical performance for improvement.

P.2b Strategic Context

Key strategic challenges and advantages, identified during the SPP, are listed in Figure P.2-3.

Figure P.2-3 Strategic Challenges, Advantages, Opportunities	
Key Strategic Challenges	
SC1	Declining payment, payment change, consumer driven care, and non-traditional competitors.
SC2	Increasing behavioral healthcare needs.
SC3	Alignment with our physicians to continuously improve value.
SC4	Workforce capability and capacity.
Key Strategic Advantages	
SA1	Most comprehensive medical center in six county service area.
SA2	Lean transformation and PI broadly deployed resulting in process discipline.
SA3	Key partners clinic network, and referral loyalty to MGMC resulting in a high degree of confidence in the community.
SA4	Highly engaged staff and educated board of trustees.
Strategic Opportunities (2.1a(2))	
SO1	Develop partnerships to improve models of care.
SO2	Leverage our quality, safety and patient experience results to maintain and develop markets.
SO3	Be the convener to support community health.

P.2c Performance Improvement System

The Leadership System (Figure 1.1-1) provides the overall direction for performance improvement at MGMC. This system, as well as all systems at MGMC, are aligned with the Performance Improvement Model (Figure 6.1-1) and the PDCA method which supports a framework and culture of continuous learning and performance improvement. In 2017 MGMC adopted the DMAIC method (Figure P.2-3: **D**efine, **M**easure, **A**nalyze, **I**mprove, **C**ontrol) to support data-driven performance improvement efforts and to enhance sustainability of improvements. Combined, the PDCA and DMAIC models create a robust, systematic approach for improvement and innovation. Adding DMAIC allows MGMC to be more intentional about data collection and establish baseline metrics in the early stages of improvement (*define, measure*). Additionally, the *control* phase adds focus on sustainability through ongoing metric review and systematic deployment of best practices.

Key elements of MGMC's performance improvement system are embedded in the philosophy that every employee has two jobs – 1) to do your work and 2) to improve your work. This philosophy is further supported by a commitment to engage employees closest to the work to design and redesign their work processes. Involving those closest to the work in the design and redesign of their work is a philosophy that creates a respectful work environment and one that fosters positive change and supports innovation. The adoption of the Malcolm Baldrige Performance Excellence criteria, including a commitment to the ongoing self-assessment and annual application process at both the state and national level further supports a culture of continuous improvement. MGMC incorporates the feedback received into its performance improvement strategies through the Annual Action Planning process (2.1a(1)).

Figure P.2-3 PDCA & DMAIC Method – Standard Work for Improvement & Innovation Events (6.1a(1); Figure 6.1-1)		
Plan	**Define**	• Pre-work meeting to discuss project • What is the goal of the project? • Strategic Initiative this project supports? • Complete charter; define scope, problem • Identify participants including wild card • Select dates for project • Identify metric(s) for project • Determine future state opportunity
	Measure	• BI - Data-mining /collection of current state ** • Conduct observations if necessary • Identify source for benchmarks/comparison • Develop baseline report via data collection
Do	**Analyze**	• Project kick-off with full team • Review scope of project with team • Team develops purpose statement • Team maps out current state • Team 'goes to see' the process/work
Check	**Improve**	• FMEA & team selects opportunities • Works key opportunities into system • Create & test Standard Work to support improvement • Conduct small test of change • Monitor baseline metrics to determine improvement • First Friday report out; sharing and learning
Act	**Control**	• Standardize new process • Monitor metrics • Celebrate wins • Sustain through validation of Standard Work • Deploy improvements as appropriate • Post-event follow up with executive champion **

The process for evaluation and improvement of key organizational projects and processes begins with the visionary goals established during the SPP (2.1-1). Additional priorities include consideration of high volume, high risk, and problem-prone areas. The Performance Improvement Model (Figure 6.1-1) provides the framework for the Improvement & Innovation Council to vet improvement initiatives. A project selection matrix (AOS) prioritizes initiatives and assigns resources to projects. Activities, such as Rapid Improvement Events (RIE) or Value Stream Mapping (VSM) events are deployed. The re-design of workflows to improve efficiency and reduce variation are vetted by multi-disciplinary teams during these events. These systematic events are designed to engage the workforce to look for variation and waste in the current state, identify opportunities for improvement, test new processes, and implement best practices. In 2016 MGMC added the 'Critical to Quality' process to events in order to better align outcomes with key customer requirements. Priority

Mapping allows teams to systematically create actions plan at the conclusion of the event, essentially providing a roadmap for what steps to take next. Standard Work (1.1c(1)), an organized, interdisciplinary and collaborative approach with a customer-supplier focus, aids in the systematic validation of improvements, serves as an educational tool for the management of organizational knowledge (4.2b(1)), and prepares the workforce for changes in organizational structure and work systems (5.1a(3)). To further support organizational improvement and foster respect in the workforce, MGMC began creating Work Systems Maps for its key work systems (2.2a(4) and 6.1a).

The Performance Measurement System (Figure 4.1-1) **provides the framework to evaluate progress** of improvement using data and holds process owners accountable to monitor results toward established efficiency and effectiveness goals. The Workforce Management System (Figure 5.2-2) supports high performance work and engagement and provides opportunities for rewarding and recognizing employees for contributing to improvements. Through several cycles of learning, KaiNexus, was implemented to systematically track and manage projects. KaiNexus has since been deployed to staff to support daily improvements (1.1c(1)). Communication of results is deployed through the various communication mechanisms noted in Figure 1.1-2. A dashboard of indicators with key leading and lagging metrics supports deployment of results to the workforce, Board of Trustees, and various committees and councils. These metrics are directly aligned with the short- and long-term goals and objectives of the SP (Figure 2.1-3). Knowledge sharing of MGMC's overall PI efforts and internal best practices occurs regularly through daily three-tiered safety huddles (1.1c(1)), First Friday (1.1c(1)), employee updates, and the Leadership Institute (LI). Through these key elements and its tenacious focus on organizational excellence and in Doing What's Right, MGMC is able to improve and sustain its work processes and deliver exceptional results. This commitment has earned MGMC numerous awards and recognitions including the Des Moines Register Top 100 Workplaces, the Iowa Healthcare Collaborative Patient Safety Award for the reduction of Hospital Acquired Infections and the Innovation in Patient Centered Care award for its Patient Centered Scheduling project. Additionally, the Studer Group recognized MGMC with the Excellence in Patient Care award as well as the Healthcare Organization of the Month in 2012 and again in 2017. In 2019 MGMC was recognized by the American Nurses Credentialing Center (ANCC) as a Magnet designated hospital for its nursing excellence and high-quality patient care. Additionally, MGMC is the only organization in the state of Iowa to earn the highest level of recognition from the state's Baldrige-based program, the Iowa Recognition for Performance Excellence, **twice** (2014 and again when eligible in 2017).

Our tenacious focus on getting better everyday has transformed our performance improvement journey to deliver some of the most excpetional outcomes as noted in Figure P.2-5 PI System Effectivenss – Improvement Journey.

Throughout the application, the PDCA/DMAIC model is embeded in our systems and workflows through a consistent coloring format:

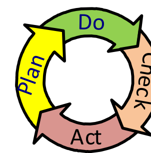
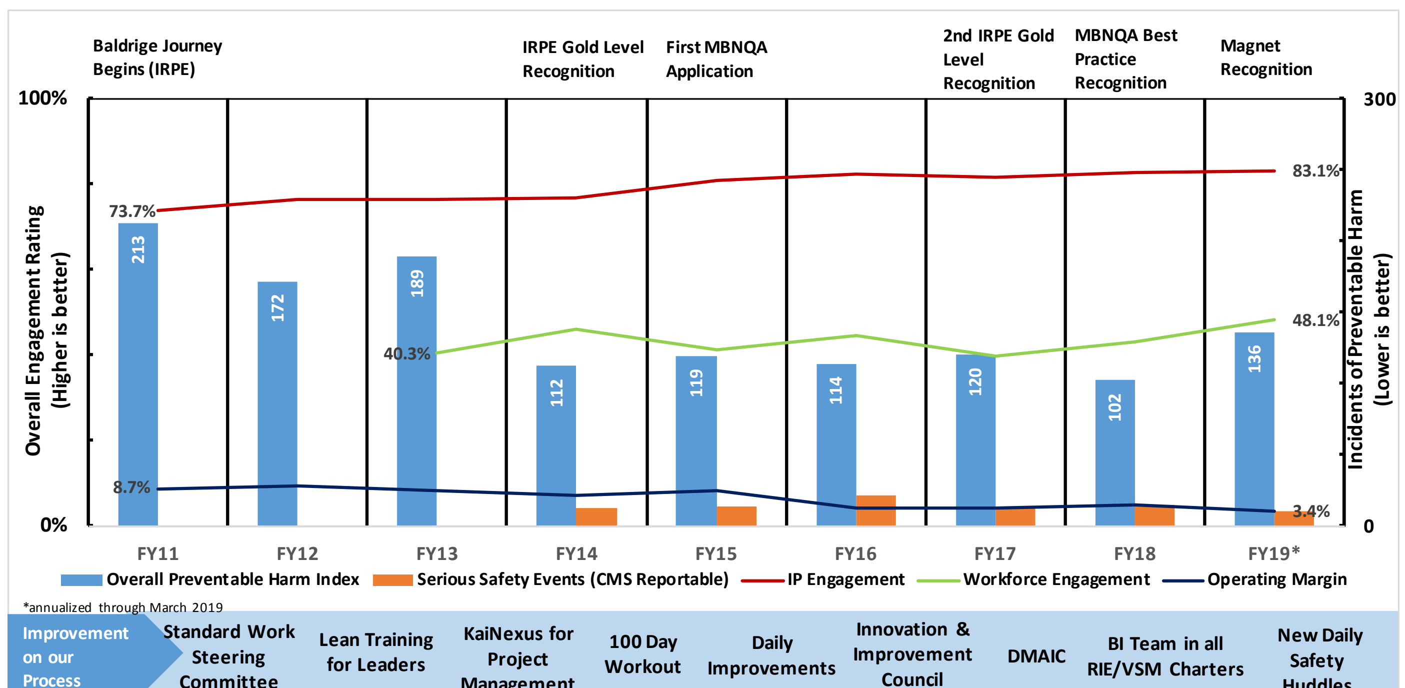


Figure P.2-5 PI System Effectiveness – Improvement Journey



CATEGORY 1: LEADERSHIP

1.1 SENIOR LEADERSHIP

1.1a Vision and Values

1.1a(1) **Senior Leaders (SL) systematically set, communicate, and deploy the mission, vision, and values (MVV),** through the Leadership System (Figure 1.1-1). This System aligns the mission, vision, and values of the organization with the requirements of patients, other customers, and stakeholders and is pivotal in deploying the medical center's commitment to the mission while balancing key initiatives to achieve performance excellence.

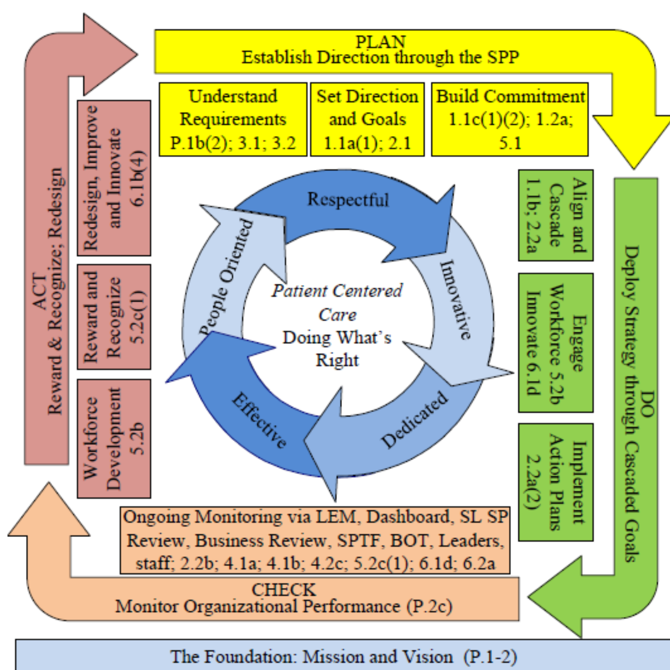


Figure 1.1-1 MGMC Leadership System

The original MVV for MGMC, developed by employees and leaders and adopted by the Board of Trustees (BOT) in 1993, serves as the organization's foundation. During the Strategic Planning Process (SPP) (Fig 2.1-1, Step 1), the MVV are assessed for ongoing relevance and modified as appropriate. During the 2014 re-branding process, employees, patients, other customers, partners, suppliers, and collaborators provided input into a new tag line "*Doing What's Right*." During the 2016 SPP, input from the workforce and VOC feedback led to a revised mission statement and a bold new vision *"To be the Best"* (Figure P.1-2). The medical center operates under a patient-centered care philosophy and, as such, all systems reflect that philosophy. During the 2019 SPP, the Strategic Planning Task Force (SPTF) affirmed the MVV and created a definition of what being the best looks like to more appropriately set targets for future performance (4.1a(2)). SL personally deploy the MVV to the **workforce, medical staff, and key suppliers, partners, and collaborators** through regular two-way communication (Figure 1.1-2) and the planning and establishment of annual goals and objectives (created with the workforce as well as with key suppliers, partners and collaborators; 2.2a(2)). The Strategic Path flyer, created in 2019, succinctly communicates the MVV, key strategic objectives and Big Dot Goals with the workforce, suppliers, partners and collaborators. Publications contain the message of the MVV through various stories and promotion of services. The employee focus groups, initiated after the 2017 engagement survey, offer the CEO an opportunity to further deploy the MVV to the workforce through two-way dialogue. The medical staff support the MVV through credentialing, privileging, and the onboarding process. In 2014, MGMC SL worked with the medical staff to create a Code of Conduct specific to interactions of physicians with patients, families, and each other. This Code of Conduct, signed at medical staff appointment and reappointment ensures a consistent patient-centered care approach. Similarly, the Volunteer Code of Agreement supports the MVV and guides interactions between volunteers and patients.

Senior Leaders' personal actions reflect a commitment to the organization's values through rounding with staff and listening to their concerns and accomplishments (people-oriented), through fair and respectful two-way communication, and through CEO led employee focus groups. Respect is reinforced through communication and support of engaging those closest to the work to be innovative in the design and re-design of their work; through SL commitment to supporting an environment where efficiency and effectiveness are encouraged in achieving goals and objectives; and through their dedication to this work and in sharing the progress quarterly with all employees at updates. Employees, with support from SL, developed and deployed a set of service behaviors to guide appropriate interactions throughout the medical center in support of the MVV. These behaviors include supporting a clean, safe environment, making eye contact with and greeting people in the hallways, and escorting patients/visitors to their destination. SL share these service behaviors with employees at twice-monthly New Employee Orientation (NEO) and ongoing throughout employment. They guide interactions between employees and patients, other customers, and stakeholders. The PRIDE values (Figure P.1-2), refreshed and reconnected with the workforce in 2018 (5.2c(3)), represent the expected values of the organization, and all employees commit to these values at NEO and throughout their employment. Through rounding, SL recognize employees for exhibiting the MVV in their daily work and send personal thank-you notes to employees' homes to recognize values-driven work. SL are visible and participate in improvement events, department meetings, monthly PRIDE recognition, monthly department recognition and quarterly employee updates. SL provide opportunities for high performing staff to attend functions such as the Iowa Healthcare Collaborative annual patient safety conference, the Iowa Hospital Annual meeting, and the Iowa Recognition for Performance Excellence celebration. It is through visibility and these activities that SL systematically reiterate and demonstrate their commitment to the MVV.

1.1a(2) **SL personal actions demonstrate a commitment to an environment that requires adherence to legal and ethical** behavior through a comprehensive 4-step process (Figure 1.2-3). SL personally communicate expectations during NEO, and, like all employees, sign the Code of Conduct acknowledging compliance with the code as a condition of employment. SL participated in the development of the code, which aligns with

the medical staff Code of Conduct and the volunteer Code of Agreement. **SL promote an environment** of zero tolerance for non-compliance to the Code of Conduct. Expectations of conduct are further reinforced by SL during the workforce on-boarding process, monthly rounding, medical staff appointment and re-appointment, annual volunteer engagement review, and annual employee performance reviews. MGMC's Compliance Officer monitors adherence to all legal and ethical behavior and regularly reports to SL and to the BOT, including immediate reports of findings. The 4-step process is reviewed during the ongoing for relevance and improvement. In 2017, due to changes in the industry and an increase in the number of investigated breaches (Figure 7.4-10), MGMC took action to improve its approach by adding a compliance session to NEO, delivered by MGMC's Security Officer. Additionally, SL share expectations of legal and ethical behavior at NEO and the CEO shares expectations and key elements of the Code of Conduct and MGMC's zero tolerance policy during employee updates. Education is done annually and tracked via the Computer Based Learning (CBL) system. A multi-disciplinary Ethics Committee, chaired by an external physician and with SL support, provides assistance to the workforce in addressing patient care issues.

1.1b Communication

SL communicate with and engage the entire workforce, key partners, patients, and other key customers through multiple methods (Figure 1.1-2), most that are designed to encourage **frank, two-way communication**. The Leadership System (Figure 1.1-1) systematically incorporates communication into its processes through its PRIDE values and the PDCA cycle. These communication methods are regularly reviewed for relevance and improvements incorporated. For example, in 2019 the daily safety huddle (1.1c(1)) was moved to the performance improvement conference room to facilitate frank, two-way interaction regarding safety. Additionally, in an effort to increase nursing attendance at quarterly updates, in late 2017 MGMC began delivering the update at nursing practice council meetings and streamed them live to nursing units. This increased attendance by more than 50% (Figure 7.4-2). In 2015, volunteers were added to the CEO anniversary breakfast. SL communicate with key suppliers and partners at mutually agreed upon intervals and during quarterly business reviews. A new Strategic Path flyer communicates key priorities and establishes a mechanism for reviewing mutual goals and achievement of supplier standards and SLAs. SL round with physicians, engaging them in solutions for process design and re-design such as the Transitions of Care (TOC) program that led to improved care coordination and a reduction of readmissions (Figure 7.1-1). **Key decisions and the need for organizational change** are communicated systematically from SL to leaders and cascaded to staff through the three-tiered daily safety huddles to ensure timely and effective messaging. Employees can now submit questions for updates via the Gram as a result of an employee submitted Daily Improvement idea in 2018. SL take a **direct role in motivating the workforce to reinforce high performance and a patient, customer and business focus** by empowering those closest to the work to participate on RIE and VSM events and to submit ideas for Daily Improvements. The Innovation & Improvement Council's project prioritization matrix supports a balanced approach between clinical and support department improvements to ensure value for patients, customers and other stakeholders. SL participate in these events to support the workforce and to encourage two-way communication. Volunteers are engaged in daily improvements through leader rounding in their assigned departments.

Figure 1.1-2 SL Communication Methods

Communication Method	Frequency	Key Decision	Need for Change	Employees	Physician	Volunteers	Patients	Community	Suppliers, Partners
Safety Huddle *	D	X	X	X	X	X	X	X	X
Patient Rounding *	S	X	X				X		
Reward/Recognition	D			X	X	X			
E-mail Including Gram (employee newsletter)	D W	X	X	X	X	X		X	X
Management Team Mtg.. *	M	X	X	X					
PFAC*	M	X	X	X		X	X	X	
CEO Breakfast *	M	X		X		X			
Employee Rounding *	M		X	X					
EAC *	M	X	X	X					
Focus Groups *	A	X	X	X	X	X	X	X	X
Health Connect	Q	X	X	X	X	X	X	X	X
Leadership Institute *	Q	X	X	X					
Employee Updates *	Q	X	X	X	X	X			
Prime Time Alive *	M	X		X	X	X			
Medical Staff Meetings	M	X	X		X		X		
Meeting Minutes	O	X	X	X	X				X
Internet	O	X		X	X	X	X	X	X
Intranet	O	X	X	X	X	X			
Social Media *	O	X	X	X	X	X	X	X	X
Innovation & Excellence *	A			X	X				
Annual Report	A	X						X	X
Neighborhood Meetings *	O	X	X	X	X	X		X	
Press Releases	O	X	X	X	X	X	X	X	X
Safety Behaviors	O	X	X	X	X	X			X
First Friday *	M	X	X	X	X	X		X	X
Strategic Path Flyer	O	X	X		X		X	X	X
*Two Way; D=Daily; S=Per Shift; W=Weekly; M=monthly; A=Annually; O-Ongoing									

1.1c Mission and Organizational Performance

1.1c(1) **SL create an environment for success and achievement of the organization's mission now and in the future** through alignment of SPP with the MVV and a culture of continuous improvement. The mission is the foundation for the SPP and, as such, provides the framework for annual action planning and the establishment of goals and objectives. Goals are cascaded to the workforce, are embedded in the annual performance planning and review process, and are systematically reviewed to ensure success.

SL create and reinforce an organizational culture of doing what's right to support patient-centered care through encouraging Daily Improvements and by engaging those closest to the work to participate in the improvement of their work. This culture **fosters workforce engagement** and supports an environment where patient-centered care flourishes. Likewise, patients and other customers are included in RIE and VSM events to give input on improvements, which creates a **culture**

that fosters patient and other customer engagement. AIDET (Acknowledge, Introduce, Duration, Explain, Thank), rounding, and bedside shift reporting are hardwired behaviors that encourage input from patients and other customers to engage them in the coordination of their care. SL and other leaders engage staff at all levels through validation of these behaviors to support patient-centered care. The Patient & Family Advisory Council (PFAC), chartered in 2012, further **fosters patient and other customer engagement** through its collaborative teamwork**.** The Big Dot Goal philosophy, cascaded to all employees in 2018 via individual Big Dot Goal cards, ensures SL create and reinforce a culture of doing what's right; **one that fosters patient, other customer and workforce engagement and a culture of patient safety.**

SL create and reinforce a culture of patient safety through adherence to the MVV, and CC. MGMC adopted the industry best-practice 6 Expectations of Safe Behavior (6.2a)**.** These behaviors outline safety expectations of all employees and are communicated during NEO and ongoing in order to hardwire them into practice. Organization-wide patient safety goals are cascaded from SL to leaders and further deployed to staff via annual performance plans. Standard Work is developed and used to ensure safety and efficiency. SL, including medical staff leadership, created the Preventable Harm Index (PHI) to create urgency around patient safety, particularly those events that may cause harm. This innovative and systematic approach captures all potential harm events, including near misses, to inform the organization's improvement work and prevent future harm, especially serious safety events. While the PHI was researched as an emerging best practice, benchmarks are not available so MGMC monitors rates for the various components of the index, which are benchmarkable. Based on results related to falls and pressure injuries, the organization trained leaders to use the A3 problem solving tool and began conducting A3s on all of these events to immediately identify and address root causes and implement improvements. A3 alerts draw attention to an event that is re-signaled, and a weekly safety bulletin is deployed house-wide. Leaders communicate A3 results and actions for improvement at daily safety huddles for further deployment to staff. As a result of a suggestion at an organizational safety huddle in 2016, the safety bulletin is now linked to the Gram to further deploy findings and improvements throughout the workforce. SL and leaders are held accountable for reducing serious safety events through the SP and its weighted goals and the Innovation & Improvement Councils prioritization matrix places a heavier weight on projects that improve patient safety. In 2014 SL implemented a daily organizational safety huddle. Leaders meet at 8:45 daily to do a stand-up report out of any safety issues or other similar operational issues, including days since last serious safety event (employee/patient PHI). This process was further refined through an innovative three-tiered approach whereby the first tier starts at the bedside, and then at the unit department/unit level, and finally at the organizational level. This three-tiered approach improves communication, raises the awareness of potential safety events throughout the organization, from clinical to non-clinical departments, and provides a process for immediate deployment of actions. Through cycles of learning, the department and organizational huddles were revised in 2018 with enhanced standardization of the huddle boards as well as greater alignment of department goals (leading measures) to the organizations Big Dot Goals. The organization conducts the Agency for Healthcare Research and Quality (AHRQ) Culture of Safety Survey every other year (Figure 7.4-1), and action plans are developed.

The very nature of the PDCA approach, built into the leadership system, **cultivates organizational agility and accountability** through the ongoing review and improvement cycle. The Leadership System supports the philosophy that every employee at the medical center has two jobs 1) to do your work, and 2) to improve your work. As such, this philosophy **cultivates organizational and individual learning** and supports **innovation and intelligent risk taking** through the continuous improvement and innovation cycle (4.1c(2)) and Figure 6.1-1). Additionally, MGMC has developed an internal knowledge base of over 65 years of examiner experience in the state and national Baldrige programs (Figure 7.3-26). Ongoing employee education, loan forgiveness, tuition reimbursement, RN to BSN support, and the Rewards for Employee Achievement Program (REAP) also aid in cultivating individual learning. MGMC implemented First Friday in 2011 to share best practices, recognize teamwork post RIE, VSM and improvement events, and to support organizational learning. In 2018 a monthly cascading of the SL SP Review of Big Dot Goals was added to First Friday to share progress to goals and to further support individual and organizational learning. MGMC's philosophy of engaging those closest to the work supports organizational and workforce learning as evidence by its approach for incorporating lean management principals into daily work. In 2014, MGMC engaged all leaders in a "100 Day Workout" event and challenged each department to identify one cost-saving or revenue-generating idea within their scope that could be completed within 100 days. Fifty-six ideas were identified and implemented with a hard savings of over $600,000. A celebration and report out was conducted at First Friday generating organization and cross-department learning. This successful program was repeated in 2016 and again in 2017 to continue to engage leaders and **deploy organizational learning** around waste elimination and value creation. This event was so successful at generating solutions to everyday issues that MGMC created the Daily Improvement program to engage the entire workforce in identifying improvement opportunities in their daily work (Figure 7.3-20). For example, a phlebotomist took wheels from a skateboard and put them on his lab cart to make the cart move easier and with less noise. All lab carts were refitted as a result.

Innovation and intelligent risk taking is cultivated through the SPP (Figure 2.1a(1), the Leadership System (Figure 1.1-1), and the continuous innovation and improvement process (4.1c(2) and Figure 6.1-1). A culture where employees seek out small improvements on a daily basis is the foundation of the "improve your work" philosophy and results in employees continuously looking for ways to make their work better. This approach also supports input to the innovation management approach (6.1d). To date, over 3,300 Daily Improvement ideas have been submitted (6.1b(4)) with over 70% of these resulting in meaningful change (Figures 7.3-20 and -21). The Business Intelligence team (BI team), a multi-disciplinary team including workforce members, physicians and suppliers, systematically support **intelligent risk taking** through a comprehensive

Business Planning approach that includes identifying opportunities for service enhancement or growth, vetting resource risk through pro-forma development, testing of opportunities, and monitoring performance to plan. This approach was improved in 2018 with the creation of a project charter that is completed to enhance data-driven decisions. The charter incorporates key qualitative and quantitative information including market analysis and how it supports MGMCs IOE, strategic objectives, CC, and workforce plans.

SL participate in succession planning and the development of future organizational leaders through career progression (5.2c(4)), which identifies high performers within the organization and develops them for future advancement. Due to projected changes in MGMCs workforce needs (P.1a(3)), SL produced a five-year list of potential leader retirements and created a succession plan for their potential replacements. This list is reviewed during the Annual Action Planning process, including workforce planning assessment to support leadership development and succession planning. This approach was successfully applied in the radiology, human resources, inpatient nursing, and IT departments when these directors retired. It was also successfully used in 2017, with the appointment of an internal candidate, when a long-term SL retired. As part of the ongoing succession planning process and to further develop senior leaders, a 360-degree tool was incorporated into the 2014 evaluation process. Results are shared by the CEO with each VP and support ongoing development needs. In 2018, a leader 360 was added to the annual evaluation process to allow for additional insights into the leaders individual development opportunities. Physician leadership succession planning is managed through the medical staff structure of identifying, grooming, and appointing department chairs, secretary, and chief of staff roles. In 2014 MGMC collaborated with McFarland Clinic to begin offering an on-site Physician Leadership Institute program to further enhance physician development and augment the traditional succession planning process. To date, more than 20 physicians have participated and several have transitioned into leadership roles.

1.1c(2) **SL create a focus on action that will achieve the organization's mission** through the Leadership System (Figure 1.1-1), effective SP, and outcomes management. **SL create a focus on action to improve organizational performance** through the cascading nature of action plans and alignment through workforce goals and objectives. As a cycle of learning through best practice research with a Baldrige organization, in 2016 SL created a systematic review of the Annual Action Plan goals to the SP to **identify needed actions and** redirect goals. This monthly Senior Leader Strategic Plan Review process (SL SP Review) monitors progress toward goals, identifies and redirects needed actions, and proactively plans for the next year's action planning process. The Leader Business Review process, added in 2017 to support leader success, is a deep dive into the leader's area of responsibility using key measures of engagement and operational performance to identify needed actions to support 90-day plans. Through several cycles of learning, Standard Work for the Leader Business Review process was refined in 2019 to align with the Baldrige categories. This Standard Work also includes a department SWOT analysis and alignment of department goals to Big Dot Goals to specifically target key opportunities for improvement and cultivate ideas for innovation and intelligent risk taking. In the 2017 Annual Action Planning cycle, MGMC adopted the Big Dot Goal philosophy to create laser focus on action required to achieve key organizational strategies (Figure 2.1-3). Metrics supporting each Big Dot Goal are developed during the Annual Action Planning process and cascaded to leaders and the workforce. Ongoing monitoring occurs via the SL SP Review and reporting occurs via the Dashboard, LEM, BOT meetings, updates, medical staff meetings, and supplier, partner, and collaborator meetings. This alignment has resulted in breakthrough improvement of the most important strategic initiatives (Figure 7.5-14). To further support workforce engagement and alignment of strategies, all employees complete an individual Big Dot Goal card during their annual performance review.

Learnings from the SL SP Review are cascaded during the leadership monthly meeting model review (4.1b), focusing on opportunities to support achievement of the plan. The same is repeated with the BOT and the Strategic Planning Task Force (SPTF) on regular intervals to monitor and report progress to plan and, if necessary, to proactively re-direct efforts. Progress to plan via the Big Dot Goal review is shared with the workforce during quarterly updates, quarterly medical staff meetings and during quarterly business reviews with key suppliers. Through this systematic review process, MGMC captures learnings to incorporate into the next SPP. The Innovation & Improvement Council supports the organization's work by systematically identifying needed actions. A project prioritization matrix aids the council in selecting improvement work that is aligned with the SP, Annual Action Plan and Big Dot Goals. Through the rigor of the SL SP Review process and ensuing Leader Business Reviews and project identification, the organization is able to **create and balance value for patients, customers, and other stakeholder**s.

SL demonstrate personal accountability for the organization's actions by leading the SPP (Figure 2.1a(1)) and through the systematic monitoring of progress to goals (1.1c(2)). The cascading nature of plans (2.2a(2)) ensure goals are aligned and monitored for progress. SL lead daily safety huddles, participate in RIE and VSM events, and conduct rounds with the workforce to support and highlight organizational priorities, ensuring consistency in messaging.

1.2 GOVERNANCE & SOCIETAL RESPONSIBILITIES

1.2a Organizational Governance

1.2a(1) MGMC **ensures responsible governance** through a five-member elected, highly engaged BOT. Each BOT member has been certified and recertified through the Iowa Hospital Association (IHA) Trustee Certification program). They are the first board in the state to achieve this certification and recertification. MGMC's President/CEO reports to the BOT and is **accountable for organizational performance and compliance.** Together, the BOT and SL **fulfill their societal responsibilities and ensure ethical behavior** as described in Figure 1.2-1.

1.2a(2) **Senior leader performance** is evaluated both qualitatively (1:1) and quantitatively (360 assessment). The BOT annually evaluates CEO performance and the CEO, in

Figure 1.2-1 Senior Leader and Governance Accountability	
Indicator	**Processes and Actions**
Accountability for SL Actions	Annual performance review (1.2a(2)); 360-degree assessment; Annual Engagement Survey including Chief of Staff; Accreditation and internal review processes; BOT review of key metrics
Accountability for Strategy	Annual Action Plans tied to short/long term SP; Plans cascaded to leaders and to staff; Cycle of learning in 2016 with creation of SL SP review (1.1c), LEM and Dashboard of indicators deployed organizationally.
Fiscal Accountability	Strict adherence to generally accepted accounting principles; Sarbanse Oxley compliance; Regulatory review/accreditation; Corporate Compliance reporting to Finance and Governance & Comp Committees.
Accountability for Patient Safety and Healthcare Quality	Medical Staff Credentialing and Privileging process; Quality & Patient Safety Council reviews and ensures adequate resources to support reduction/prevention of serious patient and workforce harm; ongoing review of key core measures.
Transparency in Operations	Regulatory and accreditation oversight (Figure P.1-4); Link to public reporting of quality and cost information; Display key quality and cost via internet site; Regulatory requirements met (Figure P.1a(5)).
Selection of BOT Members and Disclosure Policies	Open meetings; Election of BOT; Governance & Compensation Committee provides oversight of policy, nomination process; new in 2016 - BOT needs tool used for replacement of longstanding member.
Independence & Effectiveness of Internal / External Audits	External audits conducted of IT infrastructure and security; Cycle of learning in FY16 audit to include HIPAA review; External financial audit; Internal safety & biomed audits; Audits for compliance of confidentiality and security of records.
Protection of Stakeholder Interests	WORKFORCE Code of Conduct; Corporate Compliance including HIPAA compliance and reporting; LEED Silver Certification.
SL Succession Planning	Creating environment for success (1.1c(1)); Leadership Institute; IHA Leadership; IHA Governance Forum; Career Progression and Development (5.2c(4)); SL 360 (1.2a(2)) to support SL succession planning process.

turn, evaluates VP performance. Annual reviews are conducted using results from the Leadership Evaluation Manager (LEM) tool, and the 360 assessment tool. The output of both provide guidance to support SL goal setting during the next annual action planning cycle (2.2a(2)). Achievement of Annual Action Plan goals are evaluated, and input is sought from SL for the CEO through the 360-degree assessment tool. The 360-degree assessment was added for VPs in 2014 to better align SL efforts with organizational objectives. SL compensation is at risk based on weighted goal accomplishment. In support of MGMC's CC, the BOT heavily weighted quality and safety metrics for **SL risk-based compensation** in fiscal year 2015 and continues this practice to date. The **BOT performance is evaluated** for effectiveness annually utilizing the IHA and Governance Institute board assessment tools. Improvement in organizational effectiveness is achieved by combining results of senior leader and board evaluation and assessments. For example, in 2013 the BOT assessment identified the need for greater BOT involvement in quality reporting. As a cycle of improvement, these topics are now balanced to support the 6 Aims for Improvement and the Institute for Healthcare Improvements 'Framework for Effective Board Governance of Health System Quality'. The senior team, along with the Quality & Patient Safety Council (QPSC), created an annual calendar of topics for BOT meetings. Based on 2018 results, quality reports to the BOT now include physicians to demonstrate to the BOT how clinical quality improvement efforts are supported by the medical staff. **Leadership system effectiveness** is enhanced through a commitment to a learning organization (Figure 5.2-3) and a culture of continuous improvement. For example, the Leader Business Review process supports leadership success and organizational effectiveness.

1.2b Legal and Ethical Behavior

1.2b(1) MGMC **addresses current and anticipates future legal, regulatory, and community concerns with healthcare services and operations** through rigorous adherence to all applicable laws, regulations, and accreditation standards (Figure P.1-4) as well as through open, two-way communication (Figure 1.1-2) and customer and other stakeholder listening and learning approaches (Figures 3.1-2; 3.2-1; 3.2-2). Our use of FMEA (Failure Mode Effect Analysis) allows us to proactively manage potential impacts. MGMC maintains an environment whereby regulatory compliance is ensured 365-days a year and monitors such through the Organizational Integrity Committee (OIC), the Environment of Care Committee (EOC), and The Joint Commission (TJC) preparedness committee. **Adverse societal impacts** are addressed through the EOC, through proactive risk assessment of operations, ongoing compliance monitoring, HIPAA auditing, and auditing of key operations (7.4a). Figure 1.2-3 provides the approach to ensure legal and ethical behavior is systematically deployed through all interactions of the workforce, including to customers, suppliers, partners and collaborators. When findings show improvement is needed, A3s are used to determine root cause(s), and a plan for correction is initiated and monitored. This systematic approach allows MGMC to **anticipate public concerns with current and future healthcare services and operations** and take corrective action when necessary**.** The medical center includes the community and other stakeholders in the SPP, RIE and VSM events, forums, and neighborhood meetings. MGMC **prepares for impacts and concerns and proactively** addresses potentially adverse impacts on society through the Corporate Compliance Program, the Q&PSC, the EOC, and the Patient Complaint Management Process (Figure 3.2-2). Throughout the construction process, including the new patient tower, neighbors were involved in the exterior design and layout of the building as well as the new traffic flow. MGMC works to minimize the facility's impact on the environment through tracking key societal measures of its operational footprint (Figures 7.4-10). The new inpatient tower is LEED Silver Certified and was designed to conserve natural resources and be aesthetically friendly to the neighbors with landscaping strategically placed to reduce light impact to neighbors.

Key compliance processes, measures, and goals for meeting and surpassing regulatory, legal, and accreditation requirements as well as **key process, measures, and goals for addressing risks** with healthcare services and operations are displayed in Figure 1.2-2. Based on an increase in the number of reported breaches, a compliance session was added to NEO. Additionally, expectations of legal and regulatory behavior are now communicated ongoing at updates.

1.2b(2) In addition to methods described in 1.2b(1) and Figure 1.2-2, **MGMC promotes and ensures ethical behavior** through adherence to policies and procedures such as the Code

Figure 1.2-2 Key Compliance, Risk and Ethics Measures		
Process	**Measure**	**Goal**
Accreditation/Licensure (Figure 7.4-8)		
TJC	Accreditation	Full
CMS	Requirements Met	100%
CARF	Accreditation	Full
DNV	Stroke Certification	Achieved
Magnet	Accreditation	Full
Regulatory/Legal (Figures 7.4-6; 7.3-9-10)		
Workplace Safety	OSHA Incident Rate	lower
Annual WF Training	Training Completion	100%
Conflict of Interest	Disclosure of conflict	0
Risks (Figure 7.4-6)		
EOC Plan	Annual update	100%
FMEAs	On-Time Completion	100%
Ethics (Figure 7.4-7)		
BOT Open Meetings	Compliance	100%
Code of Conduct	WF Training Completion	100%
HIPPA Monitoring	HIPAA Fines	0
WF trained on HIPAA	Number	100%
OIG Sanctions	Number	0

of Conduct and Corporate Compliance, which provides the framework for ensuring requirements are met (Figure 1.2-3). This approach, coupled with the MVV, laws and regulations (Figure P.1-4), call out expected behavior with and between the workforce, BOT, patients, other customers, partners, suppliers and stakeholders. Expectations of ethical performance of partners, suppliers, and collaborators are spelled out in service contracts and Business Associate Agreements and are validated during quarterly/semi-annual vendor business reviews. In-services, training, testing, and audits all validate learning and adherence to requirements. Findings, both internal and external, may require re-training or improvement and are deployed via the learning and development system (Figure 5.2-3). Based on results of early Electronic Health Record (EHR) audits, MGMC began offering employees additional training on appropriately accessing medical records. Compliance in adhering to healthcare privacy is formally monitored through confidential reporting and ongoing auditing. Potential breaches are investigated by the Corporate Compliance Officer and the appropriate leader. Action is taken as necessary, including termination of employment. Reporting is conducted according to the *Guide & Validate* section of Figure 1.2-3. The organizational Ethics Committee provides a framework for patient-centered care and researches information to assist in the decision-making process as well as provide education to patients, families, and staff as appropriate.

Key processes, measures, and goals for monitoring and ensuring legal and ethical behavior are displayed in Figure 1.2-2 and are reported to the Finance Committee and the BOT.

1.2c Societal Contributions

1.2c(1) **Societal well-being and benefit** is built into the SPP (2.1-1, step 1), specifically through the Community Needs Assessment tool which prioritizes specific projects that align with long- and short-term goals and objectives. The 'Community Health' IOE in the current SP addresses strategies related to **societal well-being** and Annual Action Plans are created to support this IOE. For example, behavioral health was identified in the planning process as a key need and Annual

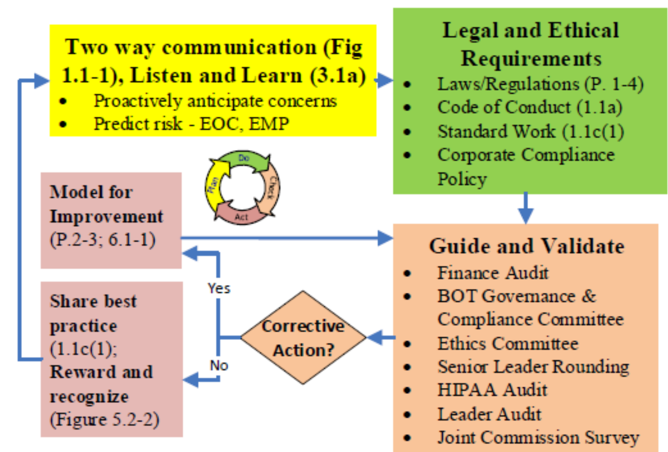


Figure 1.2-3 Process for Ensuring Legal and Ethical Behavior

Action Plans were put in place to support this need, including the expansion of the number of adult inpatient beds and expansion of the workforce. Crisis intervention capabilities were added in late 2018 when MGMC opened the Crisis Stabilization and Transitional Living Program (CS-TLP). Improvement projects such as the Admit to Discharge RIE improved clinical outcomes for patients, created operational efficiencies related to the discharge process, and supported improved care coordination – all contributors to societal well-being. To proactively respond to and support the need for conserving natural resources, MGMC committed an additional $2.1 million to achieve LEED certification in its five-year master facility project. Elimination of waste and more efficient fossil fuel consumption support these organizational efforts and improve **daily operations**. As one of the largest employers in Ames and the surrounding area, MGMC contributes to **the economic well-being** of its key communities by providing a stable workplace with outstanding benefits. Additionally, MGMC contributes significant community benefit dollars to various projects as well as through providing cost-competitive services.

1.2c(2) MGMC actively supports and strengthens its key communities **through its SPP and its** Annual Action Plans aimed at improving high quality, safe care (Figures 7.1-1 through Figure 7.1-22) and services. Key communities include those patients in and surrounding MGMC's service areas. MGMC identifies and affirms **key communities** and determines areas for organizational involvement through the SPP (Figure 2.1-1a,b, step 1), which incorporates findings from the Community Needs Assessment Survey as well as VOC feedback. Ways MGMC supports its key communities include:

- Underwriting the addition of behavioral health beds and providers (1.2c(1)).
- Collaboration with key community members to apply for a grant and, in 2014, the opening of a Federally Qualified Healthcare Center (FQHC).
- Collaboration with the City of Ames on the provision of public health services through MGMC's Home Health. This relationship eliminates costly duplication of services in and surrounding Story County (Figure 7.5-14).

SL, in conjunction with the entire workforce, contribute to building community health by actively engaging in various

community and service projects within the communities and by providing paid time-off for its workforce to volunteer for organizations like the United Way, Special Olympics, Beep Baseball, and various non-profit boards.

CATEGORY 2: STRATEGY

2.1 STRATEGY DEVELOPMENT

2.1a Strategy Development Process

2.1a(1) With the MVV as its foundation, **MGMC conducts its strategic planning** using a 4 step, integrated planning and deployment process (Figure 2.1-1a,b) that is aligned with the IOE and centered around the patient. A healthcare futurist was added in the 2016 cycle to challenge the status quo and support innovation. The full SPP is conducted every 3 years. Annual Action Plans are aligned with the 3-year plan and the SL SP Review provides ongoing monitoring of progress to plan. A quarterly review of progress to plan by the SPTF was added in 2016. In 2019, the SPTF called for an annual review of the full plan to keep up with the rapidly changing healthcare environment and to support agility where needed.

The 4 process steps are displayed in Figures 2.1-1a, b. Step 1 - of the process begins with a comprehensive strategic environmental and market assessment, which includes internal and external qualitative and quantitative data gathering, SWOT analysis, comparison to key competitors and a workforce profile. Comprehensive healthcare trends and other industry market research aid in creating a complete assessment of the current state environment. A **blind spot** in the previous cycle identified the need for a more systematic VOC feedback process, and as such, the 2016 cycle used a best practice approach from a Baldrige winning organization by incorporating feedback from internal and external focus groups. This approach not only aided in gathering more meaningful and systematic feedback, but the aggregated feedback confirmed key customer requirements (P.1-5). These feedback sessions were further improved upon in the 2019 cycle by including key insurance executives in MGMC's service area to address current and emerging challenges affecting future reimbursement and the rapidly changing healthcare market (Figure P.2-3, SC1). Aggregated feedback from these reviews became input to the strategy development process (Step 2). In an effort to ground the SPTF in the Baldrige framework, a two-page Organizational Profile and Strategic Context (OPSC) was developed in 2016 and was used and updated throughout the 2019 planning cycle. This document is used during the ongoing SL SP Review (1.1c(2)) and provides opportunities for improvements to the overall SPP. An improvement to this document in the 2019 process was a new section that calls out differences between the prior plan and the new plan. Conversation around this section created greater clarity with the new plan and serves as talking points for SP deployment.

Step 2 - The environmental and market assessment, as well as the SWOT analysis, aid the SPTF in vetting SC and SA, CC, and consideration of workforce plans. These items give way to the development of the organization's **key strategic opportunities** (2.1a(2) and Figure P.2-3) which are aligned with the MVV and support the CC, SC, SA and workforce plans. As a cycle of learning to Step 2 in the 2019 SPP, a futurist engaged the SPTF in an exercise to elicit greater ideas around innovation and intelligent risk taking. This was built into the

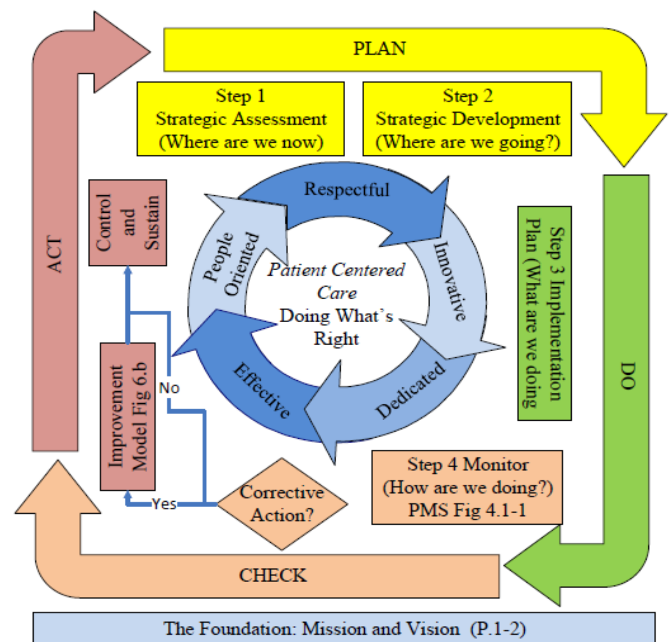


Figure 2.1-1a Strategic Planning Process

final SP as Step 4 (1.1c(2)). CC of competitors are considered to ensure MGMC's effective market positioning and together these outline MGMC's performance and market position for the SPTF and create a solid framework for setting short-term (ST) and long-term (LT) goals and objectives. An improvement in 2016 to **Step 2** of the SPP incorporated a retreat for the SPTF, the board, and the Medical Executive Committee (MEC). An overview of the visioning as well as the environmental assessment and trends (Step 1) is shared to elicit critical feedback from these participants about the challenges and opportunities the medical center faces. The SPTF takes information gathered from the assessment, feedback sessions and board/medical staff input to formulate key strategic objectives and establish LT and ST plans. Strategic opportunities are called out, and CC are affirmed. Through the rigor of the SPP, in 2019 MGMC refined its CC of engagement (formerly workforce, provider and patient) to more intentionally support the customer. Quality and safety were affirmed as critical to the success of the organization, and engagement was replaced with "patient experience." Future CC are affirmed ongoing through the SL SP Review.

Step 3 - Follow-up feedback sessions with those who provided input into the SPP are conducted as part of the planned implementation. Action plans are finalized, and the new SP is approved by the BOT. Upon approval of the plan and then ongoing through the SL SP Review and SPTF review, the plan is evaluated and opportunities for improvement are added to the SPP. For example, the 2019 cycle added the Strategic Workforce plan in step 1 to support evaluation of capability and capacity needs earlier in the process. Communication of the new SP is deployed throughout the organization as well as to key suppliers, partners and collaborators. In 2018 MGMC created a Strategic Path flyer that is shared annually and ongoing with the workforce, key suppliers, partners and collaborators (2.2a(2)).

Step 4 - Monitoring of performance to the SP and subsequent deployment occurs through the systematic

	Approach/ Learning		Deployment/ Learning	Integration/ Learning
	Step 1	Step 2	Step 3	Step 4
Time Frame	FY Q2 (October - December)	FY Q3 + FY Q4 (January - June)	FY Q1 (July - September) FY Q1 (July - September) FY Q1 (July - September)	
Participants	SPTF, PFAC, BOT, Key Stakeholders (community, non-profits, foundation, university student health), McFarland Clinic (key partner), Key Collaborators (nursing homes, education, referral sources), Emerging Leaders at MGMC	SPTF	All MGMC, SL, PFAC, Key Stakeholders (community, non-profits, foundation, university student health), McFarland Clinic (key partner), Key Collaborators (nursing homes, education, referral sources),	SL, BOT, Leadership, Staff
Strategic Elements addressed	·OFIs to the SPP ·Environmental Assessment ·Community Needs Assessment ·Community Perception Survey ·Physician Resource Plan ·Emerging trends ·Long-term Financial Plan ·Workforce Strategic Plan ·Work Systems ·Stakeholder needs ·Key requirements (customer, workforce, stakeholder) ·VOC ·Regulatory Updates	·SA, SC, SO ·Innovation (emerging trends and needs)	·Feedback ·Core Competencies ·Review Work Systems	·Performance improvement ·Control/Sustain ·Figure P.2-3 ·Review Work Systems
Strategic Outputs	·MVV affirmed ·SWOT ·SA, SC, SO, CC ·Key requirements ·Blind spots	·Innovation ·Intelligent Risk ·Key requirements ·Strategic context ·Resource needs identified ·Workforce needs identified ·Workforce Plans ·OPSC document	·Key strategic objectives ·Big Dot Goals ·Action plans cascaded, goals defined ·Measures of success ·SL shadow goals ·Strategic Path Flyer ·Evaluation of SPP (OFIs)	·Dashboard; VOM ·SP Matrix (Fig 2.1-3) ·PI Model (Fig 6.1-1) ·LEM; Monthly Meeting ·SL SP Review ·Business Review ·Employee Updates ·Key Work Systems ·Review SP

Figure 2.1-1b Key Steps & Inputs in Strategic Planning Process

Performance Measurement System (4.1a(1) and Figure 4.1-1), via Dashboard and Vector of Measure reports (4.1a(1)).

The SPTF oversees the strategic planning process and **key participants** include two MGMC BOT members, SL, the Chief of the Medical Staff, and senior leadership from strategic partner McFC. The McFC senior leader was added to align strategic efforts between the two organizations. The 2016 cycle continued with the SPTF structure and added the McFC Population Health Medical Director in order to greater align efforts between the medical center and providers, specifically around SC3 (Figure P.2-3). In the 2019 cycle, emerging MGMC leaders were added observe the process as a development opportunity and to support deployment and cascading of goals.

Key short-term (ST) and long-term (LT) planning horizons are one-year (ST) and three-year (LT) cycles. **These horizons are addressed** throughout the planning process including during the strategic development process (Steps 1 & 2), as the framework for the implementation process (Step 3), and ongoing in the monitoring process (Step 4). Annual Action Planning (Step 4), including the systematic SL SP Review (1.1c(2)) allows for **organizational agility** of the plan. Through a cycle of learning in the 2016 process, MGMC incorporated a five-year outlook to the long-term horizon due to the complex nature of the healthcare environment and to test the current mission and vision statements. In 2016 the SPTF began meeting quarterly to monitor changes in the industry and test the current plan accordingly. After visiting a Baldrige winning organization, MGMC initiated another improvement to the ongoing review process (Step 4) - the SL SP Review (1.1c(2)). This improvement allows for greater focus on current ST performance as well as maintain an eye on the LT plan. Having a futurist facilitate the SPP in 2016 and again in 2019, as well as the addition of the McFarland Clinic population health medical director and engaging health insurance executives in the VOC process aids in the identification of opportunities for **transformational change, innovation and intelligent risk taking and ensures balance among competing priorities.** As a cycle of learning to the 2016 SPP, MGMC identified the need to more intentionally align its workforce plans with ST and LT objectives (5.1a(1)). Workforce plans are evaluated during the Leader Business Review process of the SL SP Review. A comprehensive Strategic Workforce Plan (AOS) was incorporated in the 2019 cycle as an improvement to support the SPP. Strategic opportunities that are intelligent risks worth pursuing are vetted through the rigorous review and analysis process and supported by the BI team. Cascading from the SP are a series of integrated supporting tactical plans, including the Annual Action Plan, leadership plans, department plans, and Individual performance plans. The three-year cycle, with monthly reviews and cascading of results and actions along with the annual review cycle, allows MGMC to focus on LT results, yet provides for flexibility to make adjustments in the short-term if necessary.

2.1a(2) **The strategy development process stimulates and incorporates innovation** through the rigor of the process, including having a healthcare futurist facilitate the SPP and the comprehensive listening and learning sessions of step 1, including use of community focus group methods of a Baldrige organization. A commitment to aggressive goals and the cascading nature of the Annual Action Plan further stimulates ideas for innovation. Aggressive goals related to preventing harm in the 2009 SPP generated significant change related to keeping patients safe and resulted in the SL creating the Preventable Harm Index (PHI) and subsequent breakthrough improvements to preventing and eliminating serious safety events. The SPP and corresponding strategy development (Step 2) along with the BI Team Business Planning process aid the organization in **identifying which opportunities are intelligent risks worth pursuing**. The SL SP Review systematically monitors the Annual Action Plan and if a change in the market warrants a different direction, the BI team and its systematic framework are called upon to assess if the **risk is worth pursuing**. MGMC creates an environment that further **supports innovation** by empowering those closest to the work to assist in the design and re-design of their work and through the systematic Daily Improvement program. The philosophy that no idea is too small creates an environment whereby every day, every one of the 1,300 employees can contribute to improving their work and to possibly create new value

(innovation) in that work. Through PDCA cycles and the tools of statistical analysis and by empowering teams to implement small tests of change, the organization further supports intelligent risk taking. Encouraging waste elimination through process design and re-design allows MGMC to focus on opportunities that add new value to current and potential/new patients (1.1a(3)). The sharing of ideas and best practices at First Friday creates an environment of shared learning and the identification of possible new value replicated in other departments. The rigor of the SPP in 2016, including steps to obtain actionable feedback from various groups (Step 1), led to the identification of these **key strategic opportunities:** 1) Leverage quality, cost and patient experience to maintain and develop markets; 2) Develop partnerships to support improved models of care; and 3) Be the convener to support community health.

2.1a(3) MGMC collects and analyzes a variety of qualitative and quantitative data (Figure 2.1-2) for use during the SPP. These data, both internal and external, are used to help shape the SP as well as develop **strategic challenges and advantages, identify potential changes to the regulatory and business environment, potential blind spots, and ensure we are able to execute the plan.** A cycle of learning in the 2016 process included greater discussion around national trends emerging in the healthcare environment such as Accountable Care Organization strategies. Additionally, the 2019 SPP included greater VOC input and a subsequent report of the strategic assessment and findings for dialogue with the full board and the medical executive committee to ensure **blind spots in the planning process** were vetted and addressed more fully. In 2019 an insurance executive was added to the VOC input sessions to ensure blind spots in the changing payer market were addressed. This led to refining SC1 (Figure P.2-3) by adding non-traditional competitors to this challenge.

MGMC's ability to execute the strategic plan is supported by the very nature of the PDCA process (Figure 2.1-1a) including its thorough review of all inputs to the planning process (Steps 1-3) and the subsequent selection and monitoring of performance measures (Step 4) that are aligned with key strategic objectives (Figure 2.1-3). The cascading nature of the Annual Action Plans to the workforce (through employee Big Dot Goal cards), suppliers, partners and collaborators (through the Strategic Path flyer) further supports MGMC's ability to execute the SP. Results representing a balance of key organizational metrics, aligned with the IOE and Annual Action Plans and the budgeting and financial planning process (2.2a(3)) are monitored monthly via the SL SP Review and the Leader Business Review process (1.1c(2)).

2.1a(4) Deciding which key processes will be accomplished by the **workforce and which will be completed by external suppliers, partners or collaborators** begins with the SPP and is further supported by MGMC's definition of its key work systems: 1) patient care, and 2) support services (non-patient care). **Work system decisions** are made in support of the MVV and the SP using best practices for the safe, effective and efficient delivery of care and services. Comparison of MGMC's strategic objectives and CC and results to competitors are the cornerstone of the evaluation process. The BI team, through its systematic process, supports the review and vetting of plans (1.1c(1)). An example of this is the evaluation of dialysis services where the SPP identified ongoing and emerging regulatory and financial challenges related to the provision of dialysis services. Following review by the BI team, including **comparison of core competencies** of quality and safety and corresponding metrics **of potential suppliers, partners and collaborators** as well as capability and capacity of the business units, it was determined dialysis services could be provided more efficiently by an external organization. This process was later repeated for inpatient rehabilitation services which resulted in the subsequent partnership with an external organization. Ongoing review of key performance metrics between MGMC and the external organizations ensure expectations of the relationship and the SP are achieved.

MGMC determines what **future organizational core competencies and work systems will be needed** through the SPP (Step 1 and Step 2) and through the ongoing SL SP review. As a cycle of improvement, a comprehensive Workforce Strategic plan was created and incorporated into the 2019 SPP to support a more intentional review of the capability and capacity of our current work systems and plan ongoing, for **future needs of the organization's work systems**. Value Stream Mapping (VSM) was added in 2012 and since then, several events have been completed to support a thorough review of MGMC's key work systems. Baseline metrics are

Figure 2.1-2 Data Collection, Analysis and Relevant data used for SPP

Key Element	Collect	Process for Analysis; Develop Information
Strategic Challenges & Strategic Advantages	SWOT analysis; comprehensive market assessment; healthcare and industry trends; comparison of competitor results to MGMC results; gap analysis; Physician Needs Analysis; supplier trends	Step 1-4 of SPP; Qualitative and quantitative data are aggregated; emerging risks to form SC; supplier performance (backorders); support for SA, SO
Potential changes in regulatory & external business environment	External analysis of MGMC's financial condition to bond ratings; evaluation of risks/ likelihood of emergencies/disasters; ability to maintain operations in event of disaster; legal & ethical requirements; HIPAA risk audit	Ratings for financial sustainability; emergency preparedness table top info collected from internal & external drills; audit findings and action plan recommendations
Potential blind spots	Through SWOT analysis, focus groups, and emerging healthcare trends; healthcare futurist/ facilitator	Qualitative & quantitative data via VOC, focus groups, SPTF review key questions
Ability to execute the strategic plan	Results of progress (Dashboard, LEM, VOM); Value Based Purchasing results; SL SP Review; leader Business Review; Cascading plans to workforce; Big Dot Goal philosophy	HCAHPS; NRC survey; IHA financial reporting; internal financial reports; PI tools for analysis
Risks to Future Success of Plans	Market analysis (local, state, national); key services; Community Needs Assessment; patient engagement surveys	BI Team cost benefit analysis of key services; market share review by key services; projections to competitors; VOC feedback

identified and monitored throughout the lifecycle of the VSM event and improvements provide evidence of ongoing support and sustainability of CC. VSM events provide a systematic approach to the evaluation of work system needs. This approach was improved in 2018 with the addition of Work System Mapping (2.2a(4)) which enhances our approach to assessing the organization's future work system needs.

2.1b Strategic Objectives

2.1b(1) Figure 2.1-3 illustrates MGMC's, **key strategic objectives and associated timetable for achieving them.** The **most important goals** are further emphasized by the Big Dot Goal philosophy. Key **changes** are evaluated during the SPP and the monthly SL SP Review. Long-term goals (three year) are aligned with the IOE and provide overall direction to the organization, and short-term goals (one year) serve as the Annual Action Plans developed by SL in support of the SP. **Key changes** planned in our healthcare services, customers and markets, suppliers and partners, and operations include a change in the mix of services, specifically a shift from inpatient to outpatient services and the need for changes related to workforce capacity and capability planning. To proactively address emerging change, in 2016 MGMC implemented shadow goals (small tests of change for emerging trends or new metrics on the horizon) for outpatient market share and in 2018 OP experience was added as a shadow goal. Additionally, the Strategic Workforce plan considers current and future capability and capacity needs so that LT plans proactively support emerging changes.

2.1b(2) Strategic objectives are developed through the rigor of the SPP, including the SWOT analysis, and take into account the organizations CC, SA, SC and opportunities for innovation and intelligent risk as indicated in Figure 2.1-3. The very nature of the 4-step process, including the comprehensive market assessment and VOC input sessions, as well as intentionally aligning objectives with the indicators of excellence and CC, ensures strategic objectives **achieve appropriate balance among the varying and potentially competing organizational needs**. VOC input sessions include patients, other customers, suppliers, partners, collaborators, workforce, the community and other key stakeholders to ensure strategic objectives **balance the needs of key stakeholders**, as indicated in Figure 2.1-3. As a cycle of learning in 2018, the SPTF formally added a cross-walk, by Indicator of Excellence, as a validation of balance and an additional check against blind spots.

2.2 STRATEGY IMPLEMENTATION

2.2a Action Plan Development and Deployment

2.2a(1) **Key short-term (ST) and long-term (LT) action plans**, aligned with the **strategic objectives** and the IOE, are displayed in Figure 2.1-3. Based on all input (Steps 1,2) SL create Annual Action Plans (ST) to support the long-term objectives and Big Dot Goals and the BOT approves the plan. Each VP is assigned a Big Dot Goal based on their area of responsibility. VPs develop cross-functional teams, including participation of the medical staff, to evaluate the challenges, determine resources required, and identify tactics to support the annual action plan and Big Dot Goals.

2.2a(2) **MGMC deploys action plans** through the cascading nature of the Annual Action Planning process. This process ensures action plans are **deployed** and responsibility for the outcome is directed at the appropriate level (2.2a(1)). Annual Action Plans are **deployed by SL to leadership** via the Big Dot Goals. From the Annual Action Plan, leaders create 90-day tactical plans within the LEM, using SMART goals, to support the annual action plan and Big Dot Goals. Big Dot Goals are weighted for SL and leaders based on their opportunities to influence each goal. The LEM and supporting 90 day plans make up the leader's annual evaluation. The leader's department goals and 90 day plans are then **deployed by leadership to the workforce** via individual Big Dot Goal cards and are aligned with the annual performance evaluation process. These workforce goals support the department's goals and the organization's annual action plan and create laser focus on priorities. A Daily Improvement idea, submitted by an employee in 2019, resulted in the Big Dot Goal scorecard being posted monthly on the intranet home page, further deploying action plan goals and progress to the workforce. Medical director agreements contain metrics associated with achievement of the Big Dot Goals. As a cycle of improvement, the Strategic Path flyer (1.1c(2)) was created in 2019 to more systematically deploy the Annual Action Plans and Big Dot Goals to **key suppliers (Premier, HEC), partners (McFarland Clinic), and collaborators (businesses) to ensure and support achievement of our key strategic objectives**.

Annual Action Plans are evaluated and modified ongoing during the SL SP Review based on market need (1.1c(2), 2.1a(1), Step 4). Output from the SL SP Review is cascaded to the leader during the monthly meeting model and the 90-day plan review. Through SL and leadership direction, the medical staff is engaged in support of improving key metrics through regular review of the Big Dot Goals and action plans. An example of such is the creation of an Antibiotic Stewardship program, led by a key medical staff member. This physician-led program supports the appropriate use of antibiotics to reduce infections which supports Big Dot Goal strategies around preventing serious safety events (Figures 7.1-3 and -4; and 7.4-13). Results are communicated to **key suppliers and collaborators** through business reviews and annual negotiation of SLAs (6.1c) **and to partners** through the SPP and Annual Action Planning process. Adding McFC to the SPP further enhances our ability to leverage resources to address SC and SO of the SP. MGMC **ensures it is able to sustain key outcomes of action plans** through the rigorous review process, including the SL SP Review and cascading results via the Dashboard at all levels of the organization.

2.2a(3) MGMC ensures **resource allocations**, both material and workforce, are available to **support achievement of the SP and supporting Annual Action Plans while meeting current obligations** through a standardized approach that links and aligns the operating and capital budgets, workforce plans, and information systems project plans. A long-term (5 year) financial plan is developed by SL and the finance committee and is integrated into the SPP (steps 1 and 2), further aligning needs of strategic workforce plan and information technology plan into the process. Annual operating and capital budget

Figure 2.1-3 Key Strategic Objectives. Action Plans, and Performance Measures

Indicator of Excellence	Key Strategic Objectives	Key Long Term (LT) Plans; Short Term/Annual Action Plans (ST); Work Force Plans (WF) **(Most Important)**	Key Performance Measures (Results Figures) / Big Dot Goals	Baseline FY2019	Stretch FY 2020	Stretch FY 2022	Bench-mark Source	Projection to Competitor 2022
				Timetable for Achievement				
Quality & Safety	Best place in delivering safe, high quality, and reliable care. SA1, SA2 SC3, SC4 SO 1, SO2 P, C	**Eliminate Harm (LT)** • Develop an approach to classify preventable harm (ST) • Develop classification system for workforce harm (ST)	Serious Safety Events (Figure 7.1-2)	≤ 9	≤ 7	≤ 1	NDNQI	Top Quartile
			Workforce harm (Figure 7.3-11)	Develop tool	50% reduction	50% reduction	Internal	Better
		Improve performance in key Core Measures (LT) • Sepsis Bundle (ST) • OP Measures (ST)	Sepsis Bundle Compliance (Figure 7.1-8)	≥ 55%	≥ 65%	≥ 75%	Press Ganey	Top Quartile
Operational Performance	Best place to receive care, work and practice. SA1, SA4 SC4 SO1 P, C	**Achieve improved performance in overall engagement (LT):** • Leadership development/ succession plan to support WF Plans (LT)(WF) • **Employee Engagement (LT)** • Improved systems of care; **Patient Engagement (LT)** • Provider WF plans; Provider Engagement (LT) (WF)	Employee engagement (Figures 7.3-17, 7.3-18)	77th Percentile	82nd Percentile	85th Percentile	NRC Health	Top Quintile
			Patient Engagement (Figure 7.2-1)	85th Percentile	87th Percentile	90th Percentile		
			Physician Engagement (Figure 7.3-21)	80th Percentile	83rd Percentile	85th Percentile		
	Sustain financial stewardship. SA1 SC1 SO2 P, C	**Sustain key results of long term financial plan. (LT)** • Explore alternative payment models (LT) • Expense reduction/waste elimination (LT)(WF)	Net Operating Margin (Fig 7.5-1)	≥3%	≥3%	≥3%	Moody's Median	Best
			Participation in RIEs (Figure 7.3-25)	50%	60%	70%	Internal	30% Increase
Community Health	Collaborative innovations in care coordination and community health. SA1, SA3 SC2, SC3, SC4 SO1, SO2, SO3 P, C, SPC	• Develop coordinated care models (LT)(WF) • RN Case Management model (ST)(WF) • Assess continuum of care; identify gaps in services (LT) • Sustain BH Strategies (LT)(WF)(IR)	Reduce Preventable Readmissions (Figure 7.1-1)	Top Decile	≥ Top Decile	≥ Top Decile	Press Ganey	Top Decile
			Manage Cost of Care (Price Increase - Figure 7.4-14)	≤ CPI	≤ CPI	≤ CPI	CPI	CPI
Partner Relationships	Strengthen partnerships to support market development SA1, SA3, SA4 SC1, SC2, SC3 SO1, SO2, SO3 P, C, SPC	Develop business plan to identify market and service line priorities (LT) • Sustain market share in 6 Co (LT)(WF) • Create co-developed process and plans to enhance alignment (LT)(WF)(IR) • Expand TOC program (ST) • Quarterly meetings with regional partners (ST)	Overall Market Share: • Outpatient (Figure 7.5-10) • Inpatient (Overall Market – Figure 7.5-8)	OP ≥55% IP ≥50%	OP ≥55% IP ≥50%	OP ≥55% IP ≥50%	IHA	Sustain/ Better

Strategic Advantages and Strategic Challenges – Figure P.2-3; Intelligent Risk (IR); Patients (P); Community (C); Suppliers, Partners, Collaborators (SPC)

planning coincides with the annual action planning process and leaders work with their VPs to align departmental budgets with the organizations plan. All projects or initiatives are reviewed for alignment with key strategic objectives and if appropriate,

required resources are allocated through the capital and operating budgeting processes. The CFO convenes the Capital Committee to review requests, which are assessed for alignment with the SP, and the Annual Action Plans, as well as financial targets developed in the long-term financial plan. Financial targets established in the short- and long-term action planning process provide the basis for the review and **ensure** resources are available to support achievement of action plans without jeopardizing current obligations. The IT Steering Committee

appropriately designates resources for completing projects on time and on budget. This process is aligned with the capital and operating budget process to ensure requests for IT are supported appropriately through material and workforce allocations. The SL SP Review provides for a monthly review of **risks** associated with the plans and allows for timely vetting of opportunities with the workforce as well as supporting committees. Additionally, the Leader Business Review process identifies **potential risks associated with plans** and develops actions to ensure **financial viability** and success of the LT financial plan.

2.2a(4) **MGMC's key workforce ST and LT workforce plans** are noted in Figure 2.1-3 and support both ST and LT objectives of the SP. In 2018 MGMC implemented a systematic process for ongoing workforce planning which includes: identifying multiple labor pools for workforce recruitment; determining capability requirements in order to pro-actively provide staff with education to attain the new required knowledge/skill; proactively identify roles that may be impacted by future contraction to ensure the workforce is provided with the retraining needed for successful re-deployment. The new strategic workforce planning process assesses current capability and capacity gaps or surpluses and results in action plans to address these short-term needs. The strategic plan is factored in for future **workforce capacity and capability requirements** to identify workforce gaps or surpluses for Annual Action Plans to be created. Ongoing throughout the year, Leader Business Reviews and business plans also become inputs into the workforce planning process to ensure business changes are reflected in the strategic workforce plan and ST & LT action plans are identified to ensure MGMC's workforce has the appropriate capacity and capabilities when needed. This approach provides for an ongoing review of **potential impacts to workforce members as well as proactively addresses potential changes in workforce capability and capacity needs**. Work system mapping (2.2a(4)) further supports the identification of workforce capability and capacity needs. During the Annual Action Planning process, and in support of LT plans, key workforce capabilities are identified, and capacity is forecasted for existing and new services. Physician recruitment is equally critical to MGMC's long-term strategies. A cycle of learning in 2013 included a Physician Needs Assessment that is used as an input to the SPP (Step 1). This plan is updated every two years, which allows MGMC to more effectively plan for medical staff needs with McFC and others.

2.2a(5) **Key performance measures used to track the achievement and effectiveness of action plans** are illustrated in Figure 2.1-3. These high-level metrics are selected using the systematic process described in 4.1a(1). From these high level measures, SL create Annual Action Plans in alignment with the LT plan. These are cascaded to the leaders for their department plans who, in turn, cascade them to staff annually. Goals and corresponding metrics are entered into the LEM, and 90-day tactical plans using SMART goals are created in support of the organization's plan. MGMC's ensures its **action plan measurement system reinforces organizational alignment** through the cascading nature of the goal setting process and the balance of leading and lagging measures. These measures are vetted during the SPP. The addition of the SL SP Review process (2.1a(1) Step 4) further supports organizational alignment and ongoing relevance of the performance measures.

2.2a(6) **Performance projections** for ST and LT planning horizons are determined during the SPP (Figure 2.1-3) and refined during the SL SP Review. MGMC's past performance, coupled with its rate of improvement and future assumptions, compared to that of its competitors are used to develop projected performance and monitor performance of key metrics (Figure 2.1-3). Monthly, SL review performance to benchmarks, including comparison to competitors to determine **gaps in performance** as well as determine next steps in developing 90 day tactical plans with leaders. A cycle of improvement in the 2016 SPP included comparison of MGMC's projected rate of improvement around quality and safety metrics (CC) to the projected rate of improvement of its competitor's performance for the same metrics. This led to the establishment of aggressive goals around key quality and safety metrics, specifically the prevention of infections and pressure injuries (Figures 7.1-3 through 7.1-10). Projections for Big Dot Goals are listed in category 7 with the corresponding results.

2.2b Action Plan Modification

While the formal SPP, including review of the MVV occurs every three years and supports action plan modification, the SL SP Review (1.1c(2)) was incorporated in 2017 to aid in **recognizing and responding timely when circumstances require a shift in action plans and rapid execution of new plans** throughout the year. SL bring to the monthly meeting progress-to-plan for their assigned Big Dot Goal. Action required to shift or re-direct efforts is discussed and coordinated with all plans in order to appropriately balance the needs of the organization. Learnings of the SL SP Review are cascaded monthly to the leadership team via the monthly meeting model and in support of 90 day plans. An improvement to this process was added in 2018 with the implementation of monthly Big Dot Goal report outs at First Friday. This report out further engages the workforce in action plan progress and any changes necessary, as well as supports identification of opportunities for improving performance. Learnings of the SL SP Review are cascaded to the SPTF and BOT quarterly, which provides an additional review of the plan and ongoing dialogue regarding re-directing resources when warranted. When **circumstances require a shift in action plan or rapid execution of new plans**, the process follows steps outlined in 2.2a(1) and 2.2a(2) to ensure achievement of the LT plans.

CATEGORY 3: CUSTOMERS

3.1 CUSTOMER EXPECTATIONS

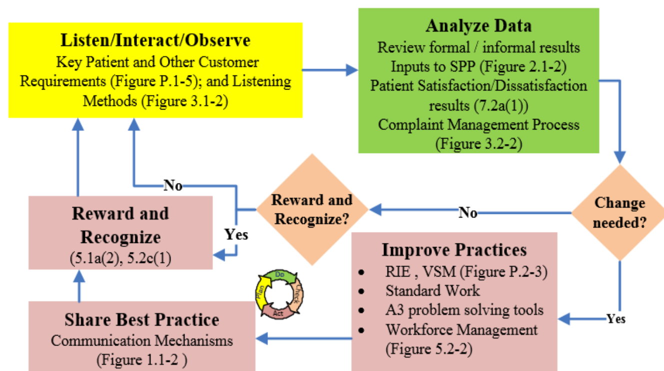
3.1a Listening to Patients and Other Customers

3.1a(1) **The approach for listening to, interacting with and observing patients** is centered around the Customer Listening System (Figure 3.1-1). SL, through the Big Dot Goal philosophy and in support of achievement of the SP and Annual Actions Plans, own this system. The VP assigned to the Patient Experience Big Dot Goal supports this system and reports progress during the SL SP Review (1.1c(2)).

Various methods to **obtain actionable information**, both qualitative and quantitative, are noted in Figure 3.1-2. These

methods provide input into the system that result in actionable steps to improve programs and services. An example of this is input received during the 2019 SPP focus group sessions (2.1a(1), Step 1) regarding the need for community health support. Aggregated input from these focus groups, as well as information received from the consumer needs assessment survey resulted in MGMC's participation in a transportation collaborative to support an improved discharge process.

Figure 3.1-1 Customer Listening System



Listening methods vary for different patient and stakeholder groups and market segments as highlighted in Figure 3.1-2. For example, MGMC uses survey tools specific to each patient group (3.2b(1)). Also, patient rounding on inpatient units focuses on key HCAHPS domains such as *'quiet at night;'* patient rounding in outpatient areas focus on *'timeliness.'* Social media and web-based technologies are used to listen to,

Figure 3.1-2 Key Patient and Stakeholder Listening & Learning Methods

Method	Patient Groups				Patient Life Cycle				Other
	IP	OP	ED	HH	C	F	P	CP	CO
Patient Surveys	X	X	X	X	X			X	
Patient Rounding	X	X	X	X	X				
Bedside Shift Reports	X				X				
Daily Patient Care Conferences	X				X				
Discharge calls	X	X	X	X	X	X			
Complaint Management Process	X	X	X	X	X	X	X	X	X
Consumer Perception Survey	X	X	X	X	X	X	X	X	X
Community Needs Assessment					X	X	X	X	
Focus Groups	X	X	X	X	X	X	X	X	X
Website/Social Media	X	X	X	X	X	X	X	X	X
Health Connect	X	X	X	X	X	X	X	X	X
RIE/VSM	X	X	X	X	X	X	X	X	X
PFAC	X	X	X	X	X	X	X	X	
Health Fairs				X	X	X	X	X	X
SPP	X	X	X	X	X	X	X	X	X
Daily Huddles	X	X	X	X	X	X	X		

IP – Inpatient; OP – Outpatient; ED – Emergency Department; HH-Home Heath; C – Current; F – Former; P – Potential; CP – Competitor Patients; CO – Community

connect with, and engage current, former and potential patients and the community and to provide critical input. The marketing department monitors real-time social media alerts and cascades relevant messages to the appropriate department for follow up and action. Such alerts provide opportunities to **seek immediate and actionable feedback** and are included in the trending and reporting that is shared with the Q&PSC. The number of likes, shares, and views are also monitored real-time to determine efficiency and effectiveness of messaging.

The opportunity to listen to patients **varies across the stages of patient relationships** (Figure 3.1-2). For example, the community perception survey is used in the early stages of relationship development and as the relationship matures and the patient becomes more engaged, patient surveys, targeted focus groups, committees and councils augment VOC input. The Patient & Family Advisory Council (PFAC) acts as the liaison between MGMC and patients (current, former, prospective, and competitors') and provides targeted feedback on services and programs. PFAC feedback led to an innovative, more user-friendly patient services guide. In 2016, a member of the MGMC PFAC was invited to participate on the state-wide PFAC strategic planning task force, further enhancing MGMC's ability to gather VOC information from prospective and competitors' patients. In 2019, this PFAC member attended the national CMS forum and received the CMS Challenge Coin on behalf of her work as a patient advocate at MGMC. Patient participation on RIEs varies from having **current patients, prospective patients, and patients of competitors,** and participation on these events is targeted at specific improvement opportunities.

MGMC seeks **immediate and actionable feedback from patients on the quality of healthcare service support and transactions** through hourly patient rounding, bedside shift reports, daily patient care conferences, discharge follow-up calls, and the direct-line email. MGMC uses these VOC mechanisms to take immediate action with individual patients and aggregates findings to inform operations and strategy. The customer Complaint Management Process (Figure 3.2-2) provides opportunities for immediate action and feedback to patients and families when service does not meet expectations (Figures 7.2-18-19). The approach for using VOC information from patient surveys is described in 3.2b(1).

3.1a(2) MGMC **listens to potential patients and other customers to obtain actionable information** and gathers qualitative and quantitative data via methods highlighted in Figure 3.1-2. The makeup of the PFAC was specifically designed to include **current and former patients** as well as those who seek services from our **competitor's patients**. An Iowa State student, who may not be established with MGMC yet, is also represented on the PFAC and acts as a liaison to the student population. **Former patients and potential patients including those of MGMC's competitors**, share their experience with MGMC via the Community Perception survey, the Community Needs Analysis, and social media. The SPP and the comprehensive VOC feedback process including focus groups (2.1a(1) Step 1) provide for additional opportunities to obtain feedback from former and potential patients and competitors' patients **to obtain actionable information on the healthcare services, support, and transactions** at MGMC.

3.1b Patient/Customer Segmentation and Service Offerings

3.1b(1) MGMC **determines its patient and other customer groups and market segments** through the comprehensive environmental assessment of the SPP (Figure 2.1-1b, Step 1) including review of internal, external and competitor data and ongoing review and analysis of market data available through various sources noted in Figure P.2-2, which provide MGMC with market information and comparisons to competitors on services throughout the state. This further **enhances the defined groups and segments** and allows MGMC to respond proactively to future market needs. The BI team, in collaboration with SL, vets this information and considers growing markets, underperforming services and competitor information **to support current, and to anticipate future patient and other customer groups and market segments.** The systematic BI process was used in 2016 when an opportunity to expand market presence in Marshall County presented itself to MGMC. Data related to volumes for this area demonstrated opportunities for MGMC to grow its market share. This framework also provides information to McFC and other providers to support recruitment activity (Marshall County Physician Needs Assessment).

3.1b(2) MGMC uses the SPP to **determine healthcare service offerings.** During Step 1 of the SPP, key **patient requirements** are determined and affirmed based on a comprehensive environmental assessment including the community needs assessment and consumer perception survey. A cycle of learning in the most recent SPP added a more robust VOC feedback, including feedback from insurance executives and regional referral sources, to further inform these discussions. Throughout the year, the SL review and affirm these requirements during the SL SP Review.

Also during SPP Step 1, the environmental assessment, including emerging industry trends and inputs from BI Team **identifies** potential **new services** for consideration using the BI Team business plan process. The BI process includes a charter and pro-forma with qualitative and quantitative data about patient and market needs, including whether the service would help MGMC **enter new markets, attract new patients, or expand current relationships with patients.**

Once approved by SL, new **services are designed to meet the requirements and exceed the expectations of patients, other customers and market segments** using MGMC's PDCA-based Process Improvement Model (Figure 6.1-1). Additional VOC data and information from **current patients** or from targeted **new markets** is gathered during the Plan phase. The monthly SL SP Review and Leader Business Review processes allow the organization to monitor whether a new service is meeting key patient, market and organizational needs and identify opportunities to **adapt services to exceed expectations, enter new markets, attract new patients, or expand current relationships.** The Improvement Process Model leverages PDCA, DMAIC and lean tools (6.1b(4)) to redesign the service as appropriate. RIE and VSM events start with a VOC segment to clearly identify the customer and understand the key customer requirements.

The most recent SPP identified the need for additional behavioral health services and crisis intervention. The market assessment, including the community needs assessment survey, affirmed this need, and MGMC called out access to behavioral health services as a strategic objective (Figure 2.1-3). Detailed plans through bed and provider expansion, in collaboration with other community programs and services, ensued.

As a cycle of learning, MGMC continues to more formally engage physicians in the SPP through early participation (Figure 2.1-1, Step 2) in the process. This involvement, coupled with the BI Team approach (1.1c(1)), helps **identify potential new service offerings important to patients**. For example, after studying outpatient general surgery market share data and realizing the growth opportunities, surgeons obtained additional training and began offering additional robotic-assisted surgery procedures. In 2015, in conjunction with the medical staff, MGMC became the first in the state to offer robotic-assisted lung surgery. Ongoing review of market share data demonstrates sustained results (Figure 7.5-10).

3.2 CUSTOMER ENGAGEMENT

3.2a Patient/Other Customer Relationships and Support

3.2a(1) MGMC's patient-centered culture and MVV-driven strategic plan provide the foundation and framework to systematically **build and manage relationships with patients and other customers.** Three of MGMC's strategic objectives drive annually updated action plans **to acquire patients and other customers and build/sustain market share** by improving access to care, increasing community engagement, and expanding the organization's regional presence.

To manage and enhance the brand image, MGMC initiated a re-branding process and reached out to patients, community members, workforce, and stakeholders to obtain feedback. The result was a new tag line, "Doing What's Right," that not only frames the organization's public-facing communications and activities, but also engages the workforce in doing what's right for patients. Marketing plans aligned with the SP leverage social media (Figures 7.2-29) to reinforce the brand and communicate key messages about programs, services, and operations that may impact the community. As part of the plans, MGMC also posts quality and safety results on the public website.

Engaging the workforce is central to MGMC's approach to **retain patients and other customers, meet their requirements, and exceed their expectations**. Even prior to hiring, MGMC begins building a patient-centered culture with workforce members dedicated to living the organization's MVV and established service behaviors (1.1a(1)). These standards along with a mission-driven focus on "personal touch" are reinforced through workforce performance management (5.2c(1)) and supported by MGMC's strategic objectives (Figure 2.1-3). To enhance patient engagement **across the stages of a patient relationship**, the organization has hardwired evidence-based practices such as AIDET, bedside shift reporting, hourly patient rounding, nurse leader rounding, and discharge follow-up phone calls. These practices, initially launched in the hospital, have been adapted and deployed to outpatient, emergency, home health and hospice settings as appropriate. For instance, home health leaders "round" by visiting patient homes. Also, hospice staff and volunteers receive special training on how to demonstrate compassion and respect with patients and families, and the hospice program offers post-death support for family members.

Figure 3.2-1 Methods to Seek Information, Support, Access		
Method	Info/Support	Services
Direct (rounding, bedside shift report)	Pt	Pt
Written correspondence	Pt, C	Pt, C
Patient Services Guide	Pt	Pt
Patient Communication Boards	Pt	Pt
Discharge Follow up Phone Calls	Pt	Pt
Publications, mailings	Pt, C	Pt, C
Website, social media	Pt, C	Pt, C,
Educational offerings	Pt, C	Pt, C
Inpatient services	Pt,	Pt, C
Outpatient services	Pt,	Pt, C
Home health care	Pt, C	Pt, C
Health fairs	Pt, C	C
Community outreach	Pt, C	Pt, C
Prime Time Alive	Pt, C	Pt, C
Support Groups	Pt, C	Pt, C
Surveys	C,	C
Patient Navigator	Pt, C	Pt, C
Patient & Family Advisory Council	Pt, C	Pt,
Pt = Patient (current, former, potential); C = community		

To further **retain, meet the requirements, and exceed the expectations of patients**, MGMC uses intelligent building design. The new inpatient tower is intentionally curved to visually limit sound and line of sight across multiple patient rooms, and family and visitor waiting rooms are intentionally placed outside patient care areas to minimize noise for patients. MGMC mocked up patient rooms for the tower and invited patients, workforce and other stakeholders to offer feedback, which was incorporated into the final room design. Nurses carry devices that alert them to patient call lights wherever they are, so they can spend more time at the bedside rather than having to watch for call lights in a nurses' station. As possible, MGMC applies the same principles to other care settings. For instance, nurses in ambulatory care and the ED use the same call system.

3.2a(2) Figure 3.2-1 lists support and communication methods that **enable patients, and other customers to seek information and support and to access services**. These methods are affirmed and modified as necessary during the SPP and supported during the Annual Action Planning process. Key **support and communication methods vary** for the various populations served ('methods' column). For example, patients who spend the night in the hospital desire a quiet environment and patients who use the ED want to be informed of delays. To reduce readmissions, MGMC implemented bedside shift reporting and family care planning sessions for chronically ill patients. **Patient and other customer support requirements are determined** through the SPP (Figure 2.1-1, Step 2), focus groups, RIE and VSM events, and other VOC methods (Figure 3.1-2). MGMC upholds these requirements through ongoing service behaviors, a commitment to CC, and a patient-centered care philosophy. Whether through implementation of best practices or through First Friday report outs, MGMC's support is centered on these key requirements and the organization seeks affirmation through regular communication with patients and other customers. Key requirements are **deployed to all involved in these support processes** through Standard Work, policies & procedures, training, alignment of work to the CC and adherence to the 6 Expectations of Safe Behavior (1.1c(1)). MGMC's patient-centered Scheduling RIE (6.1a(1)) is an example of how we listen to and improve methods to better enable patients to seek information and support.

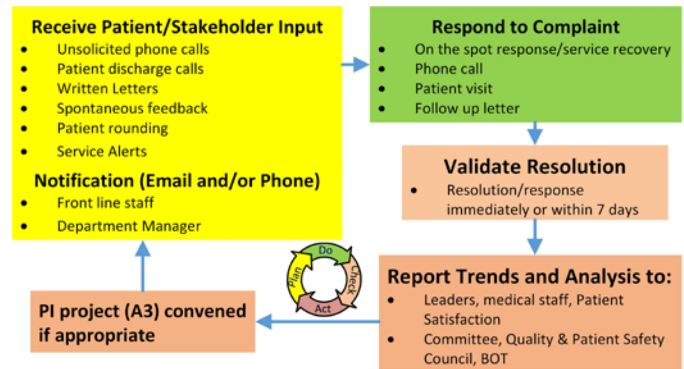


Figure 3.2-2 Complaint Management Process

3.2a(3) MGMC manages **patient and other customer complaints** and systematically tracks and trends results to ensure they are **resolved promptly and effectively** through the Complaint Management Process (Figure 3.2-2). Complaints are documented by the person receiving it and entered into Midas, the incident tracking system. This system provides early investigation of the issue by the department(s) involved and allows for ease of follow-up, which ensures the resolution is satisfactory and timely. Community Relations receives all social media complaints in real-time and brings them to the attention of the responsible department for prompt resolution. Complaints not resolved immediately or needing ongoing attention are reported to the quality management department for tracking and trending via Midas. The systematic complaint management process ensures efficient and effective follow up, thus allowing MGMC to **recover customer confidence and enhance their satisfaction and engagement**. Complaints are analyzed and segmented by patient groups (P.1-5) and type of complaint and further studied for possible trends so learning and improvement can be shared to **avoid similar complaints in the future**. Hourly patient rounding is another mechanism to address complaints in a timely manner. An example of the effectiveness of the Complaint Management Process is the dissatisfaction patients experienced with noise in the OB unit due to construction during the 2016 remodel project. MGMC learned of dissatisfaction with this patient group via rounding, discharge follow-up calls, and patient surveys and took action by moving OB patients to vacant space in the new patient tower until construction was completed. When construction was later planned for the pediatrics unit, MGMC proactively moved this patient group to vacant space in the new patient tower to prevent similar dissatisfaction. MGMC learned through patient surveys and discharge phone calls that family members were dissatisfied with the lack of information about their loved ones in surgery. This resulted in the use of an electronic track board in the surgery family waiting room that discreetly displays the status of patients throughout the surgical process. MGMC further enhanced the patient and family experience by programming the televisions in the patient rooms to also display the surgical track boards, allowing the family to comfortably wait in the patient's room until the patient returns from surgery. This innovative display board was re-created for use in the new emergency department waiting room, proactively addressing potential complaints with this patient group.

3.2b Determination of Patient and Other Customer Satisfaction and Engagement

3.2b(1) MGMC **determines patient satisfaction, dissatisfaction**, **and engagement** through VOC tools as described in 3.1a(1) and Figure 3.1-2 and through the NRC Health survey process. Patient surveys are administered by NRC Health with support from the MGMC Performance Improvement (PI) department. Survey results are used to support the SPP and annual action planning/Big Dot Goals. Results are pushed to leadership monthly, at the unit level, via the survey vendor and these results are then populated into the LEM. Results of progress to goal are reviewed during the SL SP Review by the CNO who has ownership of this Big Dot Goal. Department level results are then discussed between VP and leader during the monthly meeting model. Results are posted by leaders at the unit level on huddle boards and reviewed monthly. Trended results are incorporated into the Leader Business Review (1.1c(2)) and corrective action is taken when results deviate from progress to goal.

Determination methods differ across patient groups and other customers based on where services were received and the key requirements of each (Figure P.1-5). Determination of specific **dissatisfaction** is based on VOC input as well as those indicators that are highly important to a patient's experience, yet rate low on overall satisfaction. For example, nurses round with ED patients to communicate timing of tests and treatments and inform them of delays as there is a high correlation between satisfaction with being informed about delays and overall ED satisfaction. Expected time for testing is documented by the nurse on the patient's communication board. MGMC monitors negative patient comments in a systematic way through the NRC Health Alert process whereby survey alerts are sent to MGMC real-time for appropriate and timely action. Multi-disciplinary discharge planning for hospitalized patients with chronic illnesses was implemented as a result of VOC feedback regarding customer dissatisfaction with preparation for discharge process (Figure 7.2-4). Additionally, in 2017, key questions highly correlated with the nurse communication domain identified opportunities for improvement, and the Patient-centered Scheduling RIE was chartered, further supporting opportunities **to exceed customer expectations and improve satisfaction** regarding communication (Figure 7.2-2 and 7.2-3). This project was recognized in 2019 at the IHC annual meeting with an award for Patient-centered Innovation.

3.2b(2) MGMC obtains information on patients' and other customers' satisfaction **relative to other organizations** via the SPP (2.1a(1), Step 1), community perception survey, focus groups, the PFAC, the complaint management process, patient surveys, and social media. Publicly reported satisfaction data on all hospitals in the state and country are available via the Centers for Medicare and Medicaid Services (CMS) website and allows MGMC to **compare results of its patients' perceptions with care to those of its competitors** as well as those offering similar services (Figure 7.2-4). CC are benchmarked to top performing hospitals in the state to identify future improvements needed and to compete in the Value Based Purchasing program (VBP). Qualitative and quantitative data are aggregated and shared with SL, leaders, the SPTF, and the medical staff for awareness and support of improvement efforts. Implementation of initiatives is coordinated during the Annual Action Planning process, and goals are cascaded to all levels of the organization.

3.2c Use of Voice-of-the-Customer and Market Data

MGMC **uses VOC and market data and information** that is relevant to its markets, represents current, potential, former and competitors patients as inputs to the SPP and Annual Action Planning process. VOC feedback is derived during Step 1 of the SPP when the facilitator is conducting the organizational assessment and customer input sessions. Feedback is aggregated by the facilitator and SL and information is selected for use as the planning and development process ensues. Various listening and learning methods (Figure 3.1-2) provide additional input ongoing to the data and information selection process. The PMS (Figure 4.1-1) guides the use of **VOC and market data and information**, including aggregated data on complaints, **to support operational decision making.** MGMC's growth in its social media presence (1.1b(1)) provides another avenue for the effective selection and use of data and information and **to build a more patient-focused culture** (3.1a(1)) and **support operational decision making.** The Big Dot Goals and VP assignment of such are aligned with the organization's performance management system and are cascaded throughout the organization and hardwired into daily operations through the SL SP Review, leader monthly meeting model, Leader Business Review and workforce Big Dot Goal cards **to support operational decision making**. VOC and market data and information are used to support RIEs, such as the admission process RIE, conducted to address declining scores related to the admissions process. Aggregated VOC data from patient rounding indicated dissatisfaction with being asked the same question multiple times. The Admissions Navigator RIE studied the current work process and established and implemented improvements to create a future state work process. Baseline VOC data, established at the start of an event and monitored throughout the improvement process and into the control process, supports improvement in **operational decision making**.

CATEGORY4: MEASUREMENT, ANALYSIS & KNOWLEDGE MANAGEMENT

4.1 MEASUREMENT, ANALYSIS & IMPROVEMENT OF ORGANIZATIONAL PERFORMANCE

4.1a Performance Measurement

4.1a(1) MGMC **selects, collects, aligns and integrates data and information to use in tracking daily operations and overall organizational performance** using the Performance Measurement System (PMS, Figure 4.1-1). Selection of measures begins during the SPP when SL identify the Big Dot Goals and drill-down measures to track progress on the organization's most important Action Plans. These measures form the organizational Dashboard, which is reviewed during the monthly SL SP Review relative to aggressive targets set as described in 4.1a(2). During the SPP, SL also identified measures to track progress on the remaining Action Plans, and these measures are assigned to appropriate leaders and oversight teams. These leaders and teams review monthly performance, take corrective action if results do not perform to goal, and escalate performance issues to SL if needed. These

key organizational performance measures, including key short- and longer-term financial measures are listed in Figure 2.1-3 and cascade to all levels of the organization through the organizational Dashboard, Vector of Measures (VOM) report, LEM, and the Big Dot Goal scorecard. The VOM report was added to the review process as a cycle of improvement and is designed to provide trending information for key organizational measures, including the Big Dot Goals. Leaders review monthly operational reports with their one-up, and their department huddle boards track and report progress on leading measures (Figures 6.1-1 and 6.1-4) that align with the Big Dot Goals.

The monthly report-out of Big Dot Goal progress to plan, added to First Friday in 2019, deploys learnings from the SL SP Review to the workforce. Additionally, the Big Dot Goal scorecard is now posted to the MGMC intranet home page to inform the workforce of the organization's **progress on achieving strategic objectives and action plans**.

Results of **key organizational measures** supporting the Annual Action Plan (Figure 2.1-3) **are tracked** monthly/quarterly/annually (as appropriate) via the Dashboard and VOM, and monitored during the SL SP Review (1.1c(2)) and subsequent SPTF and board reviews, and cascaded to all levels of the organization. Measures with an adverse trend are evaluated using a drill down approach to identify and address root causes. Results via these reports are reviewed by the QPSC (bi-monthly), MEC (quarterly), BOT, and SPTF (quarterly or more frequently as warranted). The finance department reviews key financial metrics on a daily and monthly basis and provides input on progress to goal to the finance committee.

4.1a(2) MGMC's approach to **select comparative data and information to support fact-based decision making** begins in SPP as SL identify the Big Dot Goals and set annual performance measures and targets. For MGMC, its vision To Be the Best does not necessarily set the expectation that all results will be at the national top decile. Rather, the vision frames benchmark selection to focus the organization on continually striving to get better every day. Thus, for each key performance measure, SL assess current performance relative to national top quartile (if available) and project performance based on the historical trajectory. If MGMC performance has not yet reached top quartile, and reaching top quartile is a reasonable stretch goal for the year, the target becomes top quartile. If performance already exceeds top quartile, SL look at the trajectory toward national top decile and set an appropriate stretch goal to continue pushing the organization to get better every day. If national percentile rank is not available for a key performance measure, MGMC uses a hierarchy for selecting the most appropriate benchmark: (1) national specialty organization (NDNQI, NHSN) and/or government required healthcare best practice (CMS), (2) healthcare best practice, (key competitors), (3) similar industry (service), (4) recognized leader (Baldrige Award recipient), (5) internal goal/target based on historical performance. This same approach drives use of benchmarks with cascading measures and Dashboards (4.1a(2)) and in support of MGMC's vision and SP (2.1a(1)). Targets are re-evaluated at the end of the annual plan and threshold, target and stretch goals, in support

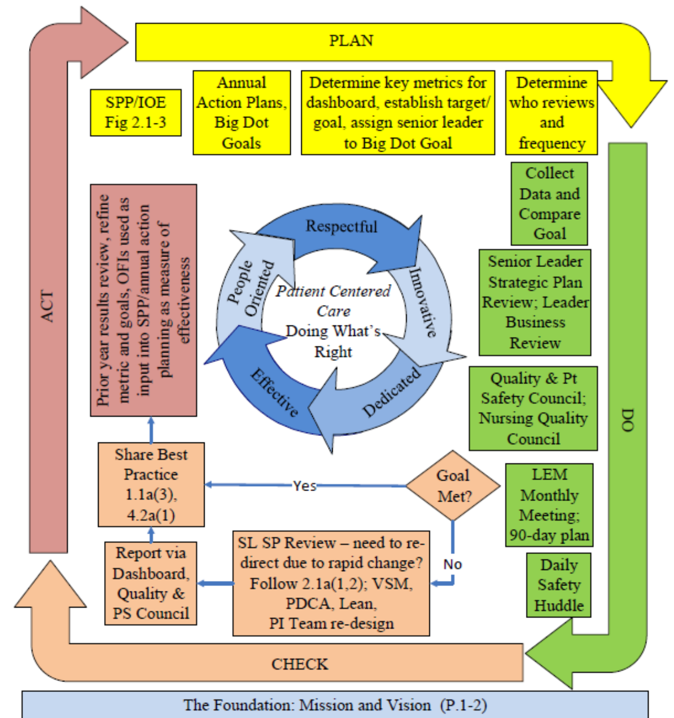


Figure 4.1-1: Performance Measurement System (PMS)

of the SP (4.1b) are re-established. In 2015, MGMC began utilizing Premiers Operations Advisor tool (OA – Figure P.2-2) to monitor and compare performance with other like-hospitals. Department-specific OA reports, as well as other key department metrics noted above, provide data and comparisons for the systematic Leader Business Review process (1.1c(2)).

During the SPP and Annual Action Planning, MGMC researches comparisons and, in most cases, is able to provide relevant ones (Figure P.2-2); however, some metrics identified as important to monitor may not have relevant comparisons and benchmarks such as rounding (Figure 7.1-32) and PHI (Figures 7.1-2). MGMC does not stifle improvement and possible innovation due to lack of benchmarks; rather, appropriate goals are established based on the most meaningful comparisons.

4.1a(3) MGMC's PMS (Figure 4.1-1) was developed based on industry best practices and comparison to similar organizations pursuing performance excellence using the Baldrige framework. The very nature of the PDCA cycle and the ongoing review of the system through the SPP as well as the SL SP Review **ensures the organization is able to rapidly respond to unexpected organizational or external change**. Leader Business Reviews provide an ongoing review of key performance measures and regular reports to the Q&PSC, Medical Staff Committees and BOT indicate the need for a deeper dive into an underperforming metric or the need for a new measure (4.1a(1) and 4.1b) to address mid-year organizational or external changes. A new annual SP review, added as an improvement to the 2019 SPP, provides a full review of the SP and subsequent Annual Action Plans to ensure desired progress is being made.

4.1b Performance Analysis and Review

MGMC uses the PMS (Figure 4.1-1) as the framework for the **review and evaluation of organizational performance**

(Figure 2.1-3) **and capabilities**. This framework supports data-driven decisions, continuous improvement, and innovation. It is aligned with the medical center's MVV and the IOE, and ensures that selection of key performance measures align desired outcomes with LT and ST goals (Figure 2.1-3). Key organizational performance reviews include:

· **SL SP Review** (1.1c(2)): Systematic, monthly review of Big Dot Goal progress to plan. Key performance measures monitored to goal and comparison to benchmarks. Findings are deployed by SL to leaders during monthly meeting; leaders create tactics for their 90-day plans and deploy to staff.

· **LEM review**: Monthly review with one-up; includes monthly meeting model, review of 90 day, what's working well/not well, tactics affirmed and deployed to staff.

· **Leader Business Review** (1.1c(2)): Deep dive into department operations; annual review between leader and SL; data reviewed includes department SWOT, operations by Baldrige categories, qualitative & quantitative data in alignment with Big Dot Goals; best practices shared; and, if necessary, improvement efforts initiated to complete systematic cycle.

· **Daily Safety Huddles**: Three tiered huddle (1.1b); reviews department and organizational safety concerns looking back (last 24 hours) and forward next 24 hours; data reviewed include employee and workforce PHI, safety concerns.

· **Quality & Patient Safety Council**: Multi-disciplinary team (SL, staff, BOT representative, medical staff and community member) reviews key performance measures every other month with a deep dive into performance of key clinical outcomes.

· **Finance Committee**: Bi-monthly review by SL, BOT and community member of key measures of financial and investment performance to plan; key operational measures are compared to budget and industry best practice to assess financial health.

· **SPTF**: Reviews performance of annual action plan to SP on a semi-annual basis.

· **MGMC BOT**: Reviews key performance measures monthly via the Dashboard; redirects plans if necessary.

· **Medical Staff Committee Structure**: Physician leadership meets monthly and quarterly to review specific measures aligned with Big Dot Goals and action plans.

Key organizational performance measures as well as comparative and customer data is used during these reviews to monitor progress to plan and to determine if gaps in performance exist. When gaps are identified, teams are assigned to initiate and charter improvements. An example of this process is when MGMC's VBP readmission data compared less favorably to benchmark performance. Improvements were initiated, including expansion of the Transitions of Care (TOC) program to key patients. Results were tracked during key milestones and to date readmission data is at top decile and is projected to be best in state and CMS overall benchmark by year 2020 (Figure 7.1-1).

Analytical techniques used to ensure conclusions are valid include Frequency Distribution, Pareto diagrams, Histograms, Run Charts, Control Charts, Cross-Tab analysis, and testing for statistical significance. Additionally, PI teams conduct RIE and VSM events, A3s, process flow mapping, cause and effect diagrams, and Failure Modes & Effects Analysis (FMEA) to **evaluate and study** opportunities for improvement. The addition of relationship diagram tools and critical to quality methods in 2016 provides greater focus on prioritizing work plans post-event as well as more closely align measures with what truly matters to the customer. In 2018, a post-review process was added as Standard Work for RIE and VSM events (Figure P.2-3) to enhance executive level support. Clinical outcomes are analyzed for frequency distribution compared to **competitors** and other like healthcare organizations to identify gaps in performance. Rates are converted to actual numbers (i.e., PHI) for greater staff understanding; conversely, numbers are converted to rates to compare to benchmarks and across units within the medical center to allow for comparison and segmentation. Use of reliable data with relevant comparisons ensures the validity of conclusions, and annual evaluation and improvement of the PMS helps MGMC respond rapidly to changing organizational needs and challenges. **SL and leaders use these reviews to assess organizational success, competitive performance, financial health, and progress on achieving strategic objectives and action plans** through the effective measurement and data selection process (4.1a(1)) and the monthly SL SP Review and cascading nature of the SP and Annual Action Plans. The systematic reporting of organizational performance at all levels, including the BOT and medical staff, provides the agility **to rapidly respond to changing organizational needs** when performance gaps are identified. **The BOT and SPTF are engaged in reviewing the organization's performance and its progress on strategic objectives and action plans** through the systematic SL SP Review (1.1c(2)). Due to the rapidly changing environment and the desire to remain nimble, an annual review by the SPTF of the full SP to progress was added in 2019 to more closely monitor progress on strategic objectives and strategize around a change in plan if progress warrants.

4.1c Performance Improvement

4.1c(1) **Projection of future performance** occurs during the systematic SPP and subsequent Annual Action Planning process and SL SP Review. MGMC reviews past performance as well as its current rate of performance and compares this to its key competitor's historical rate of performance. Changes in the industry as well as changes that may impact key competitors are factored into this review. Gaps in performance are identified during the SL SP Review, and the agility of the PMS allows for rapid change where warranted (4.1a(3)). For example, when a key competitor was planning to add oncology services, which would negatively impact MGMC's secondary market, the BI team completed a thorough analysis that projected the potential loss of patient volumes if this competitor followed through on its plans. The ability to quickly conduct this analysis gave MGMC the insight into how it would need to adjust future performance, including workforce plans, should this change be realized. Rigorous review of operational reports, the Dashboard, VOM, and measures associated with various RIE and VSM events provide opportunities to research trends and establish **projections for key services and future performance**. When projected performance is not meeting desired goals, improvements are initiated, and measures are reported and tracked. MGMC benchmarks with both internal and external sources and collaborates with others for best practice sharing. This creates an ongoing cycle of monitoring

and planning for future performance as well as provides means for discussion of future strategic challenges and opportunities.

4.1c(2) **Findings from performance reviews (4.1b) are used to develop priorities for continuous improvement and opportunities for innovation** through the SL SP Review, including the Leader Business Review process. Both provide leaders with opportunities to improve their work systems through use of data and information. Improvements in performance are directly related to successful implementation of aligned action plans of SL, leaders, and staff as well as the systematic monitoring of results via the Dashboard, LEM, and VOM. Through **regular monitoring of key results (4.1b) and effective use of the PMS (Figure 4.1-1)**, MGMC is able to focus efforts where improvements are needed and **deploy priorities and opportunities to work groups and functional-level operations**. For example, based on ongoing review of PHI, patient care technicians (PCTs) did a deep dive into the root causes of pressure injuries and identified and implemented key interventions to aid in their prevention. These interventions were re-tooled and re-deployed to all PCTs through huddles and skills day to increase learning and improvements (Figure 7.1-2). **Leaders ensure that performance review findings,** including those identified during the Leader Business Review Process**,** are deployed to work-groups and functional-level operations to enable effective support for **improvement and innovation.**

MGMC embeds effective systems into the SPP for measuring, analyzing, aligning, and improving performance at all levels (Figure 4.1-1). In evaluating **opportunities for innovation**, MGMC analyzes patient and other customer requirements (Figure P.1-5) gathers competitive comparisons/ benchmarks, creates key indicators (e.g., patient volumes, patient engagement, quality outcomes), sets targets for annual operations (i.e., supplies, salaries, utilities, etc.), and develops the overall projections for contribution margin, market share, revenue, and quality outcomes. An example of this process is the Business Plan and subsequent addition of a nurse practitioner model to support diabetic patients who are hospitalized. RIE and VSM events are chartered and involve those closest to the work **to identify improvement opportunities and innovations** and to design and re-design work processes that bring new value to the customer, supplier, partner, and collaborator. The Daily Improvement program supports the organization's learning and sustainment philosophy, engages all staff in the identification and implementation of improvements, and fosters new ways of doing the work that may ultimately add new value to the customer (innovation). Work System Mapping (2.2a(4) and 6.1b(3)), facilitated by the CEO, engages staff in identifying how their work supports the organizations work and helps detect where opportunities for improving workflows are possible. **When appropriate, priorities are deployed to suppliers, partners, and collaborators** through two-way communication including the Strategic Path flyer, and ongoing monitoring through SLAs and Vendor business reviews. Deploying clinical quality priorities to McFC led to the creation of the innovative TOC program which ensures organizational alignment through reduced readmissions and improved clinical outcomes for chronically ill patients (Figures 7.1-1).

4.2 INFORMATION & KNOWLEDGE MANAGEMENT

4.2a Data and Information

4.2a(1) MGMC **verifies and ensures the quality of organizational data and information** by interfacing and aligning computerized systems to create automated rather than manual processes, and through quality control testing of systems pre- and post-installation. The BI team supports a technology-driven environment that aides the organization in making informed business and clinical decisions. A Data Governance Council was chartered by the BI team to ensure data collected from various systems was standardized through use of a data dictionary, further ensuring **accuracy and validity, integrity and reliability and currency** of data and information at the highest level. In 2018, the BI department rolled out the BI Partnership process which assigns each department leader a BI Partner. These partnerships provide one-on-one support between BI and the department to manage data and information **to ensure accuracy and currency** of data.

Regular maintenance and system upgrades are built into all information technology to ensure the **accuracy and validity, integrity, reliability, and currency** of data. MGMC and McFC collaborate on creating documentation standards through the Health Ventures and EHR Physician Steering Committees and the Documentation and Standards Committee. A VSM event in 2015 resulted in opportunities for the timely and accurate completion of medical records and resulted in enhanced record **accuracy and integrity**. Greater than 85% of all physician orders are entered electronically through Computerized Physician Order Entry (CPOE), a key measure of EHR adoption and standardization that greatly enhances order **accuracy**.

MGMC Information Systems ensures the **reliability** of its hardware and software through a highly redundant infrastructure and continuous replication of all systems between onsite and remote data centers. Equipment is upgraded on a scheduled cycle to accommodate performance, response time and disk space capacity, or to improve reliability and availability. Server and desktop operating systems are security patched according to vendor recommendations and installed as soon as they are considered stable for release. To ensure connectivity between critical operating systems (EHR), MGMC has multiple physical and geographically diverse direct fiber connections routed through redundant networking equipment. Mission critical cloud application availability and internet connectivity are assured using vendor Internet Service Providers located in the remote data center.

The **integrity, reliability, and currency** of the EHR (and other systems that support MGMC) is ensured through standardization of data entry, mandatory training for end users, including the medical staff and volunteers, and ongoing vendor-supported upgrades. The enterprise-wide EHR is built using the model system which supports standardization and ensures system integrity and reliability. Information Systems (IS) helps support the infrastructure within which data-driven operational and clinical decisions are made and as such, MGMC has successfully achieved all Stage 1, 2, and 3 Meaningful Use requirements.

4.2a(2) MGMC **ensures the availability of data and information** through methods described in Figure 4.1-2. Financial and operational reports are issued monthly to leaders

Figure 4.1-2: Availability of Data and Information

User	Access/Availability	Type of Data/Information
Workforce (**employed only)	·Big Dot Goal Cards ·Huddle Boards ·Safety Huddles ·MGMC Intranet ·Employee Updates** ·Gram ·Leadership Resource Site ·Workplace FaceBook** ·First Friday ·LEM ·Performance Evals** ·KaiNexus** ·Policy Medical** ·NetLearning** ·Med Staff Meeting notes	·Big Dot Goals/Progress ·Department Goals/Progress ·Patient/Workforce Safety ·Daily Census/Staffing ·Policies/Procedures ·Standard Work Documents ·Engagement Survey results ·HR Benefits/Plans** ·LI Material/Linkage Grid** ·Compliance & Learning
Patients	·HealthConnect ·MyChart ·MGMC Website ·Social Media ·Hourly Rounding ·Bedside Shift Report ·Radio/TV ·Direct Mailings ·Publications, Newspapers	·Community Health Information & Education ·Quality Reports ·Personal Health Information ·Billing Statements/Payments ·Community Events
Suppliers, Partners, Collaborators	·Reptrax ·Strategic Path Flyer ·MGMC Website ·FaceBook/Social Media	·Big Dot Goals/Progress ·Vendor Compliance Tracking ·Vender Learning Modules ·Community Events
Community	·HealthConnect ·MyChart ·MGMC Website ·FaceBook/Social Media ·Hourly Rounding ·Bedside Shift Report ·Radio/TV ·Direct Mailings ·Publications, Newspapers	·Community Health Information & Education ·Quality Reports ·Personal Health Information ·Billing Statements/Payments ·Community Events

and reported to the MGMC Finance Committee, leadership, medical staff, and the BOT. Ad hoc reports are created with end user input and shared with others as needed. Epic (EHR) report writing has been enhanced, and department and unit-level Dashboards of key metrics provide operational support and guidance to those leaders. A cycle of learning resulted in the development of a common data resource site for leaders that contains links to commonly used data and information **to ensure data and information is readily available**. In 2016, MGMC initiated a data strategy review, and the result has been the creation of the Business Intelligence department (4.2a(1)) to ensure data and information are systematically made available to the end user to support fact-based decision making. Patient information, entered electronically into the EHR and updated in real time, **is made available to providers, partners, collaborators, patients** as needed and as appropriate. Order sets and standardized templates built into the EHR allow physicians to share and utilize best practice protocols throughout the medical center. Clinical outcomes are electronically submitted to clinical benchmarking vendors, which then allow the public to directly assess MGMC's clinical and operational quality via public websites.

MGMC ensures the **reliability and user-friendliness** of its hardware and software through regular interaction with the end user. As a cycle of learning, the BI department assigns partners to all leaders, providing training and support for unique systems and report requests. Additionally, EHR analysts are now assigned to all relevant RIE and VSM events to support end users with work flow improvements such as the Admissions Navigator project. **Software user-friendliness** is further ensured through the IT Steering Committee and through informal communication among users, IT staff, and vendors. Assessment and definition of user requirements through a standardized Vendor Questionnaire (6.2b) is an integral part of the process for IT purchases, and the IT Steering Committee provides management of resources in the installation and support of such purchases. To further ensure user-friendliness of the EHR and other systems, MGMC utilizes a multiple domain strategy for testing, user training, and code certification.

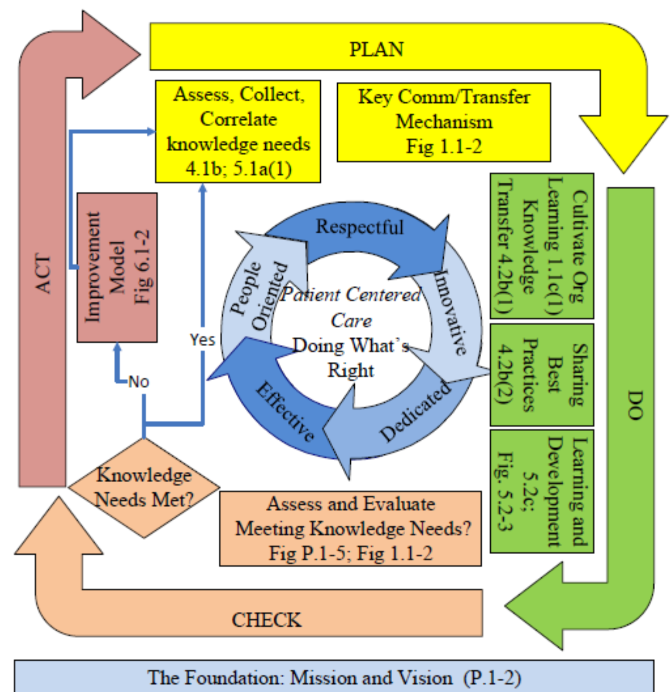


Figure 4.2-1 Knowledge Management System

4.2b Organizational Knowledge

4.2b (1) MGMC **builds and manages organizational knowledge** through the Knowledge Management System (Figure 4.2-1). This bi-directional system is designed to support the SP and Annual Action Plans, and promotes 'learning by doing', thus creating efficiency and effectiveness in the work while systematically creating an environment for organizational knowledge to flourish. The use of Standard Work, and policies and procedures ensures knowledge is transferred to and from the workforce, including physicians and volunteers. Standard Work is created by those closest to the work and is used when a task is important and requires precise repetition in order to deliver the best known result. (i.e., safe medication administration 5.1b(1)). Use of Standard Work, where available, is one of the six expectations of safe behavior (1.1c(1)) and supports the transfer of knowledge from one workforce member to another.

In addition to Figure 4.2-1, the **collection and transfer of workforce knowledge** is accomplished through participation on RIE and VSM events, shared decision making teams, cross functional work teams, and sharing of best practices at First

Friday. CBL modules provide standardized training for all employees and skills labs provide real-time, hands-on training for key skills needed on the job. The **ability to blend and correlate data from different sources to build new knowledge** is supported by the PMS (Figure 4.1-1). An example is the efficiency of environmental services (ES) room turnover correlated with efficient admissions to engage ES staff in the process of effectively and efficiently cleaning a room at discharge (using Standard Work).

MGMC has leveraged its joint EHR to support community health initiatives such as the TOC program (4.1c(2)) to improve clinical outcomes for chronically ill patients. Physician participation on the BOT, RIE and VSM events, SPTF, and the Q&PSC effectively **transfers relevant knowledge from and to this key workforce group as well as partner McFC. Suppliers and collaborators** are engaged in these events to support efficiency and effectiveness in supply use through the Supply Chain Management Process (Figure 6.1-4). Methods described in 4.2a(2) as well as participation of patients and family members in the SPP (Figure 2.1-1, Step 1) and the listening and learning methods described in Figure 3.1-2, give way to opportunities for the **transfer of relevant knowledge to and from patients**. Such examples include engaging patients in bedside shift reporting and engaging families in the multi-disciplinary patient care conferences that support the understanding of the discharge process (Figure 7.2-4). Standard Work documents are shared with suppliers during business meetings to support the transfer of knowledge and ongoing operations. MGMC systematically **manages the assembly and transfer** of relevant knowledge for use in the innovation and strategic planning process during the comprehensive market analysis review of the SPP (Figure 2.1-1, Step 1). Additionally, ideas submitted by employees into the Daily Improvement platform provide opportunities for harvesting ideas that support innovation (Figure 6.1-5) and provide inputs into the SPP.

4.2b(2) MGMC **shares best practices** throughout the organization via First Friday, daily huddles, Employee Updates, the Gram, and the e-physician newsletter. As a cycle of learning, MGMC communicates Daily Improvements that resulted in a change via a live link in the Gram. The Gram is shared with the workforce as well as the BOT, volunteers, and PFAC members. External best practices are identified through various site visits and conferences attended. Additionally, the Quest for Excellence Conference provides MGMC with best practices from other high performing Baldrige organizations. **High- performing departments are identified** through the SL SP Review, Leader Business Review Process, and quarterly review of LEM results, all of which align with the SP and Annual Action Plan and Big Dot Goals. An organization-wide 5S project, conducted at a LI, led to leaders completing a project within their department with staff involvement. Leaders shared their learnings at a LI, and MGMC then created a walking tour of departments with sustained 5S projects. **Best practices** were highlighted during this walking tour, and leaders implemented additional learnings within their own areas including a standardized KanBan system for ordering non-stock supplies and visual management approaches for storing equipment. MGMC further used these learnings in the intelligent design of all patient supply cabinets in the new inpatient tower. The best practice 5S walking tour has been shared with other outside organizations throughout the state, both healthcare and non-healthcare, as an opportunity for them to learn from our best practices. In support of its Big Dot Goal of reducing patient harm, MGMC identified the **best performing unit** related to preventing patient falls that have the potential to result in serious harm. This unit implemented an innovative Shift Safety Huddle approach that provided breakthrough improvements in preventing falls that cause serious harm. This Shift Safety Huddle approach was standardized and deployed to all units to support the prevention of serious patient harm. (Figure 7.1-2).

4.2b(3) MGMC utilizes its **knowledge and resources to embed learning in the way it operates** through the systematic deployment and review process of the SP (Figure 2.1-1, step 4; 4.1b), use of Standard Work, including engaging those closest to the work to design and re-design their work (4.2b(1); 6.1a(3)), and the systematic sharing of organizational learning through First Friday, daily huddles, and the SL SP Review and Leader Business Review Process. The 2017 100 Day Workout resulted in new learnings in using the software system to allow documentation of Return on Investment (ROI) and to support the transfer of knowledge. The Knowledge Management System (Figure 4.2-1) provides the framework for harvesting needs and deploying resources and education to support organizational learning. Monitoring and improvement supports ongoing learning needs. Employees who participate on RIE and VSM events are empowered to take learnings from these events to their own department to become agents of change. This systematic approach has been deployed to all levels of the medical center and has resulted in improved and sustained results for identifying **new and innovative** ways of cleaning rooms (Terminal Room Cleaning RIE), processing of payments (Business Office VSM), and timeliness of seeing patients in the Emergency Department (ED VSM). Each of these events involved having those closest to the work study the current state, identify areas of waste/improved efficiency, and implement small tests of change. Upon completion of each event, team members share best practices at First Friday to further embed learning in the organization. As a cycle of improvement and to embed learning with the medical staff, RIE report outs are now shared by physician participants at quarterly Medical Staff meetings. Examples of these physician-led report outs include the Hand Hygiene RIE and the Sepsis Bundle RIE.

CATEGORY 5: WORKFORCE

5.1 WORKFORCE ENVIRONMENT

5.1a Workforce Capability and Capacity

5.1a(1) Workforce **capability and capacity needs** are assessed using a five-step process (Figure 5.1-1). Assessment of long-term needs identified during the SPP (2.1a(1) Steps 2, 3, and 4), as well as short-term needs identified during the Annual Action Planning process, are vetted during the SL SP Review and subsequent budgeting process. This strategic workforce planning process (2.2a(4)) considers capability and capacity needs associated with the strategic plan, as well as projected gaps based on expected FMLA, retirements, historical turnover, and patient volumes. Staffing levels are compared to industry benchmarks including the National Database of Nursing

Quality Indicators (NDNQI) to ensure appropriate staffing and skill levels exist to meet the needs and support the CC. This approach allows the organization to proactively plan for and match staffing and resource requirements to deliver on customer expectations and achieve organizational results.

Assessing skills, competencies, certifications, and staffing levels of the workforce is an ongoing process which includes analyzing input such as the annual education needs assessment (Figure 5.1-1, step 1) and aggregating results of learning (outputs – Step 4) to determine where opportunities for improvements to training and development exist to ensure staff capability is adequate (Step 5). The Leader Business Review process looks at staffing compared to competitors and like-sized hospitals, which supports the organization in planning and forecasting needs. A staffing matrix allows the organization to manage staff **capacity (staffing levels)** more precisely by shift. Leaders monitor this matrix daily and by shift, which allows for more predictable staffing levels based on volumes. A weekly report, displaying actual to expected volumes for key hospital services as well as the nursing staffing matrix, aids the organization in monitoring staffing mix according to real-time volumes. In 2017 Guest Services conducted a RIE to study the patient transport process due to an increase in dissatisfaction with delays. The RIE team blended and correlated historical data related to patient transport requests by day of week, time of day, and department initiating the request with the patient census to determine where opportunities existed to improve timeliness. This work resulted in the development of an innovative predictive staffing model that identifies, by day of week and time of day, the number of requests expected which allows Guest Services to appropriately staff for this expected need.

Annual competencies are assessed during performance evaluations and an annual needs assessment tool aids in determining new **skills and competencies** needed in the coming year to more effectively plan training and education programs. The Healthcare Source staff and applicant assessment survey tool (5.1a(2) was added in 2017 to the annual performance evaluation process to **assess skill and competencies** of existing staff and to aid in identifying new staffing levels and skills that may be needed. Volunteer Services manages the needs for volunteers according to acuity and deploys resources based on various needs. Difficult to place volunteer spots (time of day/day of week) are identified and managed for targeted volunteer recruitment. Providers are appointed to the medical staff in accordance with the Bylaws of the medical center. The Bylaws ensure the ongoing consistency of skill, competency, and certification of each provider who is privileged (credentialed) to practice medicine at MGMC. The Physician Needs Assessment (2.2a(4)) evaluates capability and capacity issues such as specialty coverage, leakage, growth, new services, and planned retirements to ensure adequate physician levels to meet patient needs. Following feedback from the SPTF, the Physician Needs Assessment is refreshed every 24 months and aids the SPP. In 2018 MGMC included nurse practitioners (NPs) and physician assistants (PAs) in this assessment to support the changing provider environment.

5.1a(2) MGMC **recruits, hires, and on-boards** new employed workforce members through a systematic Applicant Hiring and

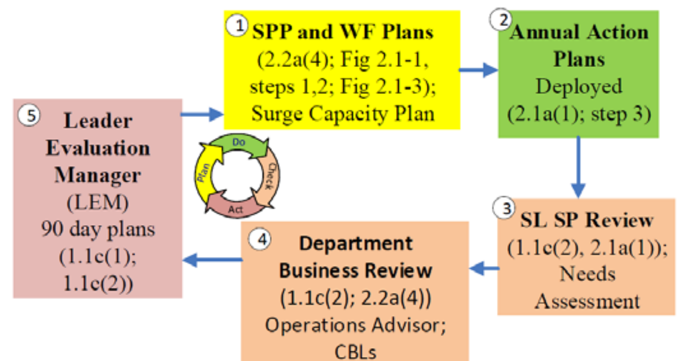


Figure 5.1-1 Process for Assessing Workforce Needs

Onboarding Process (Figure 5.1-2). This approach is aligned with the workforce needs called out in the SPP (Figure 2.1-3) and considers department capability and capacity (Figure 5.1-1) throughout the process. MGMC initiated peer interviewing in 2010 and since then, several cycles of learning have occurred with this process, including multi-disciplinary peer teams to support cross-department work relationships, improved behavioral-based interview techniques/questions, and a new staff assessment pre-interview survey to more accurately **assess skill and competencies** of potential hires as well as to **ensure the candidate is a fit for the organizational culture,** including alignment with the MVV. To support **retention**, in 2016 MGMC began offering job previews to potential candidates as a way of introducing them to an area of work. This allows the candidate to preview the work they will be doing to determine if it will be a good fit.

Based on feedback about the length of time it took to complete the recruitment process, a RIE team was chartered in 2013 and improvements were identified and implemented, resulting in a 50% reduction in the time from application submission to the new employee starting (Figure 7.3-3). This metric is monitored to ensure the systematic approach, including improvements throughout, continue to support an efficient process for recruitment, hiring/placement and retention. To support engagement and organizational alignment, new employees complete general and department orientation, which includes an introduction to the MVV, Standards of Behavior, and Big Dot Goals.

In collaboration with McFC, MGMC participates in physician recruitment and on-boarding, which includes the MVV and the medical staff Code of Conduct (1.1a(1)). Based on feedback regarding physician on-boarding, SL now do a 90-day reconnect session with all new physicians and ask what's working well and what systems could be improved. As a cycle of improvement, the Strategic Path flyer (1.1c(2)) is shared with physicians during the on-boarding process to engage them in the MVV and share strategic priorities. MGMC recruits, places, and retains volunteers through the Volunteer and Older Adult Services department. Volunteers are matched with departments where their skills are of similar fit and are oriented to the MVV and Volunteer Code of Agreement (1.1a(1)). Rounding with the non-employed workforce (volunteers and physicians) is done by SL, leaders, and Volunteer Services.

MGMC ensures its workforce represents the **diverse ideas, cultures, and thinking of its hiring and patient community** through 1) its Equal Employment Opportunity (EEO) status, 2)

a commitment to hiring, training, and developing a workforce that is representative of the community it serves (Figure 5.1-2), 3) supporting shared decision making teams that allow diverse views and thinking from the workforce, and 4) providing annual diversity awareness and inclusion training. As a cycle of learning, in 2017 MGMC augmented its approach to hiring by adding the Healthcare Source applicant assessment survey tool to its hiring process to **ensure the fit of new workforce members with the organizational culture**. This survey is completed by all applicants and provides a comprehensive fit-for-culture report, as well as key interview questions to the hiring director. Workforce diversity is evaluated every two years relative to the EEO report and benchmarking with local markets. Identified diversity gaps drive targeted recruitment.

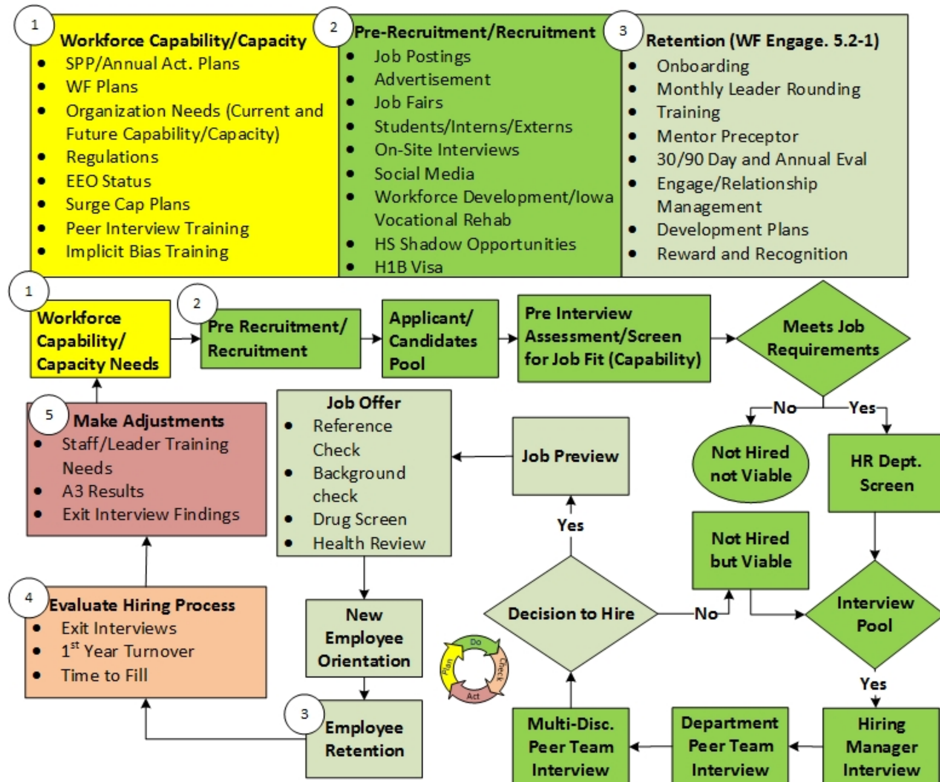


Figure 5.1-2 Applicant Hiring and Onboarding Process

5.1a(3) Preparing the workforce for **changing capability and capacity needs** begins with workforce planning in the SPP (Figure 2.1-3) and ongoing through effective management of the environment (5.1a(1,3) and Figure 5.1-1) and effectively communicating key messages (Figure 1.1-2). Workforce plans are incorporated into the monthly SL SP Review process so focus remains on this organizational strategic challenge (Figure P.2-3, SC4). This systematic and ongoing cycle of review allows the organization to effectively and efficiently **balance the needs of the workforce and the organization to ensure continuity, prevent workforce reductions, and minimize the impact of any necessary reductions.** Through the strategic workforce planning process, MGMC projects three years out to know where capability and capacity changes may occur and, thus, is able to work with those department leaders to reskill and reallocate impacted workers. For example, when the industry moved total joint replacements from an inpatient to an outpatient procedure, MGMC restructured the inpatient med/surg unit and re-deployed employees as needed. To date, MGMC has not had a reduction in force due to its ability to proactively plan for changes to the workforce. **To prepare for workforce growth,** the BI team feeds the SL SP Review by proactively evaluating **potential growth opportunities** and workforce plans for such. An example is the analysis that **projected growth** of adult IP behavioral health volumes (SC2) and the decline of adolescent IP behavioral health volumes. This analysis precipitated a plan by SL to **prepare the workforce for changes in the organizations structure and work systems** such that adolescent beds were converted to adult beds. A subsequent plan to support the increased adult staffing while reducing adolescent staffing was developed and deployed using the SL SP Review and effective two-way communication methods (Figure 1-1-2). This approach eliminated any negative impacts of this workforce change. Periods of **workforce growth** are factored into the SPP and refined during the Annual Action Planning process and SL SP Review. MGMC prepares the workforce for **changes in organizational structure and work systems** through two-way communication methods described in Figure 1.1-2 and through its commitment to continuous improvement.

5.1a(4) MGMC **organizes and manages its workforce to accomplish the work of the organization** and to provide exceptional patient-centered care through its commitment to the MVV and CC and in support of the SP, Annual Action Plan, and departmental 90-day plans. The organizational chart defines the structure of the organization, and the Leadership System (Figure 1.1-1) grounds that work in the MVV.

The Big Dot Goal Philosophy (2.1a(1)), implemented in the FY2017 action planning cycle aligns the most important goals with the entire workforce and creates laser focus on **achieving the organization's work, capitalizing on its core competencies, and exceeding performance expectations** (Figure 7.5-13). This philosophy supports the SP and the Annual Action Plans, creates synergy through clear expectations and alignment of priorities throughout the organization, and delivers on key patient requirements (Figure P.1-5). Standard Work is supported as a method to eliminate waste, reduce variation, and reinforce processes that are systematic and repeatable and produce desired results (1.1c(1)), thus **reinforcing a focus on patients, other customers, and health care.** Leaders conduct daily patient rounding to gather feedback from patients specific to their needs and those who care for patients conduct hourly (or more frequently, such as the ED) patient rounds to anticipate patient needs. As an improvement to the bedside shift reporting process, MGMC engaged a multi-disciplinary team to conduct case conferences to improve the health outcomes of patients with chronic

illnesses and to initiate discharge planning and education earlier in the process. Families were then added to increase patient compliance and satisfaction with discharge process. Effectively engaging the workforce through involving patients and families in the care and information process allows MGMC to **exceed performance expectations** (Figures 7.2-18-19).

5.1b Workforce Climate

5.1b(1) MCMG's CC and Big Dot Goals (PHI), as well as its People-Oriented Value, focus the organization on **ensuring workplace health, security and accessibility**. The Environment of Care (EOC) plan – developed, monitored and annually updated by the multidisciplinary EOC Committee – proactively addresses security/risk management, hazardous materials, utilities, medical equipment, and life/patient/workforce safety. It is presented to the BOD annually. The EOC Committee established the EOC Dashboard to systematically monitor plans to ensure workplace security, safety (6.2c), and accessibility. The committee provides oversight for action plan development and ensures compliance through audits and EOC rounds. Results are shared with leaders for follow up and creation of plans for improvement. Figure 5.1-3 describes methods and goals to **ensure and improve workforce health, security and accessibility, including performance measures and results**.

Workforce screenings, including pre-employment physicals and when necessary, fit-for-duty testing, are conducted at hire (5.1a(2)). Working on Wellness (WOW) provides learning and fitness opportunities for the workforce and engages them in activities to promote health and wellness. Employee Health conducts A3s on workforce PHI, and outcomes are reported at the daily organizational safety huddle for awareness and action. As a cycle of improvement, an A3 deep dive of all needle sticks was conducted, key causes were identified, and Standard Work was created for safe medication administration, which has resulted in a significant decrease in needle sticks (Figure 7.3-11). MGMC ensures **accessibility** through its Reasonable Accommodations process. This process is owned by the HR department and includes an interactive conversation between HR, department leadership, and the employee to determine needed accommodations such as workstation accommodations, flexible work schedules and specialty assistive devices.

5.1b(2) MGMC **supports its workforce** through offering a competitive and comprehensive **benefits** package, including market competitive **services** (Figure 5.1-4). Annually, HR conducts a comprehensive benefit and salary review, benchmarking plans to the market. Salary adjustments based on market conditions are built into the Annual Action Plan to ensure we remain competitive. We benchmark medical director reimbursement and physician salaries to the Medical Group Management Association (MGMA) surveys for market competitiveness and compliance. The Employee Advisory Committee (EAC) is the liaison between leadership and the employees and provides input regarding **benefit design, existing and new policies and procedures**, and topics that impact the workforce. MGMC has developed accommodations tailored to meet the needs of its diverse workforce groups and segments including job sharing and flexible work hours. To support an aging workforce, enhanced retirement readiness programs were created in 2015.

Figure 5.1-3: Key Workplace Health, Security, Accessibility

Type	Methods	Segment	Measures	Goals
Health	Flu Vaccination Hand Hygiene Needle sticks	WF WF WF	% Compliance (Fig. 7.3-12) % Compliance Reduction of # (Fig. 7.3-11)	≥ 95% ≥ 80% < 50
Security	Security incidents EOC rounds	WF EWF	Incidents (Fig 7.3-10) Logs completed	100% 100%
Access-ibility	Reasonable Accommoda-ions	WF	Hours provided (Figure 7.3-10)	More

WF = employed/non-employed; EWF = employed

5.2 Workforce Engagement

5.2a Assessment of Workforce Engagement

5.2a(1) MGMC **determines key drivers of workforce engagement** primarily through the annual employee engagement survey, administered by NRC Health and the workforce engagement process (Figure 5.2-1, Steps 2 and 3). Engagement data, segmented by workforce groups, are analyzed to determine differences. As a cycle of learning and based on a Baldrige awardee's best practice, MGMC added focus groups following the 2017 engagement survey to identify and affirm key drivers of engagement, augment the workforce listening and learning process, and support improvement in action taken (Figure 7.3-16). These focus groups, led by the CEO, consisted of participants from a random sample of all segments of the employed workforce. Results of the previous survey were used to develop questions for the focus group sessions. A team, consisting of HR, leaders and SL correlated focus group feedback with results of the survey and affirmed these key drivers. In 2018 SL added key focus groups for the four lowest scoring departments. Input from these sessions, as well as input from all groups provided feedback for improvement plans throughout the year. Based on input from employees following 2018, the focus groups were expanded in 2019 to accommodate all employees.

Figure 5.1-4 WORKFORCE Key Benefits, Services & Policies

Type	Description	Segment
P	On-line access to Policies, Procedures, Standard Work	WF
S	Professional development plans	EWF
B	Discounts to cafeteria and gift shop	WF
S	Education and Training	WF
B, S	Tuition Assistance, Reimbursement, Career Planning	EWF
B, S	Employee Assistance Program	EWF
B	Medical, Dental, Vision, Retirement plans	WF
B	Reduced copayments for MGMC provided services	EWF
B	Paid Time Off (PTO/FMLA)	EWF
B, S	Financial Wellness Planning	WF
B, S	Wellness programming, assistance, screening	EWF
B	On-site graduate education program	EWF
B, S	CME and CEU opportunities including Grand Rounds	WF
B, S	Financial assistance for specialty certifications	EWF

B = Benefit; S=Service; P=Policies
WF = employed/non-employed; EWF = employed

Determining drivers of engagement for physicians and volunteers, similar to the employee process, is done through annual volunteer and physician engagement surveys. Focus groups for the non-employed workforce are conducted and input is used to affirm key drivers for the non-workforce segment.

5.2a(2) MGMC **assesses workforce engagement** through the systematic Workforce Engagement Process (Figure 5.2-1), using formal and informal assessment methods and measures. The MVV and SPP provide the foundation, and annual workforce engagement surveys provide the roadmap for continuously improving this culture (Figure 5.2-1, Step 2). MGMC uses third-party vendor NRC Health to administer employee and physician surveys and a separate vendor that offers a volunteer survey. For employees, SL and leaders review organizational results and identify opportunities, while VPs review results with their teams to identify department-level opportunities. Employee focus groups provide qualitative input. This data and information go to the workforce planning committee, which recommends a plan for action. The Annual Action Plan and supporting 90-day plans are shared and implemented across the organization. MGMC follows a similar process with physician and volunteer results to develop and implement improvement plans addressing each of these key workforce groups.

MGMC tracks workforce satisfaction with action taken from previous surveys to ensure efforts are having a positive outcome (Step 5 and Figure 7.3-16). Focus groups were added (5.2a(1)) as a means of gathering greater input from the workforce regarding key drivers. Action plans are monitored, and leading measures are tracked to ensure favorable outcomes (Step 6). Leading measures, segmented by department and job class, aid the organization in assessing the effectiveness of workforce systems and processes and are correlated with formal survey results to factor in both qualitative and quantitative results for workforce engagement.

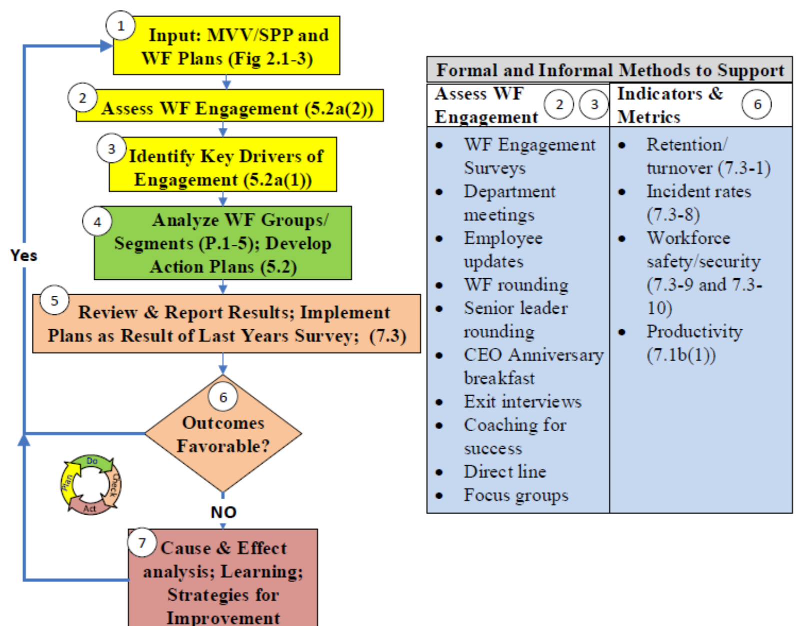


Figure 5.2-1: Workforce Engagement System

5.2b Organizational Culture

MGMC **fosters an organizational culture that is characterized by open communication** (Figure 1.1-2), **high performance** (1.1b), **patient safety,** (1.1c(2)) **and an engaged workforce** (1.1c(1)). MGMC begins building this culture, even before an employee, physician, or volunteer joins the organization, through onboarding processes that ensure and reinforce cultural fit and alignment with the **vision and values** (5.1a(2)). The Leadership System (Figure 1.1-1), grounded in the MVV, provides a framework for the culture, and links the work of employees, physicians and volunteers to the MVV, which is fully deployed as described in 1.1a(1). SL role model and intentionally promote **two-way communication** (Figure 1.1-2) and have established team work as Standard Work to both require **communication** and leverage **the diverse ideas, cultures and thinking the workforce**. Rounding, shared decision-making teams, daily huddles, and RIE and VSM events further support communication. Through cycles of learning and improvement, MGMC has identified key requirements (Figure P.1-5) that support a culture of **high performance work and engagement**. MGMC systematically works to improve **engagement,** and through its Workforce Engagement Process (Figure 5.2-1) and its Workforce Performance Management System (Figure 5.2-2) is able to drive **high performance**. MGMC **empowers the workforce** and supports a culture of doing what's right through the Daily Improvement platform and by engaging those closest to the work to participate in the improvement process. To augment this culture, leaders participate in the 100 Day Workout process (1.1c(1)), engaging their staff in identifying ideas for improvements. Three-tier patient safety huddles foster a culture of patient safety, with active participation in the A3 review process for all near misses.

5.2c Performance Management and Development

5.2c(1) MGMC uses its Workforce Performance Management System (Figure 5.2-2) to **support high performance.** During the PLAN phase, SL and leaders establish goals, Annual Action Plans, and tactical 90-day plans to support the organization's Big Dot Goals ((1.1c(1) and 2.2a(2)). Goals are weighted by IOE and goal achievement factors into **compensation.** To engage and empower staff, leaders then work with employees to help them set their own goals via employee Big Dot Goal cards, also aligned with Annual Action Plans. The LEM, monthly meeting model (2015 cycle of learning), and employee rounding facilitate regular and frequent review of progress to goal and may prompt corrective action if necessary. As a cycle of learning, the Big Dot Goal scorecard (4.1a(1)) is now posted to the intranet monthly. The annual employee performance review includes evaluation of goal achievement, as well as performance relative to the Code of Conduct and the patient-centered Standards of Behavior. SL review reports from monthly meeting models during the SL SP Review. Annual Action Plans of SL, leaders, and staff (Figure 5-2-2, CHECK phase) support improvements and innovation (Figure 5.2-2, ACT phase) and give way to the next cycle of action planning and goal setting (Figure 5.2-2, PLAN phase).

The annual employee performance review also includes creation of a professional development plan, and as a 2017 cycle of learning, staff completed the Healthcare Source assessment survey to further understand workforce learning and development needs. Further evaluation through department-level high/middle/low reviews occur throughout the year as described in 5.2c(4). To reinforce intelligent risk taking, employees earn points through the Rewards for Employee Achievement Program (REAP) for participating on RIE and VSM events. Additional **rewards and recognitions** are described in 1.1b.

MGMC uses the medical staff credentialing and peer review processes to manage physician performance. Re-credentialing integrates specialty-specific quality metrics and the Code of Conduct reinforces the MVV and MGMC's patient-centered environment. Medical director contracts contain metrics aligned with the Big Dot Goals. For instance, the ED medical director is accountable for patient experience and cycle time, while utilization management has metrics related to readmissions and length of stay. Volunteers are evaluated annually based on input from the departments where they work.

The very nature of the systematic goal development process at all levels of the organization and the linking and aligning of systems (SPP Figure 2-1-1; Workforce Performance Management System Figure 5.2-2; Performance Measurement System Figure 4.1-1; Performance Improvement System-Figure 6.1-1) **supports achievement of action plans that support a patient and business focus and reinforce intelligent risk taking.**

5.2c(2) MGMC's **learning and development system (Figure 5.2-3) supports the personal development of the workforce and the needs of the organization.** Identification of organizational learning and development needs begins during SPP and is ongoing through the Leader Business Review process (1.1c(2), 2.2a(4)). Additional inputs into the PLAN phase of the learning and development system include an annual education needs assessment survey (5.1a(1)), the Healthcare Source assessment (5.2c(1)), and department-level high/middle/low employee reviews (5.2c(4)). These needs are aggregated and analyzed to determine, balance and resource the highest-priority learning and development needs. As a cycle of improvement, individual staff and leader development plans are now created during the annual performance evaluation process to support **personal workforce development**. Additionally, a leadership needs assessment survey, modeled after MGMC's best practice staff survey, was added in 2017 to systematically assess leader development needs and to systematically support an annual Leadership Institute (LI) calendar. Learning and development offerings include support for professional certifications, annual computer-based learning, skills days, just-in-time training and the LI. To support performance improvement and intelligent risk taking, MGMC provides just-in-time training for all RIE events and as a cycle of learning, established RIE Standard Work (Figure P.2-3).

The learning and development system supports **ethical healthcare and ethical business practices** through orientation and subsequent annual training on the Code of Conduct (1.2b(2)). Ongoing monitoring of key ethical and compliance measures informs curriculum improvements and may indicate

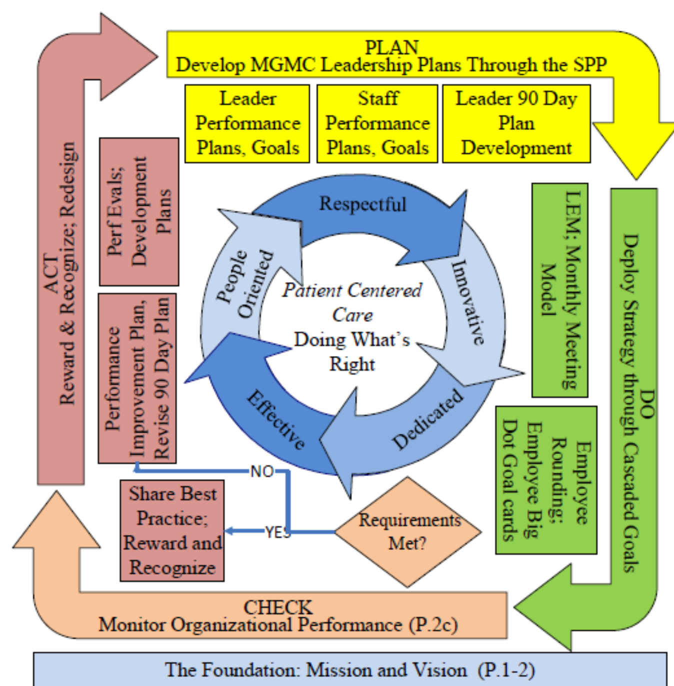


Figure 5.2-2 Workforce Performance Management System

the need for additional just-in-time training. The Continuing Medical Education (CME) Committee assesses and addresses physician development needs, while volunteers receive appropriate department-specific training.

5.2c(3) **Evaluation of the effectiveness and efficiency of the learning and development system** is done in the 'check' phase of Figure 5.2-3 as well as through the Knowledge Management System (Figure 4.2-1). The annual needs assessment survey determines training and education required to support the work. Post-training surveys measure improvement in scores. Post-education responses for nursing skills for the past three years have demonstrated an improvement in skill by more than ten percent in each topic. As a cycle of learning and to more systematically address the training needs of leaders, MGMC now uses a leader needs assessment and a 360 evaluation to assess leader needs. The result is a year-long curriculum for LIs and a data-driven mechanism to evaluate effectiveness of learning. By correlating learning assessment results with engagement scores, MGMC identified 'communication' to be one of its greatest opportunities for improvement (Figure 7.3-17). **Opportunities to improve workforce engagement results** regarding communication include the addition of focus groups post workforce engagement survey, monthly 'Engage' flyers, a refresh and reconnect to the PRIDE values, and validation of employee rounding during monthly meetings with leaders. Additionally, 'Department in Focus' videos highlight the work of each department and a new video is shared at updates and posted to the MGMC website. A new MGMC Workplace Facebook site was added in 2019 to foster interdepartmental engagement. The EAC provides input that is reviewed and acted upon by a multi-disciplinary work team. Actionable recommendations are brought to SL for enhancing learning and development opportunities for the workforce. An example of the action taken based on EAC recommendation is improved training and Standard Work documents for logging in

and out of the nurse call system. Additionally, based on feedback from volunteers, Standard Work for telephone extension look-up was created. The Continuing Medical Education (CME) committee creates and schedules an annual multi-faceted educational curriculum, evaluates the effectiveness of these programs, and uses feedback for ongoing training and development opportunities. Results of the CME program demonstrate the ongoing effectiveness (Figure 7.3-27).

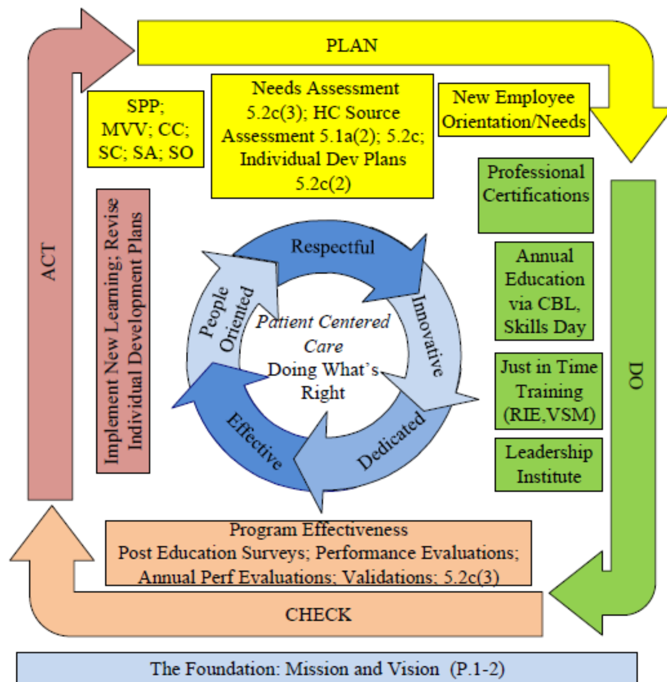


Figure 5.2-3 Learning and Development System

5.2c(4) MGMC **manages career development for the workforce and future leaders** in a proactive manner that begins with departmental high/middle/low review of all staff. This annual review, supported throughout the year during employee rounding, identifies **staff advancement and leadership development** opportunities (high performers) from those who may not be ready for advancement but could benefit from additional mentoring (middle/low). As a cycle of learning, leaders now rank all staff to clearly identify top successors.

While the RN to BSN program is a condition of ongoing employment, it serves as an advancement opportunity for those who come to work at MGMC with a two-year degree. Individual development plans (5.2c(2)) support proactive staff development and encourage leaders to have discussions with high performers about career goals and determine future potential. Mentors are assigned, and **future development** is offered through various training and educational programs (5.2c).

The medical center compares pending vacancies/retirements of leaders to its list of potential successors to determine if an internal candidate exists. This approach was refined in late 2011 by incorporating the IHA Leadership development program. To date, more than 63 individuals completed this 10-month program. MGMC prepares potential leaders by developing their leadership skills consistent with the MVV and in alignment with the leadership system (Figure 1.1-1).

MGMC partners with McFC to identify physicians with leadership potential. These physicians are invited to complete a formal physician leadership development program and participate in RIEs. Volunteer development is ongoing and commensurate with the skills and desires of the individual.

CATEGORY 6: OPERATIONS

6.1 WORK PROCESSES

6.1a Service and Process Design

6.1a(1) **MGMC determines key healthcare service and work process requirements** through the Process Improvement Model (6.1-1) which incorporates the inputs and outputs of the SPP (Figure 2.1-1, Step 1 "inputs' and Step 2 'outputs') and are aligned with the IOE (Figure 2.1-3). Annual Action Planning, and the SL SP Review support and drive key work process requirements through a patient-centered care approach. VOC feedback methods (Figure 3.1-2), research on best practices, and close collaboration with partners, suppliers, and vendors support and affirm key requirements. Standard Work for RIE and VSM includes evaluation/affirmation of key work process requirements during the VOC input (both internal and external) portion of the event. For example, the Patient-centered Scheduling RIE, affirmed key workforce requirements of timeliness and communication (6.1-2) and initiated improvements that enhanced these requirements. As a cycle of improvement, key work process requirements are now reviewed during all work system mapping events (2.1a(4)) to ensure the work is meeting customer requirements. The Improvement Process Model (6.1-1) guides ideas for innovations and Daily Improvements.

6.1a(2) **Key work processes and key requirements** are listed in Figure 6.1-2 along with their leading and lagging measures. To proactively respond to emerging trends in healthcare and to leverage SA1, continuum of care was added as the fifth key work process.

6.1a(3) MGMC **designs its healthcare services and work processes to meet key requirements** and to ensure effective and efficient use of time and resources through the Process Improvement Model (Figure 6.1-1) which is grounded in the PDCA methodology. DMAIC was added in 2017 (Figure P.2-3; 6.1b) to enhance learning and to promote a data-driven approach. Service design and re-design begins with the SPP as input and proceeds to evaluate VOC feedback to align key requirements with the design/re-design efforts. Identifying where value versus non-value work exists in the process is supported by those closest to the work who are trained to identify waste (non-value added). Teams implement small tests of change and explore opportunities for additional improvements. Monitoring of measures occurs, and this cycle continues until key measures of the process are stable. As a cycle of learning, the Standard Work Steering Committee was restructured in 2017 and is now the multi-disciplinary Innovation and Improvement Council. This restructure aligns with the Process Improvement Model (Figure 6.1-1) and supports priorities identified in the SP as well as findings of the SL SP Review. This approach allows the organization to systematically align improvements where the greatest need exists, while ensuring appropriate resource allocation is

available. The BI team supports these efforts through consideration of risk tolerance and subsequent review and analysis to support opportunities for improvement.

Incorporating new technology (i.e., KaiNexus roll out to support Daily Improvements, 1.1c(1)) is factored into the review process as is **organizational knowledge** (i.e., Safety Huddle, 4.2b(2)), **evidence-based medicine** (i.e., SSI improvement team and Standard Work documents), **healthcare service excellence and patient/other customer value** (i.e., award winning Patient-centered Scheduling, P.2c), and **consideration of risk and potential need for agility** (i.e., BH strategy, 1.2c(1)). All support the design and re-design concepts of work processes. Eliminating waste through the re-design process ultimately produces **greater value for patients and other customers**. Participation in state and national initiatives like the IHC Partnership for Patients program, provides opportunities for MGMC to learn from others and to benchmark for refinement of its own programs.

6.1b Process Management and Improvement

6.1b(1) MGMC **ensures its day-to-day operation of work processes meet key process requirements** through the PMS (Figure 4.1-1) and are supported by the leadership system (Figure 1.1-1).

The LEM and 90-day action plans (1.1c(1)) provide an ongoing review by department of the success of work processes and key process requirements that align with the SP. Standard Work aids in reducing variation and waste associated with these key work processes and supports a culture of accountability. Leaders are responsible for and monitor performance on a real-time basis (daily, weekly, monthly or quarterly – depending upon the metric) to ensure desired outcomes are achieved. When results are not meeting expected, leaders are empowered to take corrective action.

Key performance measures used to control and improve key work processes are listed in Figures 6.1-2 (leading). The addition of the Big Dot Goal philosophy creates greater alignment of those key measures that in turn support the organization's SP and **quality and other performance outcomes** (lagging).

6.1b(2) MGMC **addresses and considers each patient's expectations** through the SP and its patient-centered care approach. Patient-centered care is at the center of all work systems at MGMC and, along with the MVV, it provides the framework for the SP. This systematic approach is integrated through all work systems and reinforces consideration of not only **meeting, but exceeding patient expectations and preferences** regardless of market segment. Effective communication with patients is essential in **setting realistic expectations**. Patient rounding, follow-up phone calls, and informal discussions with patients and families are deployed, where appropriate to all patient groups. Rounding and AIDET approaches are hardwired through validations and deployed across service offerings and customer groups by both patient care and support staff as a means of easing patient anxiety. This **allows the workforce to explain the healthcare service delivery process and communicate likely outcomes to set realistic patient expectations** directly with the patient. RN bedside shift reporting, initiated in 2014 and refined in 2016,

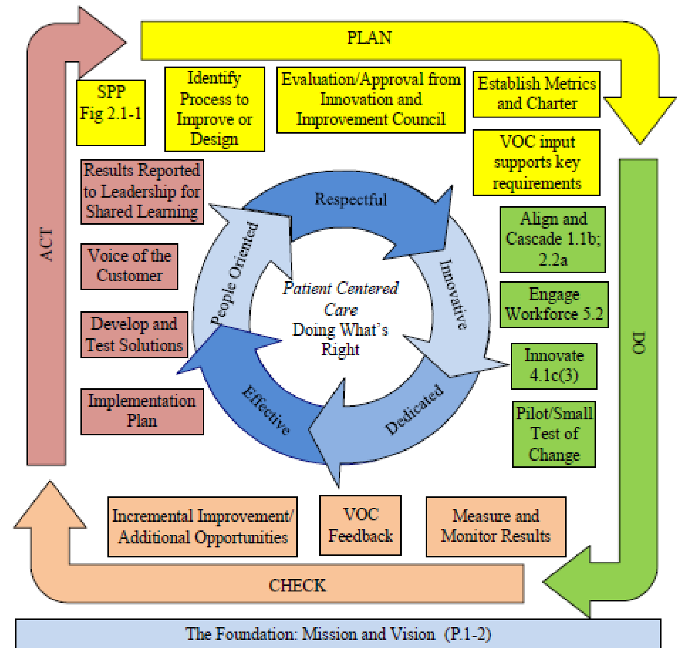


Figure 6.1-1: Process Improvement Model

improves the handoff process and allows for clear explanations of the care delivery process to patients and families to ensure **realistic expectations** and **shared decision-making**. Findings from bedside shift report funnel to the department safety huddles and on to the organizational safety huddle, thus supporting the innovative three-tiered safety huddle 1.1c(1)). As a cycle of learning, and to improve care coordination, multi-disciplinary care conferences are conducted for chronically ill patients. In 2016 MGMC took this approach to the OP setting through the implementation of the ED Care Coordination process. This multi-disciplinary approach between hospital and physicians supports patients with a high frequency of ED visits through case managing their individual needs. In 2019 MGMC went live with the Epic Home Health and Hospice EHR modules to support the Home Health and Hospice care delivery process, allowing more effective care coordination for these patient between all care settings. Hospice volunteers are specially trained to support the terminally ill patient and their loved ones, anticipating and supporting their individual

Figure 6.1-2 Key Work Processes, Requirements and Measures

Key Work Processes	Key Requirements	Key Performance Measures	Leading Figure	Lagging Figure
Admitting Patients	Timely, Communication	PACU Boarding ED Decision to Admit	7.1-24 7.1-25	7.2-2 7.2-10
Assessing (Diagnose) Patients	Quality, Safe, Timely, Communication	Door to Doctor ED Lab turnaround	7.1-27 7.1-28	7.2-10 7.2-10
Treating Patients	Quality, Safe, Timely	Clinical outcomes ED LOS OR On Time Starts	7.1-27 through 7.1-36	7.1-1 through 7.1-22
Discharging Patients	Timely, Communication	In-patient LOS ED LOS	7.1-38 7.1-39	7.2-4 7.2-10
Continuum of Care	Care Coordination	Readmission Rates	7.1-40	7.1-1

preferences and decision making throughout the very delicate end-of-life cycle.

6.1b(3) **Key support processes** are vital to the delivery of safe, effective, and efficient healthcare called out in our key work processes (Figure 6.1-2) and as such, they follow the same method of shaping, monitoring and improving as noted in 6.1a(1). **Key support processes, requirements and performance measures are listed in Figure 6.1-3. Day-to-day operations are aligned** with these key support processes through Annual Action Plans and are validated during the SL SP Review, Leader Business Review and 90-day plans and improved as noted in 6.1b(1) **to ensure key organizational requirements are met**.

6.1b(4) MGMC's commitment to performance excellence (P.2c), its rigorous SPP (Figure 2.1-1), and the leadership system (Figure 1.1-1) provide a comprehensive systems approach to the **improvement of work processes, support processes, healthcare services and performance to enhance and reinforce core competencies, and reduce variability.** The organization's commitment to a culture of continuous improvement and learning is embedded in the Improvement Model (Figure 6.1-1) and supported by the Knowledge Management System (Figure 4.2-1). Through a commitment to the Baldrige framework as well as a philosophy of improving your work (1.1c(1)), MGMC is able to drive organizational improvement in work processes by engaging those closest to the work. Systematic monitoring of results and multidisciplinary teams utilizing PDCA, DMAIC, and lean tools encourage innovation and support improvement of healthcare services and performance. Use of appropriate benchmarks and comparisons (4.1a(2)) ensures the organization is monitoring results relative to goals and long-term strategies. Encouraging teams to implement small tests of change supports intelligent risk taking and intelligent design of work systems. Standard Work assists in the systematic approach for implementing and sustaining organizational improvements that align with the MVV and the SP. Employees are empowered to identify opportunities to improve their work processes, eliminate waste, reduce variation, and support a culture of safety and accountability (1.1c(1)) through the Daily Improvement program. The Innovation & Improvement Council (1.1c(2)) enhances efforts to improve work processes and recognize potential innovation by identifying and prioritizing work systems that support key work processes. This effort resulted in the prioritization, planning, and implementation of key VSM events. To engage the workforce in sharing their work and to demonstrate how that work supports the overall system, department work system maps are developed (2.2a(4)). Thoroughly examining value- and non-value-added steps through VSM events and work system mapping allows for system optimization by elimination of waste and reduction of variation. This allows MGMC to focus on what truly provides value to the patient. Finally, through the use of several new approaches (organizational VSM, use of FMEA for prioritization of improvements, patient involvement in improvement events, etc.) MGMC has been able to more systematically identify top improvement opportunities and create implementation plans for getting to the desired state more efficiently. MGMC **enhances core competencies** through a focus on the Process Improvement Model (Figure 6.1-1) particularly the 'do' phase. Through this model, we have realized breakthrough improvements related to key clinical outcomes. Additional information about MGMC's approach to service and process improvement is highlighted in 6.2a.

Figure 6.1-3 Key Support Processes, Requirements and Measures

Key Support Processes	Key Requirements	Key Performance Measures	Leading Figure	Lagging Figure
Dietary Services	Efficient and Effective	Temp, Variety, Freshness	7.1-45	7.2-4
Employee Relations (HR) Services	Respect Communica-tion	MGMC Turnover Turnover by Segment HR Days to Fill	7.3-1 7.3-2 7.3-3	7.3-17
Environ-mental Services	Safe Effective	Patient Room Turnover	7.1-44	7.2-4
Fiscal and Materials Management	Efficient Cost Effective	Inventory Turns Supply Fill Rate Overall Supply Expense Segmented Expenses	7.1-50 7.1-51 7.1-47 7.1-48	7.5-1 7.1-49

6.1c Supply-Network Management

MGMC **manages its supply network** through membership in the Premier Group Purchasing Organization (GPO) and through its regional buying collaborative, Health Enterprise Collaborative (HeC). Membership in Premier's GPO provides MGMC Supply Chain Management with access to nation-wide data and market intelligence. The regional buying collaborative with HeC allows MGMC to further negotiate beneficial contracts more locally that impact the supply spend. The Premier GPO brings best practices and competitive buying power to MGMC, like the ASCEND program which has helped MGMC save $600,000 through committed contracts and management of opt outs. Bi-weekly conference calls with HeC and all regional supply chain members bring operational issues forward, such as when members experienced delivery delays with the regional distribution partner. HeC stepped in to resolve the issue and deliveries improved. Quarterly, HeC hosts strategic round-table meetings with members to discuss emerging trends and identify collective opportunities to further enhance buying power. An innovative and collaborative approach between MGMC, suppliers, physicians, and McFC that focused on bringing cost-effective solutions to supply chain processes through standardization of orthopedic supplies and inventory saved the organization over $900,000 since inception in 2016. This model was replicated for additional specialties including cardiology and spine.

Selection of suppliers to ensure qualifications and enhance performance is accomplished through membership in the Premier GPO, as well as HeC. All suppliers in these organizations are systematically reviewed via the vendor approval process, which ensures they are qualified and positioned to support our MVV and **strategic initiatives, and enhance performance**. MGMC CEO and Director of Supply Chain Management hold seats on the board of HeC and attend regular review meetings with Premier where approvals are communicated and managed. Regular communication with end users provides additional feedback on the level of **satisfaction**

with products being considered for use and ensures key requirements are met (P.1-6).

MGMC promotes alignment and collaboration within the supply network through ongoing attendance at all bi-weekly and quarterly HeC meetings. Additionally, participation in the annual Premier member conference allows the MGMC to learn from other national members of best practices and to share emerging issues/trends. The Supply Chain Management process (Figure 6.1-4) systematically reviews and monitors acquisition of supplies and products thus ensuring **supply-network agility in responding to changes in patient and other customer, market, and organizational requirements is maintained.**

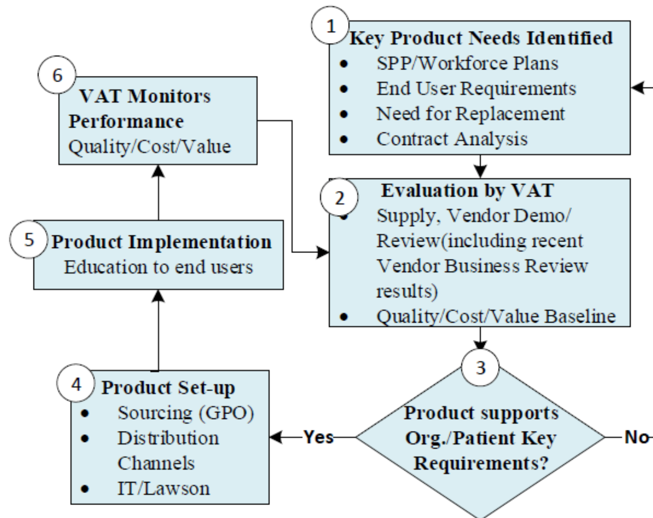


Figure 6.1-4 Supply Chain Management Process

Performance expectations are communicated through the Vendor Business Review process which provides MGMC and each supplier a baseline understanding of the arrangements and allows for appropriate monitoring of key supply chain requirements through a systematic review of Service Level Agreements (SLAs). Suppliers must demonstrate and document in the Reptrax system that they have met defined qualifications, including agreement to abide by the MGMC Code of Conduct. The Supply Chain Management department monitors inventory so that supply replenishment is conducted timely, and waste is avoided. Departments support inventory management through sustaining 5S improvements including adequate levels of supplies (PAR levels) in their areas. Membership in the American Hospital Association (AHA) and the American Association for Healthcare Resource & Materials Management provides MGMC with best practice approaches and resources to identify supply or utilization variations, and opportunities for standardization.

Supplier performance is measured and evaluated via the medical center's Vendor Business Supplier Guidelines and contractual SLAs. MGMC annually evaluates suppliers on factors related to competitive pricing, delivery performance, adherence to purchase order pricing, and rejects because of poor quality. Quarterly Vendor Business Review meetings are held with key suppliers to monitor what's working well, what needs improvement, and what innovative savings ideas they may have for consideration. Adherence to MGMC's policies and procedures, as well as expectations of the SP, Annual Action Plan, and CC, are the cornerstone of all SLAs and are communicated during vendor business reviews. As a cycle of improvement, the annual Strategic Path flyer is shared with key suppliers to communicate the MVV, organizational priorities and Big Dot Goals. **Underperforming results** are addressed immediately with the supplier rather than waiting for a quarterly review.

Reptrax allows MGMC to monitor **vendor compliance** with credentialing and other requirements of the medical center, as well as monitor the number of visits a vendor makes to the medical center to determine if contract compliance is being maintained. Management of SLAs, monthly meetings, and vendor non-compliance with policies provides opportunities to **improve supplier performance.**

The Value Analysis Teams (VAT) include the Product Improvement Team (PIT) and the Operating Room (OR VAT). Collectively, these teams provide a systematic review, including introduction to and approval of all new products and services to the medical center. Physician involvement is sought when appropriate. The PIT and OR VAT research new products with evidence based consideration, monitor variances on products, report on specific products and equipment purchased, and take action as necessary. The medical staff is engaged as appropriate. For example, when a new plastic surgeon began operating at MGMC, she collaborated with the OR VAT to determine appropriate supplies and equipment needed prior to her first case. Additionally, collaboration with the VAT and an orthopedic surgeon resulted in successful conversion of the preferred supplies for back procedures be added to the surgeon's preference list to produce the safest, desired clinical outcome. Ongoing monitoring of inventory aids operations by balancing the need to have supplies available just in time while ensuring patient and other customer needs are met.

6.1d Innovation Management

MGMC **pursues opportunities for innovation, including strategic opportunities that are determined to be intelligent risks** through the Innovation Management System (Figure 6.1-5). The systematic SPP and the cascading nature of the SP and Annual Action Plans provide inputs for intelligent opportunities and risks to pursue. The BI team develops the **intelligence** through aggregation of market share research, pro-forma creation, workforce consideration, and VOC feedback to develop a set of actionable recommendations for consideration. In 2018 the BI team added a project charter to this process to augment the recommendations with additional qualitative and quantitative research in order to more thoroughly evaluate opportunities. Upon approval, opportunities are resourced through the budgeting or capital processes. If the innovation is deemed worthy of pursuing, a full business plan is initiated. This new approach **ensures financial and other resources, including workforce, are available** to **support intelligent risks** through the long-term strategic financial plan and the strategic workforce plan**.** The decision to develop a joint venture with an external vendor for dialysis services followed this process, and today this joint venture is delivering high quality care as well as exceeding all pro-forma projections. Other intelligent risks that have gone through this process

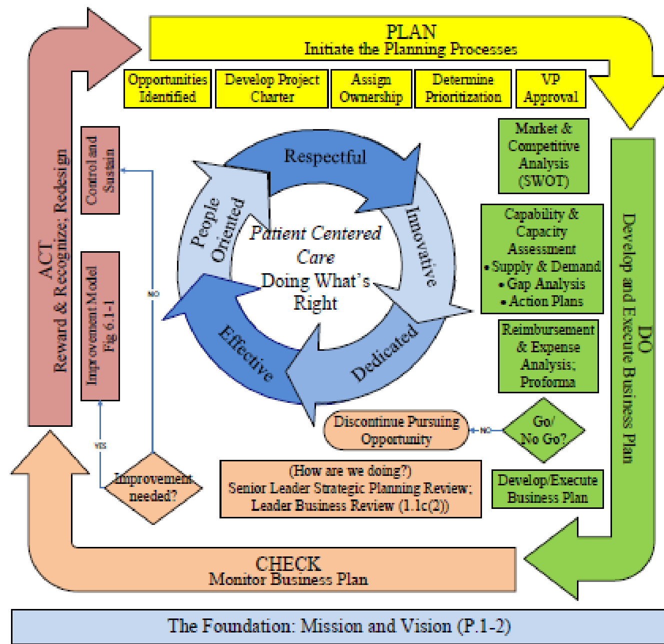


Figure 6.1-5 Innovation Management System

include the addition of a nurse practitioner to support diabetes care management as well as the addition of hyperbaric services.

MGMC **discontinues pursing opportunities** in a similar fashion. The BI team reviews service performance, market intelligence, and legal, regulatory and reimbursement changes to make sound business decisions on programs that may be **underperforming or are no longer sustainable** based on specific goals identified during the pro-forma process. By focusing on services that are core to its business and market through the SP and by implementing ongoing review practices (1.1c(2)), MGMC is better equipped to **pursue the most appropriate, high priority opportunities and discontinue under-performing services**. The decision to discontinue providing adolescent behavioral health services in 2017 followed this systematic approach.

6.2 OPERATIONAL EFFECTIVENESS

6.2a Process Efficiency and Effectiveness

MGMC **manages the cost, efficiency and effectiveness of its operations** through its systematic process improvement model (Figure 6.1-1; Figure P.2-3), review of key work process metrics (Figures 6.1-2 and 6.1-3), implementation of Annual Action Plans, and monitoring of key processes that support operations (1.1c(2)). The PDCA method is the standard method for improvement and all systems are grounded in this approach. MGMC augmented its performance improvement methods by including the tools of lean and Six Sigma in 2011 and improved it again in 2017 by adopting DMAIC. Various methods of lean, such as Standard Work, RIE, and VSM events, help the organization identify value- and non-value-added steps in work processes to optimize systems and eliminate waste. In order to systematically address improvement efforts that are identified, teams now conclude events by creating a relationship diagram. This diagram creates a visual of the interdependency of each improvement idea which then allows the team to systematically rank order each improvement initiative. VOC needs are incorporated into improvement events during the planning and implementation process to ensure opportunities do not negatively impact patient expectations or requirements.

Key measures of **cycle time, productivity, and other efficiency and effectiveness measures** are identified during the pre-work for each RIE and VMS event and are tracked throughout the test period to ensure key requirements are met. To balance improvement in these metrics, the team blends and correlates cycle time metrics with patient engagement metrics so that improvement in cycle time does not negatively impact patient expectations (ie: ED VSM to support door to doctor time and patient engagement). **Cycle time, productivity, cost control, and other efficiency and effectiveness** measures are factored into work processes to support organizational outcomes, while balancing work processes related to patient care and support services. With the new (2019) Leader Business Review Standard Work process (1.1c(2)), leaders now include their key cycle-time metrics in the quantitative portion of their report. Additional approaches MGMC uses to control costs include effective supply-network management (6.1c), and labor and productivity control (5.2a(1), 5.2a(3)).

Rework and errors, including unintended harm to patients and added costs associated with inspection, tests, and audits are minimized through several methods noted in Figure 6.2-1. These methods provide a systematic approach to the prevention of unintended patient or workforce harm. Key learnings as a result of these methods are communicated at the

Figure 6.2-1 Methods to Prevent Rework, Errors, Unnecessary Costs

Process	Desired Outcome
Preventable Harm Index	Systematic tracking of all events of harm and near misses to learn; prevent serious harm.
6 Expectations of Safe Behavior 1.1c(1)	Outlines key steps for the prevention of unintended patient or workforce harm. These behaviors support the prevention of rework, errors and unnecessary costs associated with the healthcare delivery process.
SBAR	Effectively communicate patient information to the care team to ensure safe patient care.
Best Practice Alerts	System generated alerts alert the care team of best practices available to maximize outcomes.
CPOE	Accuracy of physician orders with zero room for error related to illegible hand writing
FMEA	Evaluation and prevention of risk associated with high-risk procedures
Hourly Patient Rounding	Proactively anticipate patient needs; address 4 p's (pain, potty, position, pump); prevent falls with harm
Patient Care Conferences	Multi-disciplinary care conferences to ensure appropriate resources are provided during patient stay and post discharge.
A3's/Root Cause Analysis	Identify root cause of patient harm and implement counter measures to prevent future harm.
EOC Rounds	Proactive review of departments to ensure safe environment for patients, visitors and the workforce.
Infection Prevention Rounds	Review of clinical and operational practices to ensure infection free environment; monitor hand hygiene practices throughout environment.
RIE, VSM	Improvement events that address opportunities to streamline work and prevent waste; ensure VOC and critical to quality is addressed; eliminate harm.
365-Day Accreditation Readiness	Ongoing preparation for upcoming surveys and audits to incorporate requirements into daily work to eliminate waste of re-work and negative findings.
Work System Mapping	Proactively assess and reassess work to identify opportunities for improving workflow; utilize the tools of lean to reduce waste and eliminate variation.
Critical to Quality	Aligns VOC and patient needs with key metrics to ensure **expectations and needs** are not compromised as the result of improvement efforts.

daily safety huddles, through the weekly safety bulletin, at monthly First Friday events and at quarterly employee updates.

MGMC **balances the need for cost control with the needs of its patients and other customers** through a strong focus on the SP and its patient-centered approach to delivering the highest quality care in the most efficient manner while meeting key patient and other customer requirements (Figure P.1-5). **When these differ**, MGMC defaults to safety as its top priority.

6.2b Security and Cybersecurity

MGMC ensures the security and cybersecurity of sensitive or privileged data and information and of key assets through a multi-layer defense approach. This systematic approach allows the MGMC security team to manage risk with diverse defensive strategies so that if one layer of defense is inadequate, another layer of defense is in place to prevent a breach. Real-time alerts assist in **detection and response to potential cybersecurity events**, ultimately **protecting** the environment from attacks. With preassigned roles, the team works to identify where the threat originated, what it is doing to the network, and how it can be blocked or **recovered.** Cyber-security de-briefings provide opportunities to **mitigate future threats and to strategize as to how to respond to and recover in the event of a cybersecurity incident.** In the event of a major issue, a cutting edge data protection suite of systems is in place to restore applications to a specific point in time (6.2c(2)).

Physical and electronic data, information and key operational systems are managed to ensure confidentiality and only appropriate physical and electronic access through secure role-based access. Policies and procedures, including the Code of Conduct, outline appropriate use of computer equipment (including sensitive or privileged data) for all employees, volunteers, and medical staff. The EHR is audited daily and a new (2018) artificial intelligence tool that uses employee job roles and every day activities systematically determines if the employees are appropriately accessing patient records.

The IT department performs internal audits and risk assessments, penetration and vulnerability assessments of its systems, and annually has these systems audited by an external firm. The annual HIPAA risk assessment and full internal security audit identifies risk and vulnerabilities, and helps **maintain awareness of emerging security and cybersecurity threats** and creates detailed action plans to **prioritize and address security findings, which reduces the risk of a malicious attack**. The risk assessments were initially developed based on the guidelines of regulatory requirements and have since been revised to incorporate elements of COBIT, COSO, ITIL, and NIST 800- 53 Revision 3. A weekly Risk Assessment Management (RAM) meeting is conducted by the IT security team to discuss the status of achieving the recommended results and track progress of each action item. MGMC works with the external auditors to ensure issues have been resolved.

MGMC manages electronic and physical data and information to ensure confidentiality and appropriate access through a robust monitoring process that alerts IT security staff of potential issues 24x7, 365 day/year. Comprehensive logging of all system activities allows staff to quickly evaluate potential breaches and take appropriate action. An Information Security Compliance Officer (ISCO) was hired in 2015 as an outcome of the Annual Action Planning process and workforce plan. The ISCO and IT staff meet weekly to maintain an awareness of emerging and cybersecurity threats (both locally and globally), **identify and prioritize key information technology and operational systems to secure**, discuss opportunities in its cybersecurity defenses and set medical center security policy. Information is deployed to the BOT, the workforce, and stakeholders through ongoing compliance training and reporting. Security staff hold advance certificates in systems security and uphold all required continuing education. The security staff participates in incident response webinars and tabletop training to **maintain awareness of and prepare for potential cyber events**. As a cycle of learning, the ISCO now reviews key expectations at New Employee Orientation and maintains an annual CBL for ongoing education and learning and to support organizational compliance. Continuous communication to the workforce on updated risks and best practices pertaining to end user security is deployed organization-wide via newsletters, email, and daily safety huddles. MGMC has also formed a multi-disciplinary shared decision making Security Council where results of spam blocking, phishing events, the risk assessment, and the latest cyber security concerns are reported. This council recently moved to change organization wide passwords to 14 characters that change every 90 days. MGMC collaborates with McFC as part of the joint EHR, as well as suppliers to ensure Security compatibility. The McFC and MGMC Security teams meet monthly to discuss emerging cyber threats and potential policy changes and issues are brought forth to the Health Ventures board level. A questionnaire is completed by all suppliers to set forth the expectations of our security requirements.

6.2c Safety and Emergency Preparedness

6.2c(1) MGMC **provides a safe operating environment** through adherence to all local, state, and national safety requirements (Figure P.1-4) in order to maintain licensure and accreditation, and proactively address patient and workforce safety. Additionally, workforce safety is ensured through a systematic process that includes pre-employment screening, outlining expectations at NEO, and specific role-based training. Effective and proactive risk management ensures a safe operating environment for patients, customers, and the workforce through ongoing environmental and operational planning practices and the EOC plan and processes (5.1b(1)). In 2018 the EOC created a Dashboard to systematically monitor and manage all EOC plans (5.1b(1)). The Standard Work philosophy aids in **ensuring safety in the healthcare delivery process** across all groups and segments of the workforce. MGMC adopted plain language codes (language that is common to reporters and listeners to reduce confusion) to its overhead paging system to clarify the communication of emergency events. A new electronic system (Alertus) was implemented in 2016 to ensure these codes are systematically communicated to all workforce groups and segments via overhead and desktop notifications. The three-tiered safety huddle (1.1c(1)) is designed to address patient and workforce safety issues on a daily/shift basis to prevent future events or near misses and to consistently communicate these for organizational learning. As a cycle of learning in 2018 and to replicate its own innovative best practice for monitoring

preventable harm, MGMC created the *employee* PHI (7.3a(2)). Key measures of the most commonly occurring and preventable harm in the workplace, including patient care and non-patient care environments, are shared at the daily safety huddle to more intentionally address and **proactively prevent** accidents in the workplace. As a result of this reporting and to prevent future harm, MGMC created Standard Work for the safe administration of medications following an increase in needle sticks (5.1b(1)). The A3 problem solving tool is utilized internally **to address root cause analysis of failures** and near misses and involves all relevant workforce groups and segments, patients, families, and other customers in the problem solving and resolution process. As a cycle of learning in 2019, these A3s are now reported and tracked at the daily organizational safety huddle for greater awareness and visual management of the event. Learnings from A3s are shared at First Friday report outs for organizational learning and a new weekly Safety Bulletin aggregates key findings for sharing at department huddles.

6.2c(2) MGMC **ensures the organization is prepared for disasters or emergencies** and considers both MGMC's needs as well as the needs of the community through a comprehensive Emergency Operations Plan (EOP) that is supported by the Hospital Incident Command System (HICS). The EOP serves as a guide and provides direction to the workforce based on their role during a given disaster, including the need for emergency credentialing for additional physicians. The HICS provides the framework for managing the event as well as the After Action Reporting (AAR) following an event. This approach systematically guides and improves emergency management planning and response and recovery capabilities for planned and unplanned events. As a cycle of learning, in 2019 MGMC implemented monthly disaster drills to mirror the type of event that is likely to occur for each month in order to more effectively prepare the workforce for an event. MGMC conducts and updates its hazard vulnerability analysis (HVA) annually and ensures proper workforce training and knowledge management related to situations under its control and considers proper workforce capacity and capability based on the most common/likely events to occur. Planning for drills related to high risk events is done internally and externally, and after action reports (AARs) are conducted to determine opportunities for improvement. An Emergency Management Plan (EMP) ensures response times meet the needs associated with various disasters. Systematic disaster planning and the EMP allow the organization to be prepared and **prevent incidents, sustain continuity of operations, and recover loss** should there be an incident. The plan provides for rapid deployment of additional healthcare professionals and addresses the need for increased supplies and space. To take into account **reliance on workforce, supply-network, and partners**, a Disaster Planning Reference Guide was created to plan for emergency provisions from key suppliers and partners with contracts and contingency plans where applicable. If internal resources are insufficient to meet the demand (both clinical and support services), provisions exist to call upon resources of neighboring communities through a Memorandum of Understanding. Through several cycles of learning with the HICS planning and drilling and AAR process, MGMC was able to prevent further damage and ensure continuity of operations in 2013 when a water main broke on the hospital's main property. Similarly, in 2018 when winter weather caused a major traffic pile-up on the interstate involving 50 cars, MGMC was prepared to efficiently and effectively collaborate with other community resources to respond and treat injured motorists. The discipline of using this system and conducting an AAR immediately post event, including shared learnings, proved beneficial when only two weeks later another pile-up on the same interstate involving more than 70 cars occurred. The workforce responded expeditiously and with great ease while **ensuring continuity of operations**.

MGMC ensures **continuation of information technology systems continue to be secure and available to serve patients and other customers and meet business needs** in the event of an emergency through its disaster recovery (DR) site data center. The use of multiple data centers with redundant systems technology and on-site cloud infrastructure provides a framework for disaster recovery for critical systems. **Information technology system availability and recoverability** are ensured through back-up to disk, off-site physical tape storage, and bi-directional disk array replication. Backups are retained on MGMC's local Storage Area Network (SAN), which is then replicated to a secondary location (the DR site located approximately 30 miles south of MGMC). The DR site replicates its backups back to the main datacenter at MGMC. An additional backup to tape is then performed and delivered to yet another separate, secure location. MGMC's virtual environment resides on either an on-site data center storage array or the DR site array for high reliability and availability. These arrays are continually replicated to the opposite respective locations and are capable of restoring a server fully from any point in time within the past 24-48 hours. This split hosting and journaling allows not only for physical protection but protection from possible data corruption. MGMC incorporates downtime plans based on the application or system that is affected. Various factors are considered, including whether the downtime is planned or unplanned and if the downtime is the result of loss of power, network or datacenter damage, or ransomware. With the implementation of the EHR in June, 2010 MGMC has enhanced its downtime plan to provide for a standardized process in the event of planned/unplanned downtime. This procedure is reviewed annually or more frequently as needed, and ensures that patient care continues in an environment where safety and quality are never compromised.

CATEGORY 7: RESULTS

MGMC strives for excellence in clinical and operational performance on key performance metrics aligned with the SP (Figure 2.1-3). Relevant benchmarks or comparisons are selected for each measure to continually strive to get better every day (4.1a(2)) and address patient, community, workforce, process, and action plan requirements. MGMC has the ability to segment many results presented throughout Category 7. With space limitations, sample segmentation is presented here, and additional segmented results are AOS. In some cases, comparative data is available only at the organizational level, not at the unit level. Reporting lags from various national and state data sources limit the availability of some benchmarks; those presented here represent the latest-available. Comparative data from key competitors is presented throughout Category7, denoted by: = DSM; = DSM and = **Figures highlighted in green align with the Big Dot Goals**.

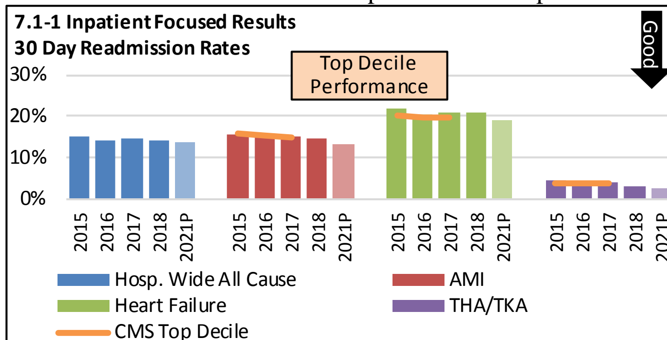
7.1 HEALTH CARE AND PROCESS RESULTS

7.1a Health Care and Customer-Focused Service Results

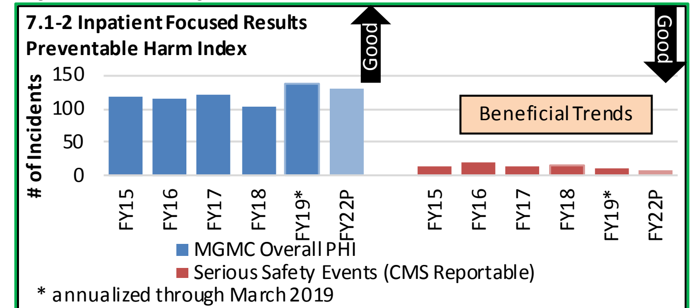
To address the key patient and community requirements of quality, safe, timely, coordinated and cost-effective care (Figure P.1-5), MGMC measures healthcare and customer-focused service results for its main service offerings and key patient groups of inpatient, outpatient, emergency, and home health/hospice care. To understand performance across the broad inpatient service offering and patient group, MGMC shows segmented data for key hospital units. Additional results and segmentation are AOS.

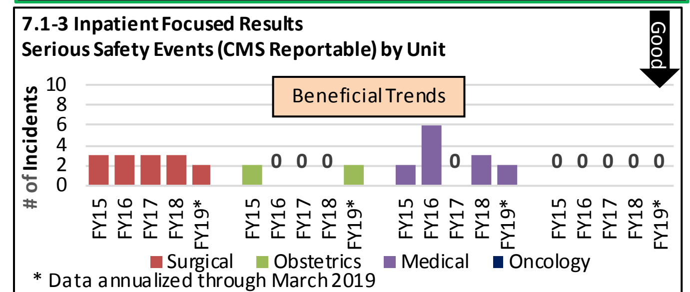
Inpatient Focused Results

Readmissions (patients who return to the hospital within 30 days or less of being discharged - **Figure 7.1-1**) is a key outcome measure (and a VBP measure) related to coordinating the care of patients, especially those with chronic diseases. The TOC program aids in preventing readmissions by supporting patients post-discharge via home nursing visits and ensuring timely follow up with their provider (Figure 7.1-40). Results segmented by the most prevalent conditions demonstrate favorable trends and top decile performance.

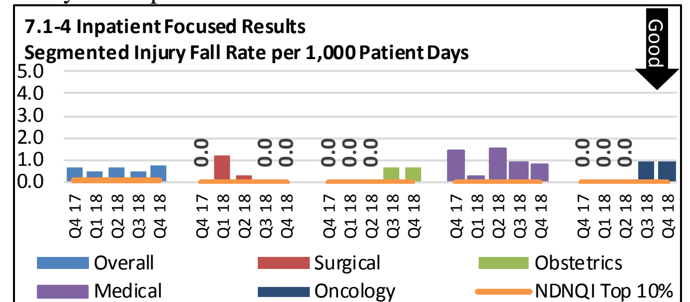


The innovative Preventable Harm Index -- MGMC's quality/safety Big Dot Goal – captures all reported events of potential patient harm, including near misses. An increase in reported events is a sign of an effective just culture where the workforce feels safe bringing them forward to support improvement in patient care. Leveraging sustained high levels of reporting (**Overall PHI, Figure 7.1-2**) to systematically understand and prevent harm**,** MGMC has been able to drive down the number of actual serious safety events (**Figures 7.1-2, 3).** PHI is not an industry-reported metric; therefore, benchmarks are not available. However, MGMC monitors the individual index components, which are benchmarkable, to understand its performance relative to high-performing organizations (Figures 7.1-4 – 7.1-10).

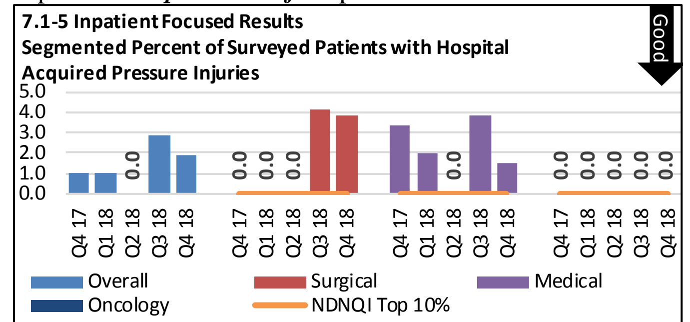




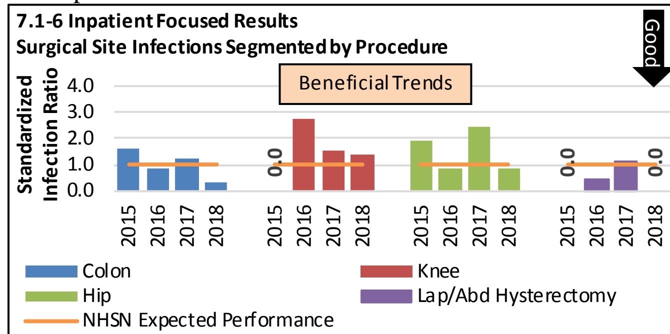
MGMC monitors patient falls with harm (**Figure 7.1-4**) as one of the components of PHI. Performance overall and segmented by unit shows sustained or improving performance near the top decile of the national Magnet database. Using data from A3s, the falls team was able to drill down and make direct interventions. The result was a therapy-initiated program to safely lower patients to the floor.



Hospital-acquired pressure injuries (**Figures 7.1-5**) are another component of the PHI. Through rigorous focus and improvement efforts, including a Patient Care Tech improvement project aimed at prevention strategies, we have experienced a ***positive shift*** in performance.

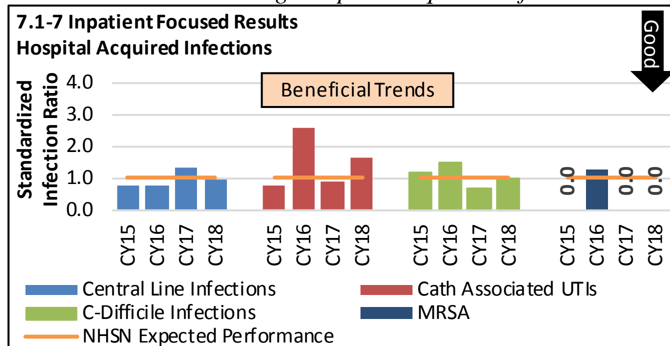


Surgical Site Infections (**Figure 7.1-6**) are another component of the PHI. Performance across top surgeries shows a beneficial trend at levels better than or near rates predicted by NHSN's risk-adjustment methodology, relative to other organizations in its national database. Adherence to best practice protocols aids in prevention. Infections are segmented by procedure for greater focus on improvement opportunities such as the expansion of the TOC program to patients having orthopedic or colon procedures.



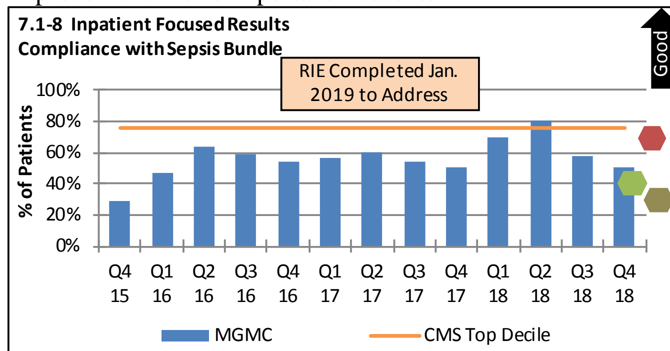
7.1-6 Inpatient Focused Results
Surgical Site Infections Segmented by Procedure

Hospital Acquired Infections (**Figure 7.1-7**) are also monitored within the overall PHI and segmented by type to identify opportunities for improvement. For the most part, MGMC has sustained performance at or near the NHSN-expected rate for the past four years. The physician-led Antibiotic Stewardship program has supported positive results in reducing the incidence of C-Difficile in hospitalized patients. This program has earned the Iowa Healthcare Collaborative's 2018 award for *"Excellence in Preventing Hospital Acquired Infections."*



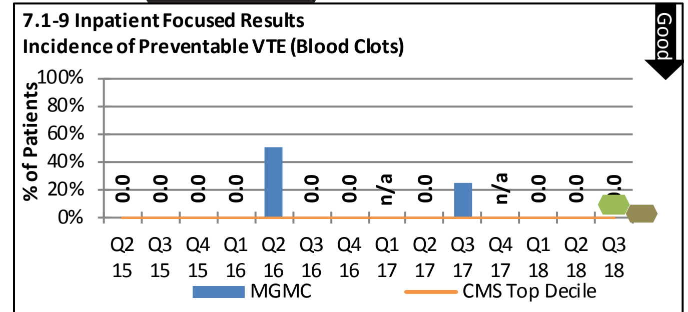
7.1-7 Inpatient Focused Results
Hospital Acquired Infections

Early identification and treatment of patients with sepsis is a core measure and important to our strategy to provide safe, high quality care. Compliance with sepsis evidence-based care continues to show an overall improving trend **(Figure 7.1-8).** As the result of a Jan 2019 RIE, a new workflow supports better physician and staff communication to drive further improvement in this important measure.



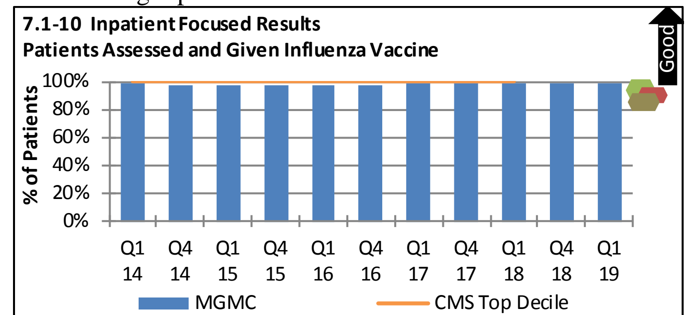
7.1-8 Inpatient Focused Results
Compliance with Sepsis Bundle

We have sustained near-perfect, top-decile performance with efforts to Prevent Blood Clots (**Figure 7.1-9**), and results surpass the benchmark and one of its competitors (insufficient numbers for



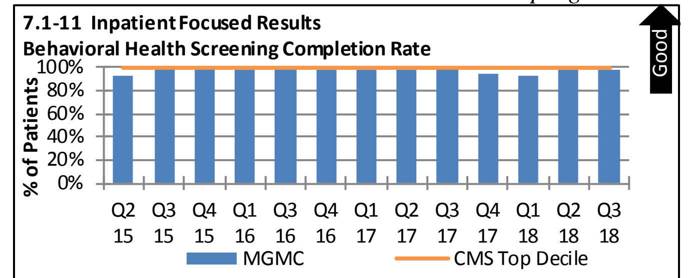
7.1-9 Inpatient Focused Results
Incidence of Preventable VTE (Blood Clots)

Preventing the flu through proper vaccination of hospitalized patients (**Figure 7.1-10**) represents evidence-based care. Our results show sustained performance better than the competitors and reaching top decile.

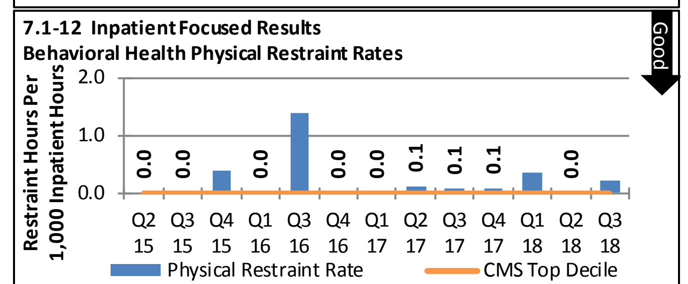


7.1-10 Inpatient Focused Results
Patients Assessed and Given Influenza Vaccine

Care and treatment for behavioral health patients is a long-term strategic objective and as such, we monitor performance of appropriate core measures (**Figures 7.1-11, 12**). Completion of behavior health screenings shows sustained performance at or near top decile. Except for one quarter, the same is true for use of restraints. *Additional BH measures in the VBP program AOS.*

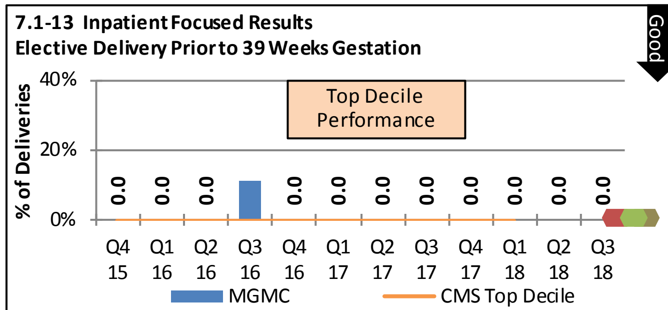


7.1-11 Inpatient Focused Results
Behavioral Health Screening Completion Rate

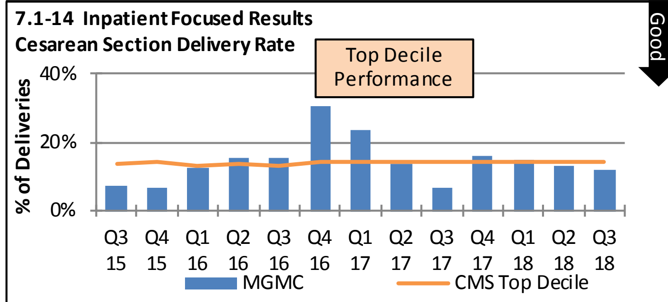


7.1-12 Inpatient Focused Results
Behavioral Health Physical Restraint Rates

Participation in IHC's *Partnership for Patients* provides opportunities to share MGMC's best practices related to preventing early elective deliveries (**Figure 7.1-13**) and managing C-Section rates (**Figure 7.1-14).** Both demonstrate role model performance.

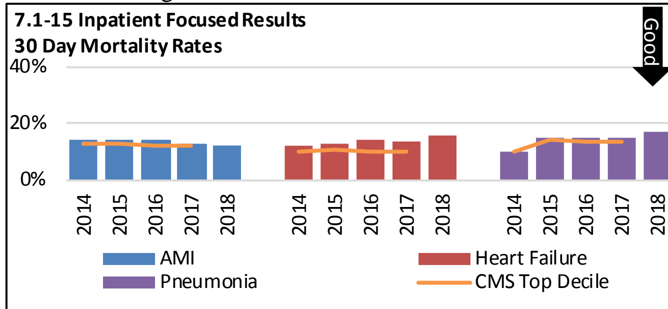


7.1-13 Inpatient Focused Results
Elective Delivery Prior to 39 Weeks Gestation



7.1-14 Inpatient Focused Results
Cesarean Section Delivery Rate

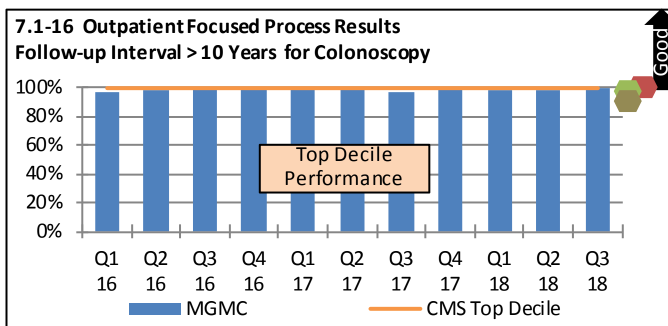
Mortality (**Figure 7.1-15**) is an outcome measure used to monitor overall quality of care internally and for VBP. The 30-day mortality rate for heart-attack patients (AMI) shows a sustained, favorable trend with performance at the national top decile. Results for heart failure and pneumonia are near top decile performance and the subject of ongoing improvement work, including use of standardized order sets.



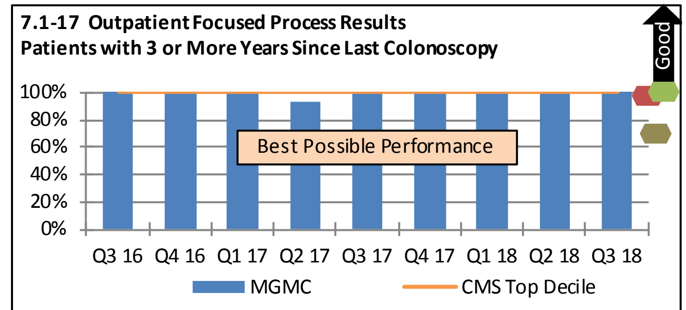
7.1-15 Inpatient Focused Results
30 Day Mortality Rates

Outpatient Focused Results

Preventing colon cancer is a state-wide initiative and, as such, we use evidence-based best practice such as having a colonoscopy screen every *ten* years (**Figure 7.1-16**) for patients aged 50-75 with no risk, and every *three* years (**Figure 7.1-17**) for those 18 and older with a history of a prior polyp. Performance for both is consistently at the top decile and is better than our competitors.

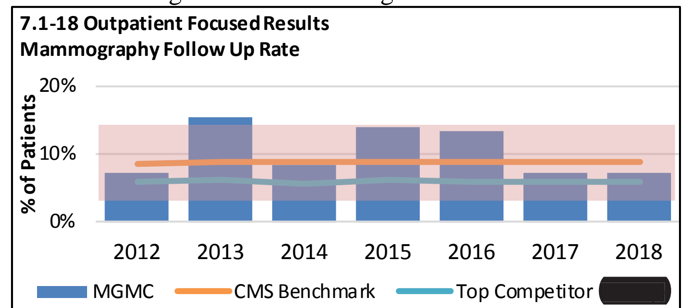


7.1-16 Outpatient Focused Process Results
Follow-up Interval > 10 Years for Colonoscopy



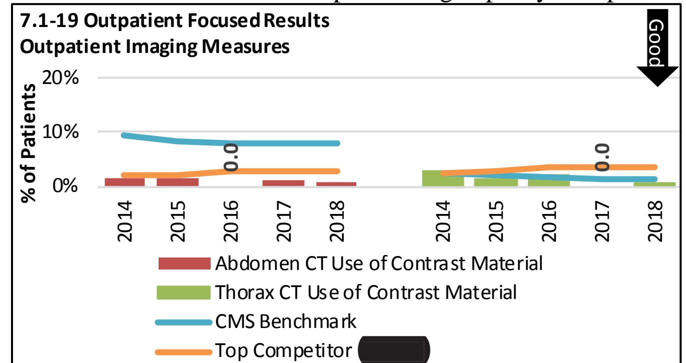
7.1-17 Outpatient Focused Process Results
Patients with 3 or More Years Since Last Colonoscopy

Protecting patients from unnecessary radiation is supported through adherence to best practice protocols for Mammography screening (**Figures 7.1-18**). A rate near zero may indicate a possible missed cancer (patient needed follow-up but didn't get it); a rate higher than 14% may indicate unnecessary follow up. MGMC's results consistently perform within (shaded area) the recommended guidelines for testing.



7.1-18 Outpatient Focused Results
Mammography Follow Up Rate

Figure 7.1-19 measures appropriateness of imaging tests and includes the percent of patients who received appropriate use of contrast material. MGMC's results are better than the only benchmark available and outperforming top key competitor.



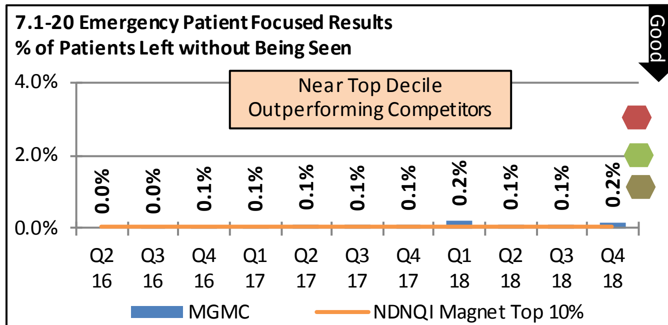
7.1-19 Outpatient Focused Results
Outpatient Imaging Measures

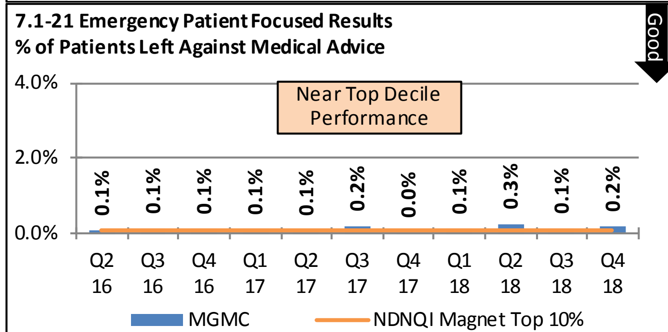
Emergency Patient Focused Results

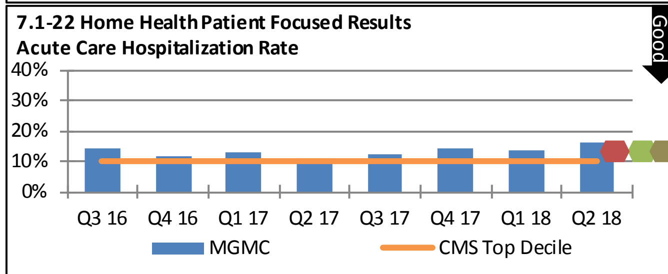
EDs with a high percentage of patients who leave without being seen (**Figure 7.1-20**) or against medical advice (**Figure 7.1-21**) may indicate a lack of adequate staff or resources to provide timely and effective care. Monitoring these patient-focused measures ensures we meet the needs of ED patients. MGMC has sustained near-top decile performance since 2016 and outperforms key competitors.

Home Health Patient Focused Results

Managing patients in the home **(Figure 7.1-22)** aligns with our quality and safety IOE and supports strategic opportunities of care coordination as well as reduction of readmissions and infections. The rate of home health patients who have to be hospitalized is near the top decile. Hospice results are presented in **Figures 7.1-30 and 7.1-37**.

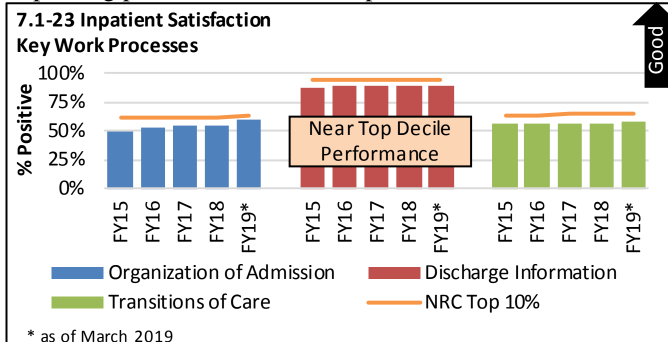






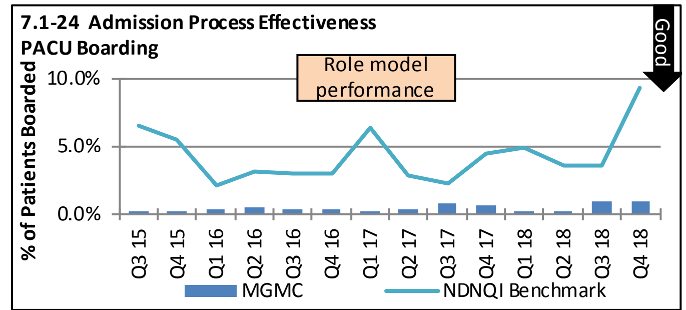
7.1b Work Process Effectiveness Results

7.1b(1) Results for measures of effectiveness and efficiency of key work processes (Figure 6.1-2) and key support processes (Figure 6.1-3) are displayed in **Figures 7.1-23 through 7.1-45**. Innovations related to RIE and VSM events support these improvements. In addition to process measures, MGMC also monitors patient satisfaction related to each key work process **(Figure 7.1-23).** Inpatient results show sustained and/or improving performance to near top decile.



Admitting Key Work Process Results

Post Anesthesia Care Unit (PACU) boarding (**Figure 7.1-24**) occurs when a patient is held in the recovery unit because an inpatient room is not available. This causes a less-than-favorable patient experience as well as disrupts hospital operations. MGMC is **consistently better** than the NDNQI benchmark.



ED Decision-to-Admit to Departure (**Figure 7.1-25**) is a key measure of efficiency. A project with students from Iowa State University identified innovative improvements resulting in a 20% reduction in the overall time. Our time of 52 minutes outperforms top decile and key competitors.

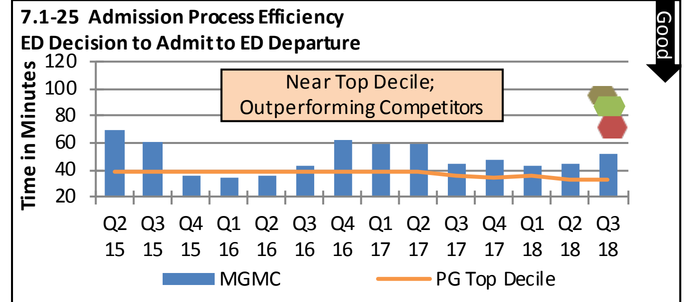
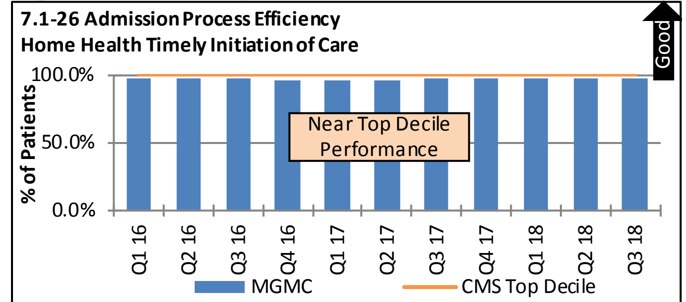
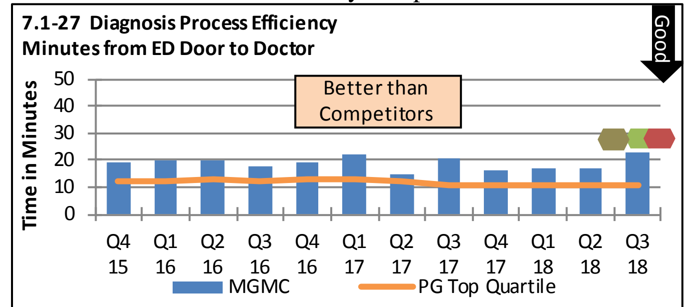


Figure 7.1-26 represents the percent of patients admitted within 48 hours of referral to home care. This measure – with near top decile performance – supports our key admission process requirement of 'timely' care.

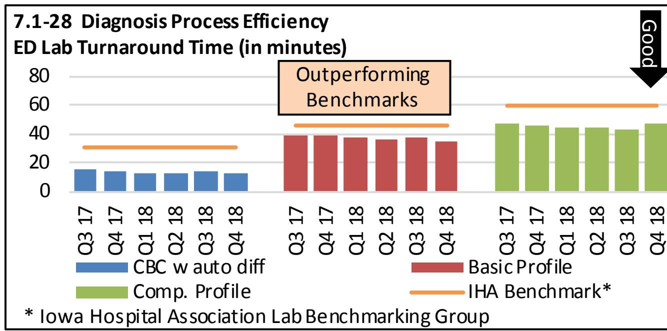


Diagnosis/Assessing Key Work Process Results

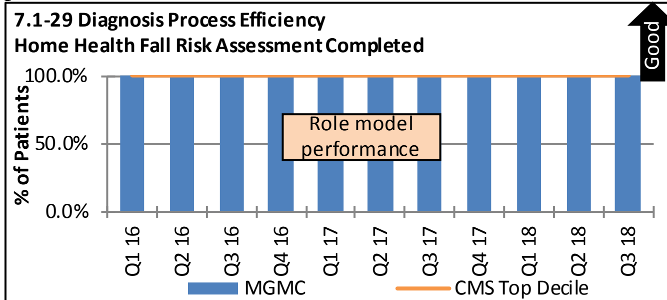
Door to doctor (**Figure 7.1-27**) is a key measure of efficiency in assessing patients in the ED. It also supports our key patient requirement of timely. Opportunities for improving this key work process were implemented following a VSM event. We consistently outperform the benchmark, and our time of 23 minutes is better than that of key competitors.

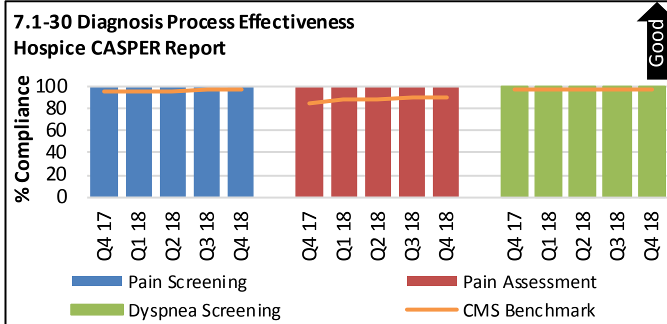


Lab turnaround time (**Figure 7.1-28**) measures the time from an order being placed to the time the results are provided. MGMC consistently outperforms benchmarks and shows favorable trends.



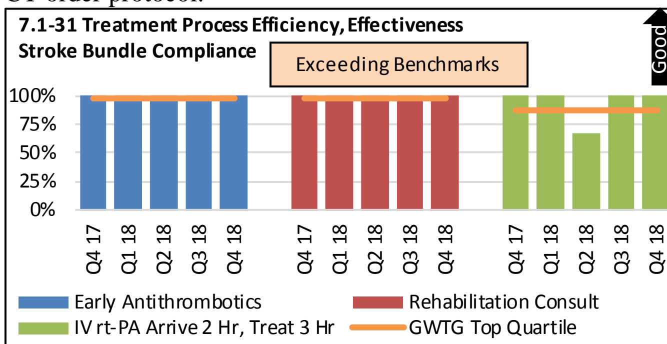
Diagnosis process measures for Home Health and Hospice (**Figures 7.1-29 and 7.1-30**) demonstrate role model performance across all indicators.



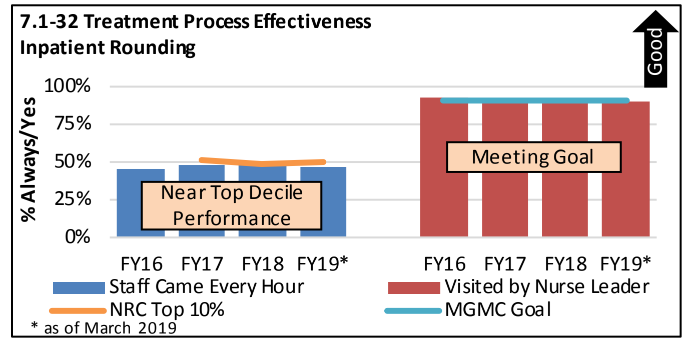


Treatment Key Work Process Results

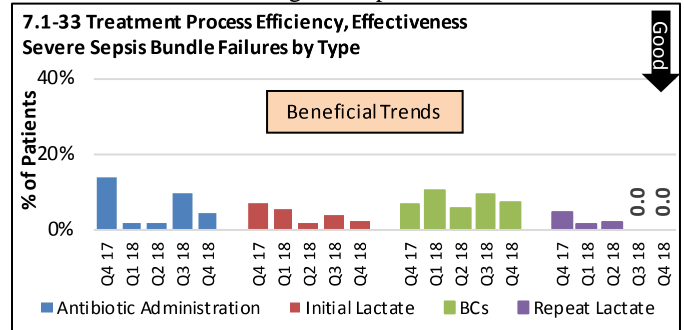
As a certified Stroke Center, we monitor compliance with *"Get with the Guidelines"* best practices for treating patients who come to the ED with stroke symptoms (**Figure 7.1-31**). Current top quartile results demonstrate superior performance following a RIE that resulted in improvements including a standardizand triage workflow to capture key information and a streamlined CT order protocol.

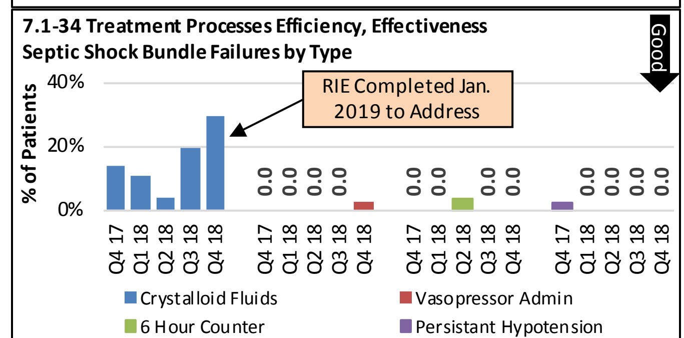


Leader and SL rounding with patients during their stay **(Figure 7.2-32)** supports effective coordination of care and ensures patients needs are met. MGMC results related to leader rounding are near top decile.

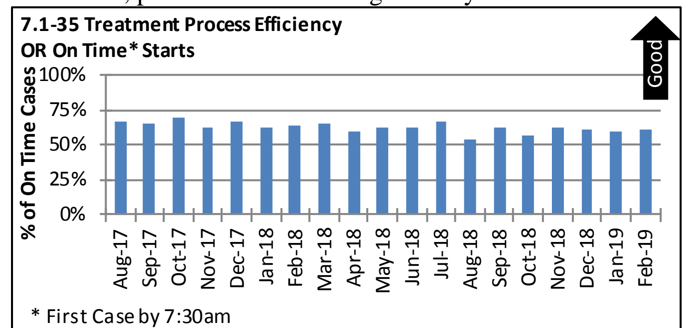


To identify opportunities to improve sepsis care (figure 7.1-8), MGMC measures how frequently patients do not get evidence based care (**Figures 7.1-33 and 7.1-34).** Failures to comply with the severe sepsis bundle show beneficial trends. Results for appropriate administration of Crystalloid fluids prompted a 2019 RIE. Results showing the impact of the RIE will be AOS.

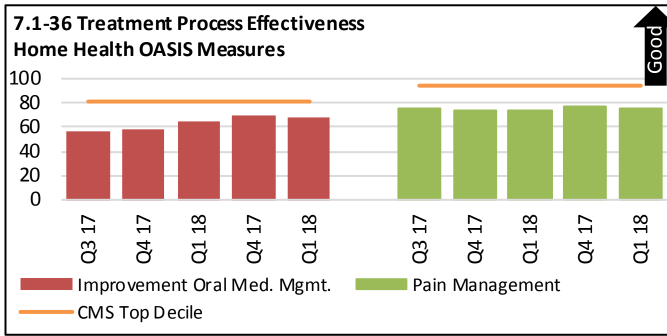




MGMC measures OR on-time starts (**Figure 7.1-35**) as a key measure of efficiency and to prevent bottlenecks in this high-volume environment. Through ongoing monitoring and reporting to the physician-led surgical services executive committee, performance is nearing industry standard.



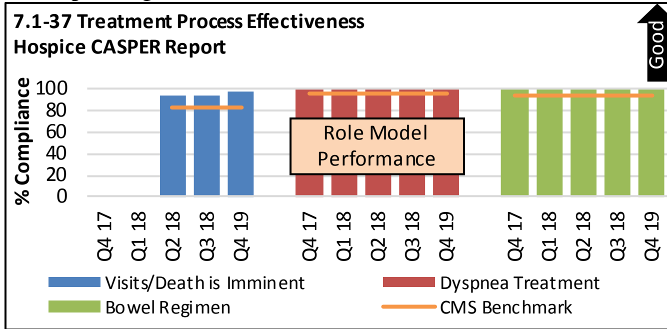
Figures 7.1-36 and 7.1-37 demostrate treatment process effectiveness for home health and hospice patients. Performance nearing top decile for hospice patients.



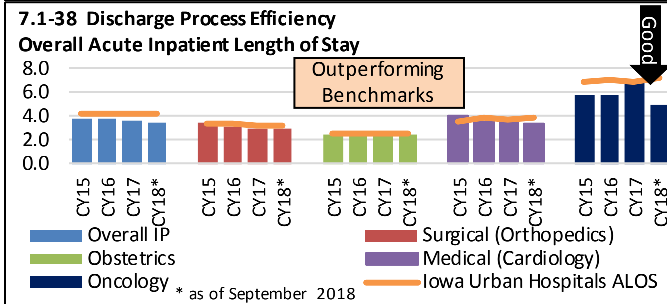
7.1-36 Treatment Process Effectiveness
Home Health OASIS Measures

Discharge Key Work Process Results

The length of time a patient is hospitalized is a key measure of efficiency in caring for patients. Overall Length of Stay (LOS) and LOS segmented by key services (**Figure 7.1-38**) are better than the state benchmark for comparably-sized hospitals and are improving in all areas.

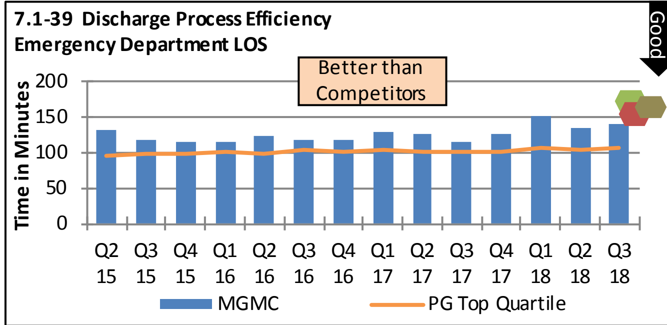


7.1-37 Treatment Process Effectiveness
Hospice CASPER Report



7.1-38 Discharge Process Efficiency
Overall Acute Inpatient Length of Stay

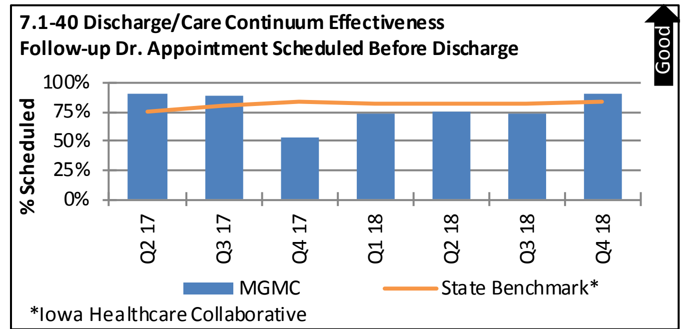
ED LOS (**Figure 7.1-39**) measures the time a patient presents to the ED to the time the patient is discharged to home and is a key work process measure of efficiency. Results outperform our competitors.



7.1-39 Discharge Process Efficiency
Emergency Department LOS

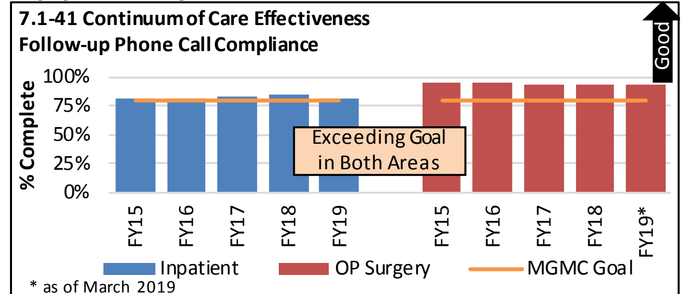
Continuum of Care Key Work Process Results

The percent of time the chronically ill patient has a post discharge follow up visit scheduled before leaving the hospital (**Figure 7.1-40**) is a key measure of the effectiveness of the continuum of care work process and is supported by the TOC program and our care coordination efforts. MGMC outperforms the Iowa Healthcare Collaborative.



7.1-40 Discharge/Care Continuum Effectiveness
Follow-up Dr. Appointment Scheduled Before Discharge

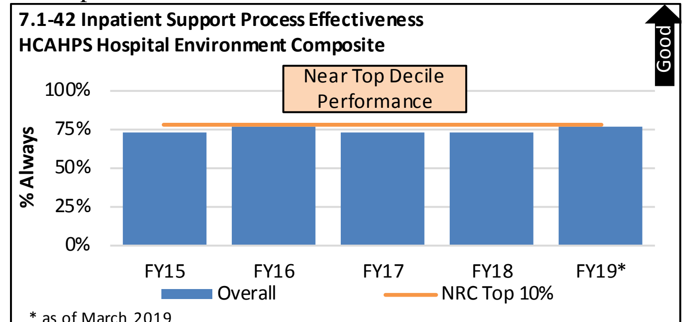
Discharge follow-up phone calls (**Figure 7.1-41**) supports care coordination and are done by the nurse discharging the patient. MGMC's goal is not 100% because not all patients can be reached post discharge. These calls support prevention of hospital readmissions (Figure 7.1-1) and enhance patient engagement (Figure 7.2-18).



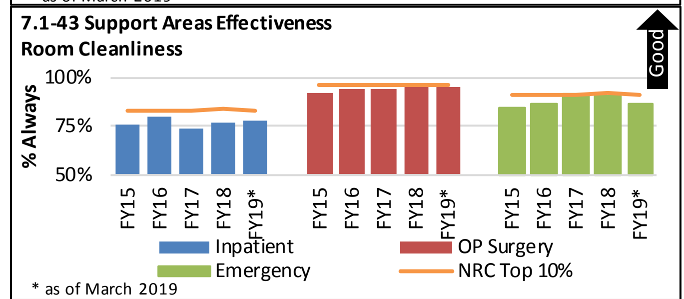
7.1-41 Continuum of Care Effectiveness
Follow-up Phone Call Compliance

Key Support Process Results

Figure 7.1-42 represents the percent of patients who indicate the area in and around their room was 'always' clean and quiet. HCAHPS results and specific cleanliness measures (**Figure 7.1-43**) broken out by key patient group demonstrate near top decile performance.



7.1-42 Inpatient Support Process Effectiveness
HCAHPS Hospital Environment Composite



7.1-43 Support Areas Effectiveness
Room Cleanliness

Cycle Time for Patient Room Turnover (**Figure 7.1-44**) measures the time it takes to efficiently clean a patient room after discharge. There is no benchmark; however, a 60-minute goal was established following a RIE. Q1 17 increase in time is the result of a new product that is more effective in preventing infections but has a longer (10 minute) dwell time. The benefits of preventing infections (*safety*) outweigh efficiency.

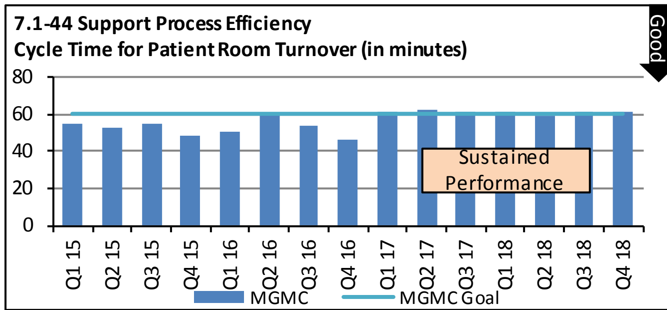
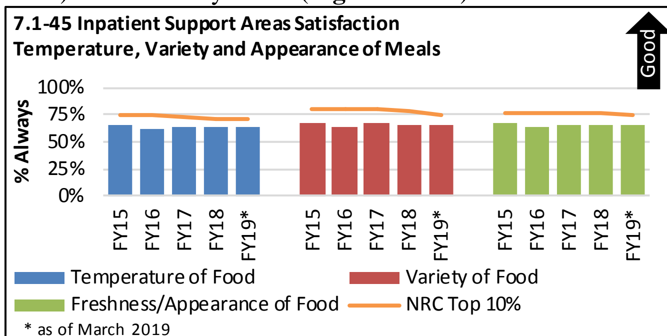
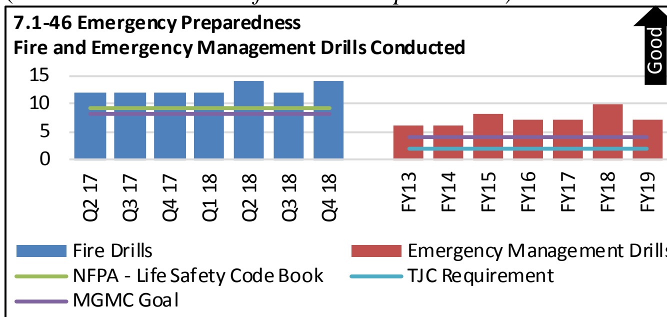


Figure 7.1-45 demonstrates the effectiveness of Dietary's key support processes in ensuring optimal freshness, temperature and variety of food.

Additional key support process effectiveness measures and results (Figure 6.1-3) include: Human Resources: Average Time to Fill Vacancies (**Figures 7.3-3**); Days in A/R (**Figure 7.5-4**) and Inventory Turns (**Figure 7.1-50**).

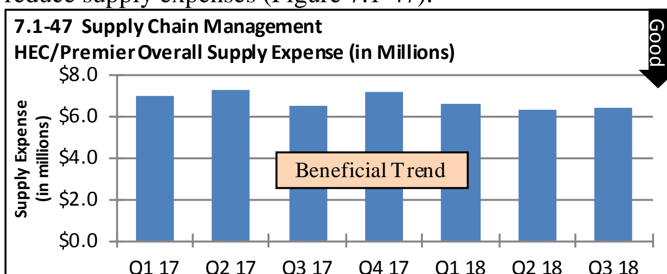


7.1b(2) Regular drills are conducted, both internally and externally, to prepare for potential disasters and multi-disciplinary team After Action Planning is done post event to learn and improve. **Figures 7.1-46** shows the number of drills conducted per quarter. Cycles of learning resulted in additional drills related to new plain language for overhead paging. (*Additional drills and after action reports AOS*).

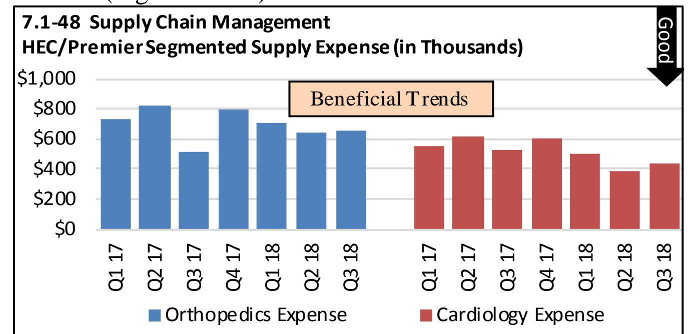


7.1c Supply-Network Management Results

MGMC monitors key measures of supplier performance to ensure that suppliers are meeting the requirements of timeliness, availability, cost effectiveness and expense reduction. GPOs Premier and HEC continue to help MGMC reduce supply expenses (Figure 7.1-47).



Specific supply-chain initiatives targeting orthopedic and cardiology implants continue to yield supply savings for MGMC, thanks to a collaboration with physicians and preferred vendors (Figure 7.1-48).



Overall supply expense as a percent of net revenues **(Figure 7.1-49)** demonstrates favorable performance to budget.

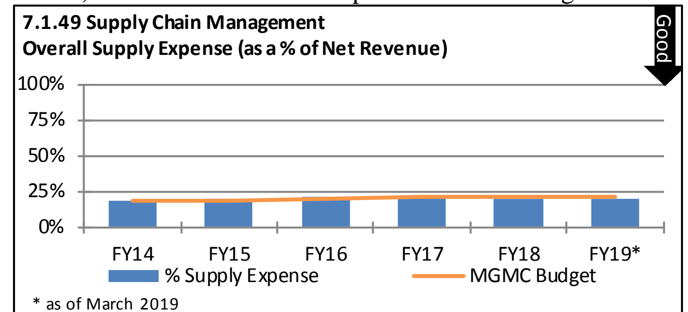
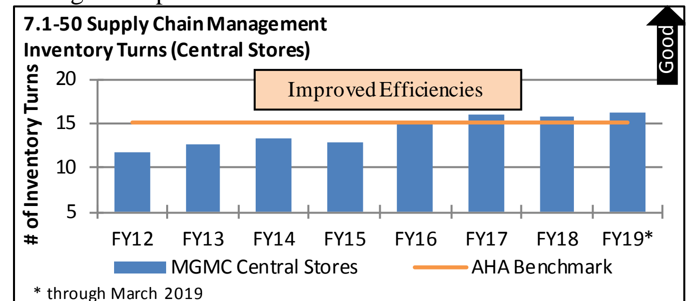
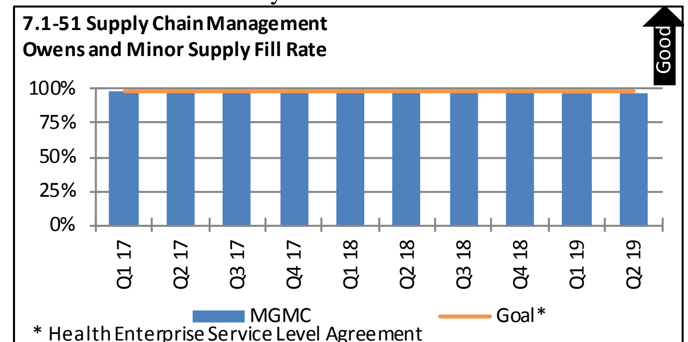


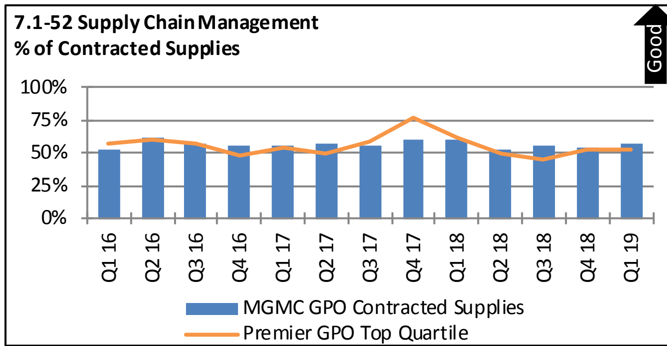
Figure 7.1-50 presents the number of times inventory is turned. A higher number of turns demonstrates efficiency and reduces overall cost. MGMC's superior performance, outperforming the AHA benchmark, is the result of rigorous supply chain management practices described in 6.1c.



Supply Fill Rate (**Figure 7.1-51**) is a key supply chain metric that monitors order fulfillment and product availability. Performance consistently meets the established SLA.



Adherence to purchasing supplies via contracts is built into the ordering process and, as a result, Percent of Contracted Supplies (**Figure 7.1-52**) exceeds best GPO performance.

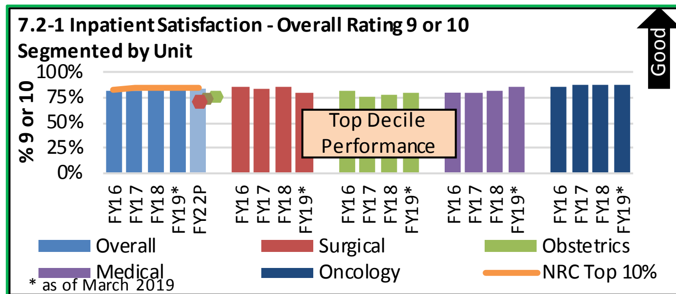


7.2 CUSTOMER-FOCUSED RESULTS

7.2a Patient-and Other Customer-Focused Results

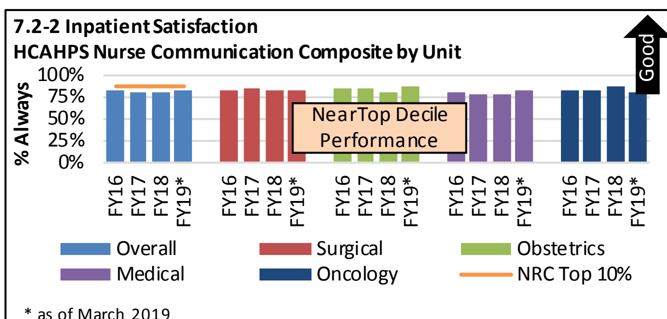
7.2a(1) MGMC measures indicators of patient satisfaction, dissatisfaction and engagement for its service offerings and key patient groups of inpatient, outpatient, emergency and home health/hospice, as well as for its community stakeholder. The NRC survey allows segmentation of inpatient results by unit, so some segmented results are shown here, and additional results are AOS. However, NRC only provides comparative data for overall results, not for unit-specific results. Some competitor results are publicly available through CMS, though there is a reporting lag.

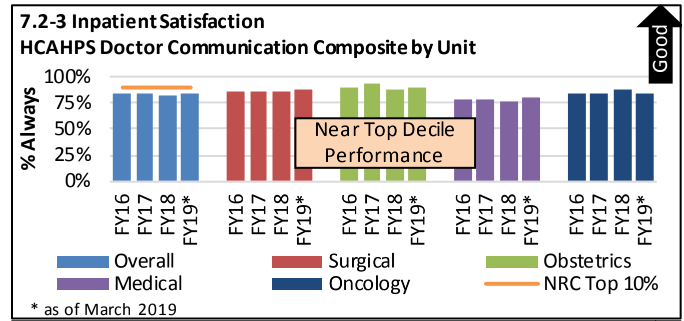
7.2a(1) For the **inpatient** service offering and key patient group, MGMC uses the HCAHPS overall hospital rating as an indicator of patient satisfaction (**Figure 7.2-1**). Hospital-wide results show sustained, top decile performance better than competitors, and most segmented results show a favorable trend.

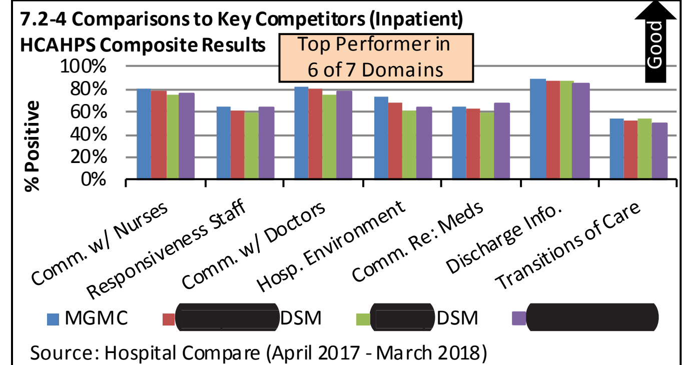


Two HCAHPS domains focus on the key patient requirement of communication (**Figures 7.2-2, 3**). Near top decile results for both nurse and physician communication affirm the effectiveness of strategies such as hourly patient rounding, leader rounding, bedside shift reporting and AIDET.

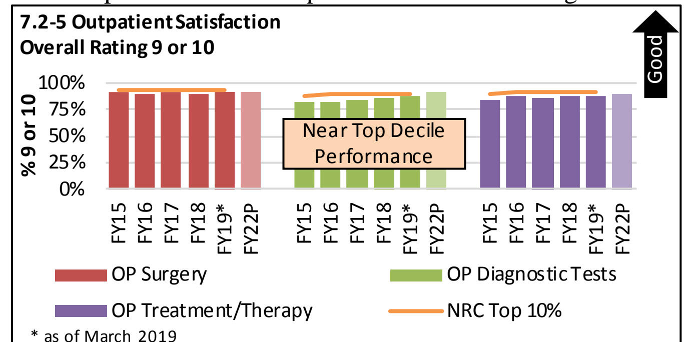
MGMC monitors its performance in each of the HCAHPS domains **(Figure 7.2-4).** MGMC outperforms all key competitors in six of the seven domains, according to publicly reported data.



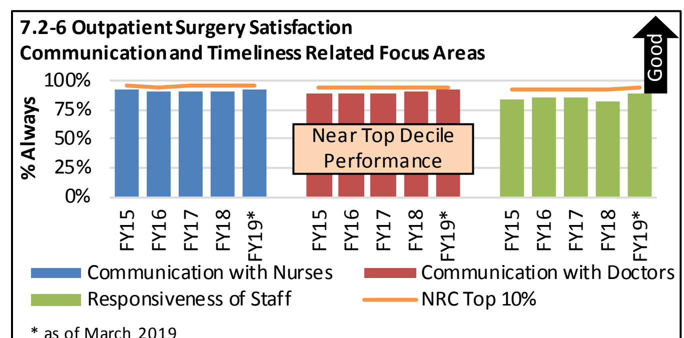


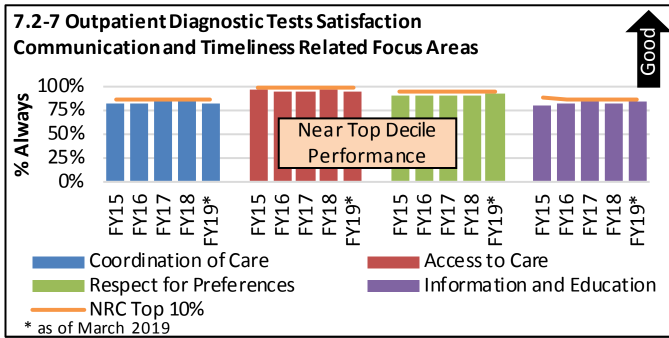


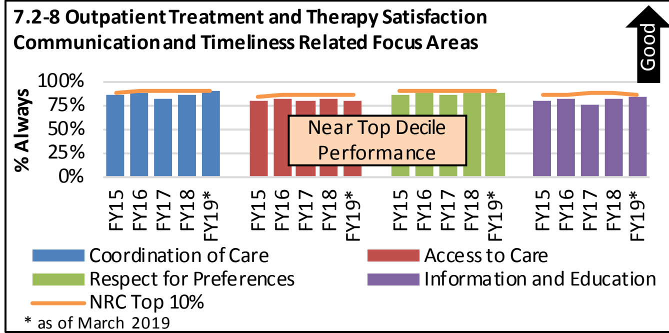
MGMC also uses the NRC survey to monitor outpatient satisfaction, including OP surgery, OP diagnostic tests, and OP procedures **(Figure 7.2-5).** Results for all three types of services/patients are near top decile for overall rating of care.



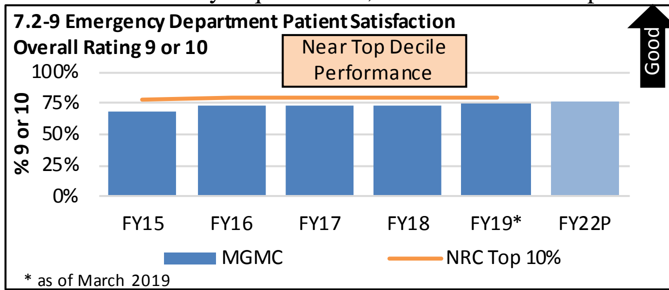
OP surgery satisfaction with communication and responsiveness/timeliness (key patient requirements) is also near top decile **(Figure 7.2-6).** Surveys for patients who have OP diagnostic test **(Figure 7.2-7)** and OP procedures **(Figure 7.2-8)** ask different questions, but MGMC is still able to map near top decile results to key patient requirements. For instance, the Access to Care questions relate to timeliness, and Coordination of Care, Respect for Preferences and Information/Education relate to communication.

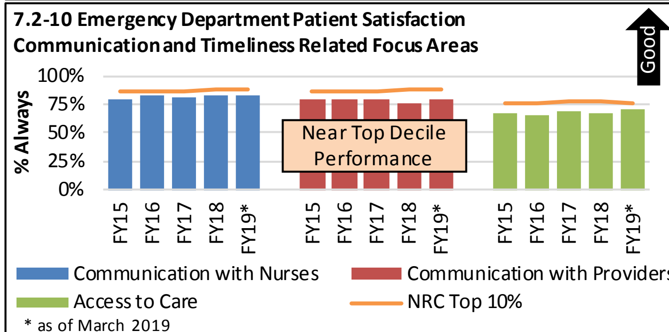


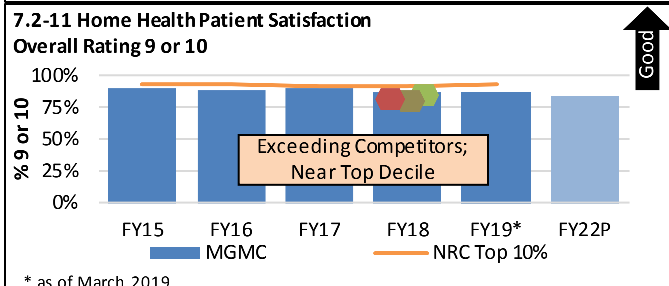


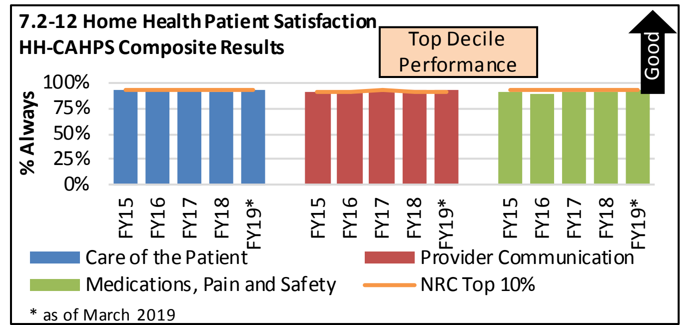


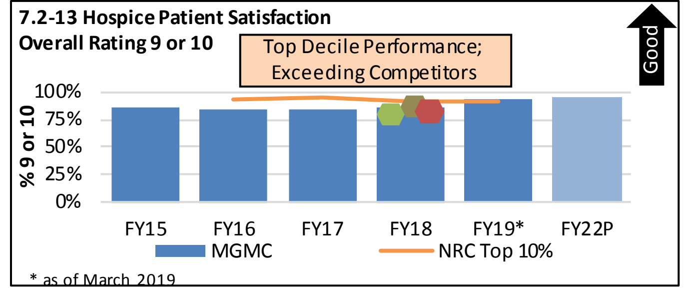
MGMC results for ED patient satisfaction(**Figure 7.2-9**), ED key patient requirements (**Figure 7.2-10**), and home health patient satisfaction (**Figure 7.2-11**) are also all near top decile, with home health patient satisfaction exceeding competitors. Competitor results are not available for OP and ED. Hospice patient satsifaction (**Figure 7.2-13**), as well as both home health (**Figure 7.2-12**) and hospice (**Figure 7.2-14**) patient satisfaction with key requirements, have all achieved top decile.

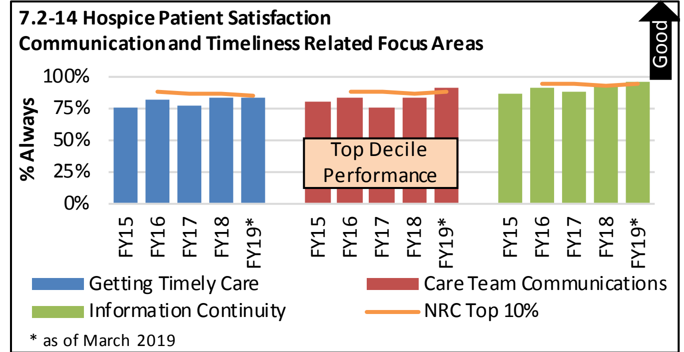




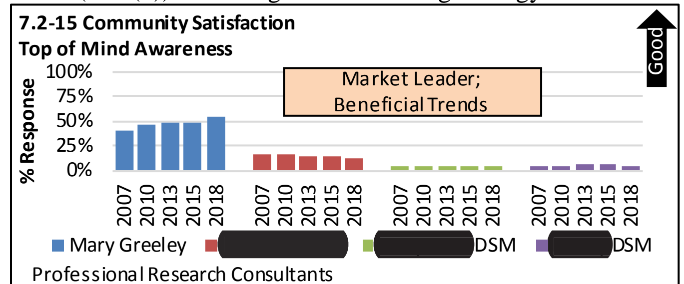




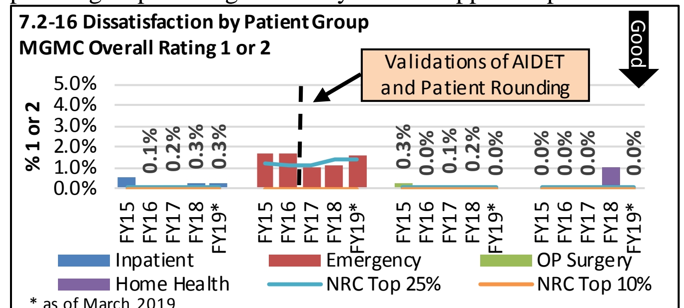




As an indicator of community, market and potential patient satisfaction, Top of Mind Awareness as measured by the consumer perception survey (**Figure 7.2-15**) demonstrates our dominance in the market compared to key competitors. Results also affirm the effectiveness of managing and enhancing our brand (3.2a(1)) following the re-branding strategy.

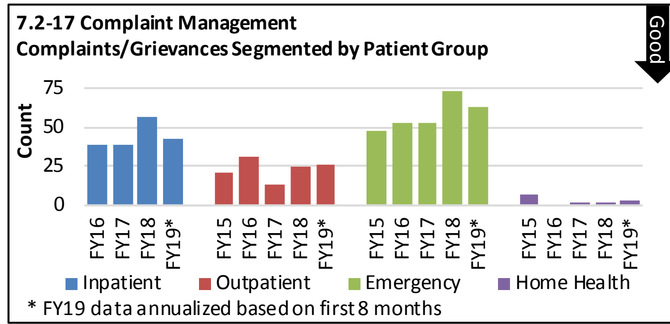


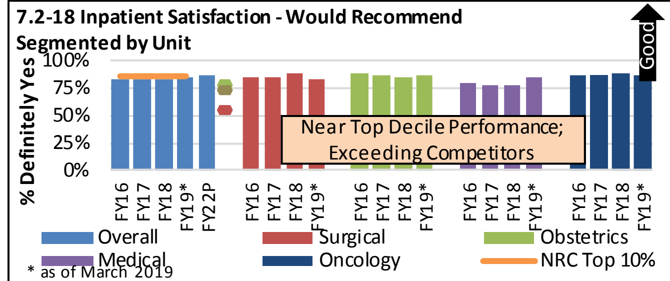
Patient dissatisfaction (**Figure 7.2-16**) is tracked both qualitatively (VOC feedback) and quantitatively via scores of 1s and 2s on the engagement survey. Results are monitored by patient group and segmented by unit to support improvement.

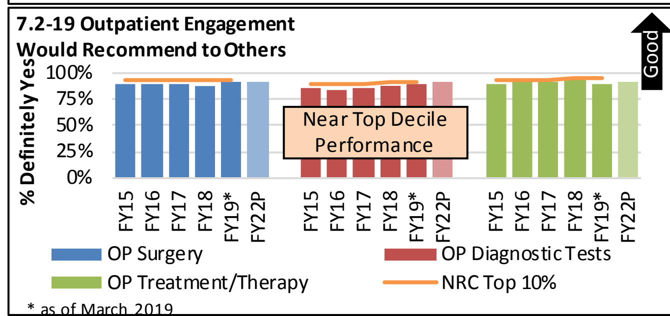


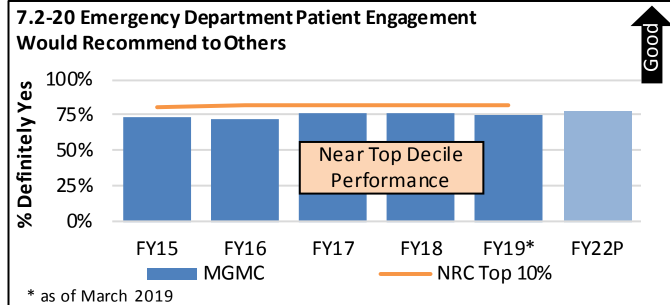
Complaints/grievances (**Figure 7.2-17**) are trended and managed through the Complaint Management Process (Figure 3.2-2). Care coordination was identified as an ED opportunity for improvement and cascaded to appropriate leaders in FY18. No comparisons exist for this internal measure.

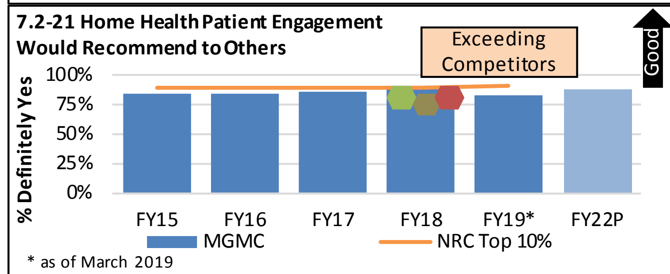
7.2a(2) Survey results for 'Would Recommend to Others' (**Figures 7.2-18-22**) is a key measure of patient engagement and loyalty. All patient groups and segments demonstrate consistently positive results nearing top decile performance.

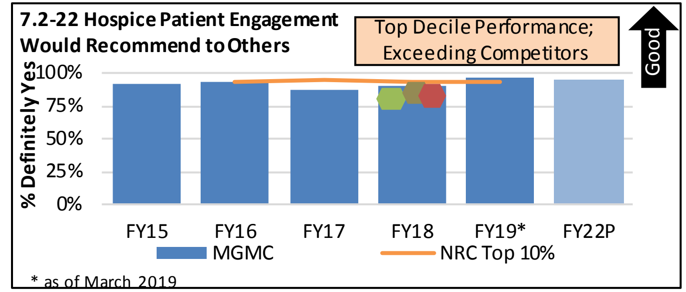




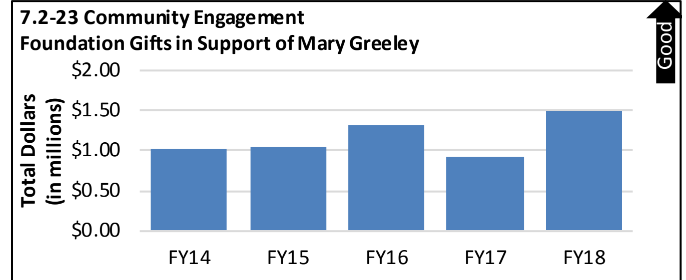


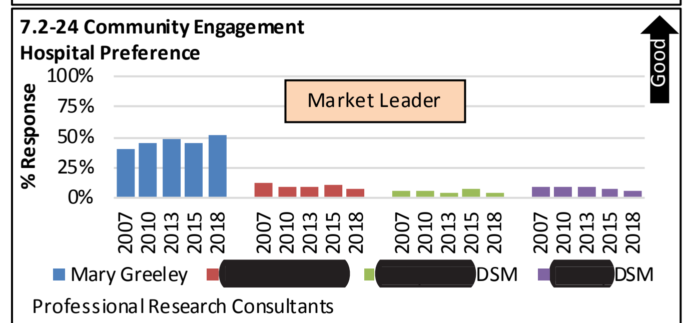




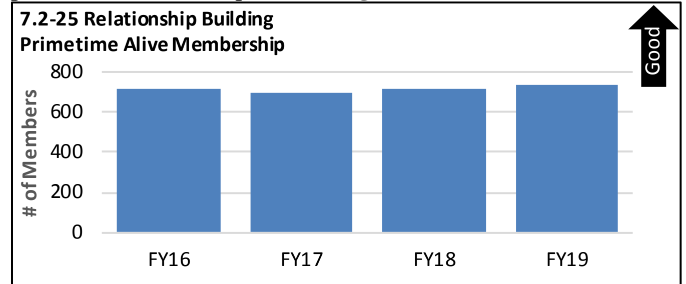


Support for MGMC through the foundation (**Figure 7.2-26**) is an indicator of strong community engagement. Consumer perception surey results for Hospital Preference (**Figure 7.2-24**) are additional measures of community, market and potential patient engagement. MGMC continues to dominate the market.





Primetime Alive, a program for ages 50 and above, focuses on promoting health and well-being. It is a mechanism MGMC uses to build relationships with the community, including potential and former patients (**Figure 7.2-25).**



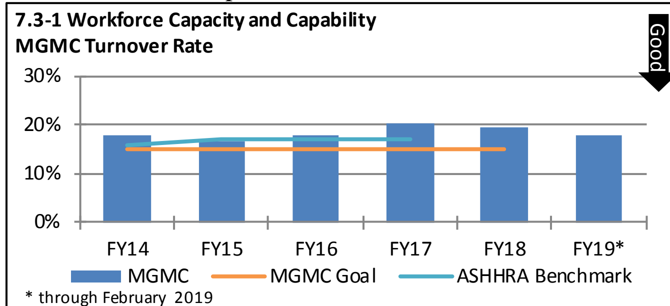
MGMC has a robust social media platform to engage patients and community members and create awareness of services and programs (**Figure 7.2-26).** MGMC has almost 7,000 Facebook followers, with more than 2 million YouTube viewers. The most popular posting was viewed by more than 84,000 people. MGMC compares its efforts with those of key competitors and uses findings to support SP and other engagement initiatives.

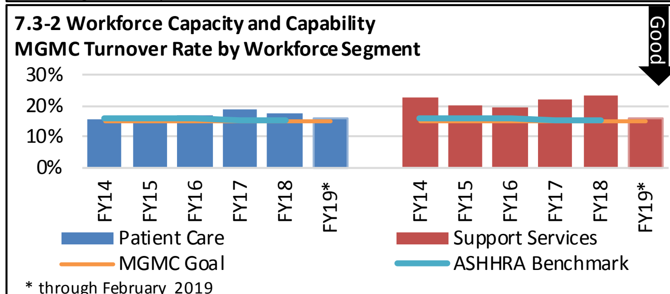
7.2-26 Patient and Other Customer Engagement - Social Media					
Key Competitor	2015	2016	2017	2018	2019
Facebook Likes					
Mary Greeley Medical Center	4,348	5,097	5,569	6,222	6,907
YouTube Views					
Mary Greeley Medical Center	188,680	318,264	654,477	1,147,030	2,192,067
- Des Moines	3,272	9,082	26,009	44,728	65,747
- Des Moines	24,748	26,019	142,348	405,387	1,056,726
	2,257	2,475	2,730	NA	NA
YouTube Subscribers					
Mary Greeley Medical Center	786	1,483	2,799	4,694	9,330
- Des Moines	10	20	38	78	116
- Des Moines	41	67	95	171	263
	26	26	25	NA	24

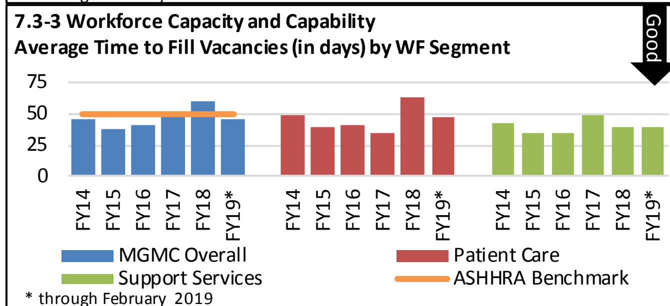
7.3 WORKFORCE FOCUSED RESULTS

7.3a Workforce Results

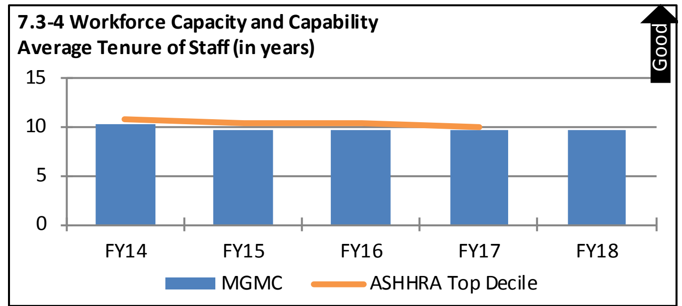
7.3a(1) MGMC uses turnover and time to fill vacancies as key measures of workforce capability and capacity (**Figures 7.3-1-3**). For both measures, MGMC outperforms the ASHHRA benchmark overall for its key employee segments. A Hiring Process RIE improved the time to fill results.







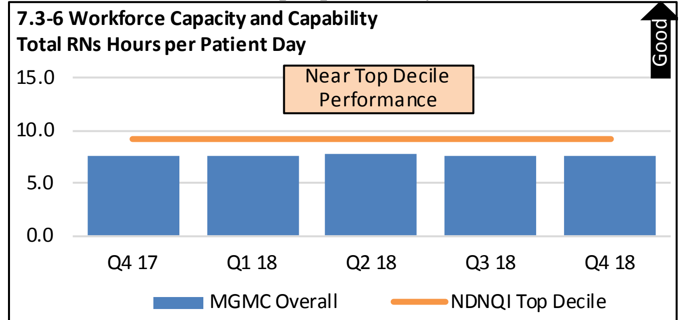
Despite a highly competitive job market, MGMC is at the national top decile for staff tenure (**Figure 7.3-4**) – another indicator of workforce capability and capacity, as well as engagement. Retention is attributed, in part, to staff being provided opportunities for growth and development (see also Figure 7.3-23 'Manager Providers Opportunities for Growth'.)



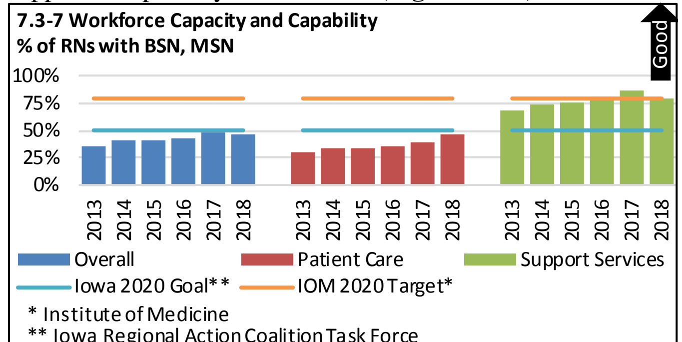
MGMC monitors the capability and capacity of its non-employed workforce to meet the needs of strategies (**Figure 7.3-5**). All volunteer and physician measures show favorable trends, and MGMC is on track with strategic workforce plans to expand behavioral health services.

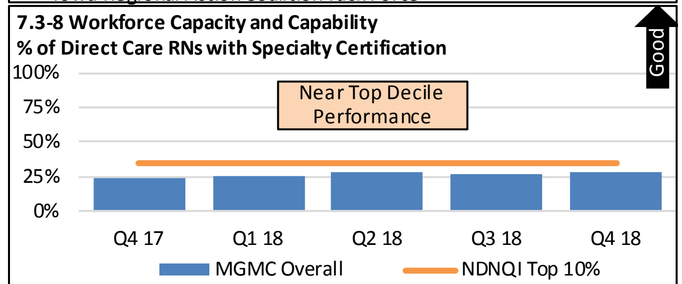
7.3-5 Volunteer and Physician Capacity and Capability				
Key Measure	2015	2016	2017	2018
# of Physicians on Active Medical Staff	154	164	151	155
# of Employed Behavioral Health Physicians	2	2	3	4
# of Volunteers	472	445	458	472
Volunteer Hours	34,618	39,409	38,130	40,182

MGMC closely monitors staff productivity to control costs and to ensure delivery of high quality care. MGMC is near top decile for total RN hours per patient day (**Figure 7.3-6).**

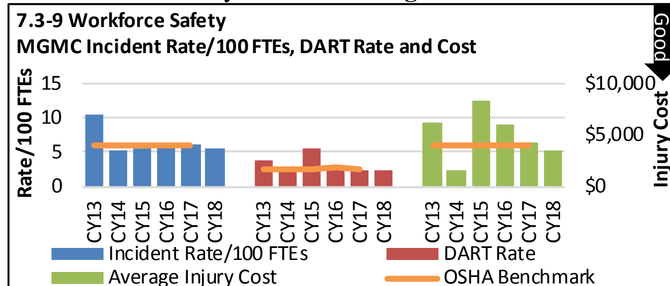


Evidence proves patient outcomes are better when nurses are trained at the baccalaureate level. To date, MGMC exceeds the states goal (**Figure 7.3-7**). MGMC ensures workforce capability through training and development programs such as support for specialty certifications (**Figure 7.3-8**).



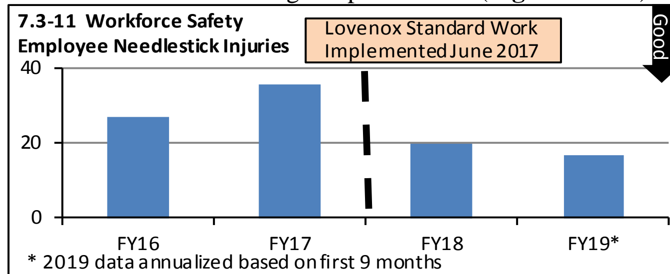


7.3a(2) Preventing workforce harm is a strategic focus for (Figure 2.1-3), and as a result, incident rate, Days Away and Restricted or Transferred (DART) rate, and injury costs **(Figure 7.3-9)** show a favorable trend to outperform the OSHA benchmark. A new initiative to safely lower patients to the floor prevents both patient and workforce harm. Decline in injury cost is directly supported by this initiative. Additional measures of workforce security and health – **Figure 7.3-10.**

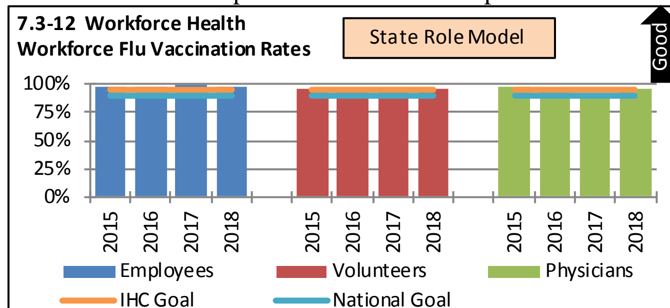


7.3-10 Workforce Security and Accessibility				
Key Measure	**2015**	**2016**	**2017**	**2018**
Hand Hygiene Compliance	81%	84%	81%	84%
Security Incidents/1,000 ED Visits	0.97	0.79	0.96	1.21
Reasonable Accommodation Hours		1,748	4,897	3,322

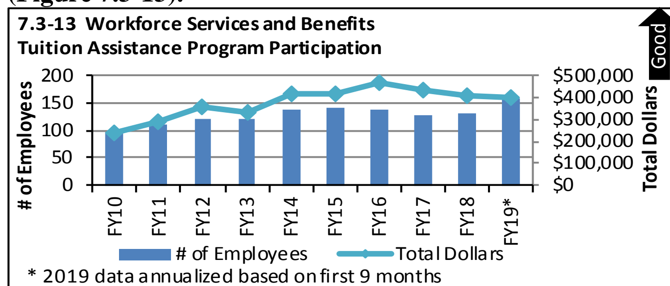
As a result of learning (5.1b(1)), Standard Work for safe medication administration to prevent needlesticks was created and resulted in breakthrough improvements (**Figure 7.3-11**).



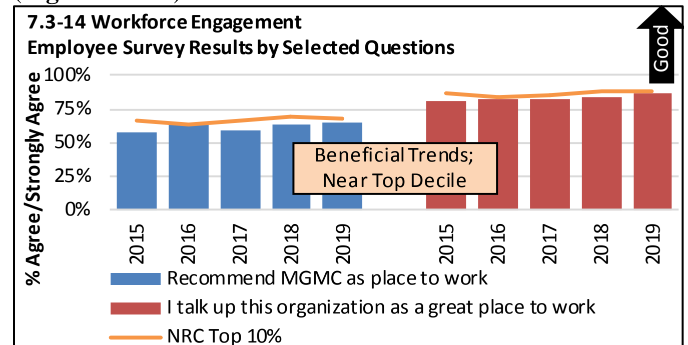
MGMC participates in the IHC annual initiative to proactively prevent the flu by requiring its workforce be vaccinated during flu season (**Figure 7.3-12**). Those who cannot be vaccinated must wear a mask to protect themselves and patients.



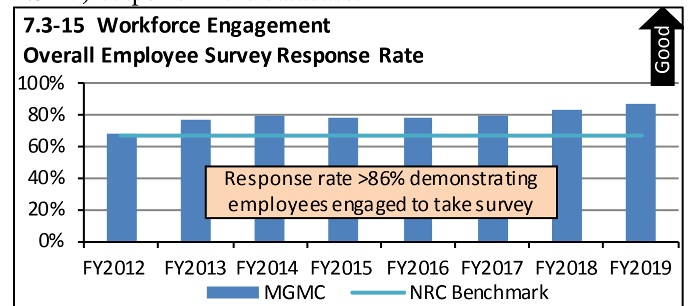
Comprehensive benefits, including tuition assistance is offered **(Figure 7.3-13).**



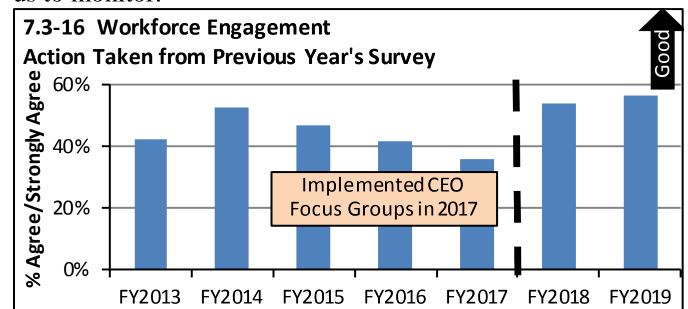
7.3a(3) MGMC continues working to systematically build a MVV-driven culture characterized by high performance and an engaged workforce. Survey results for overall employee engagement, a Big Dot Goal, demonstrate steady improvement, with sustained performance near top decile levels since 2016 (**Figure 7.3-14**).



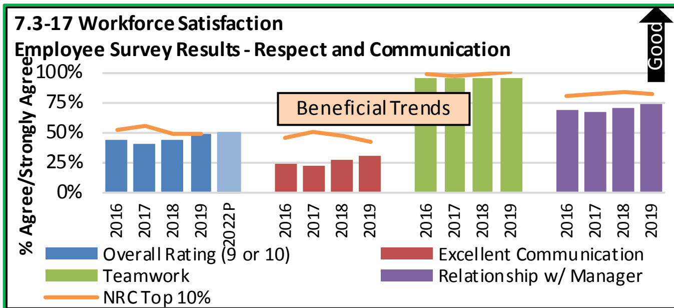
MGMC surveys employees annually and compares response rates with top quartile performance in the NRC Health database as an indicator of engagement. MGMC response rates **(Figure 7.3-15)** outperform the database.

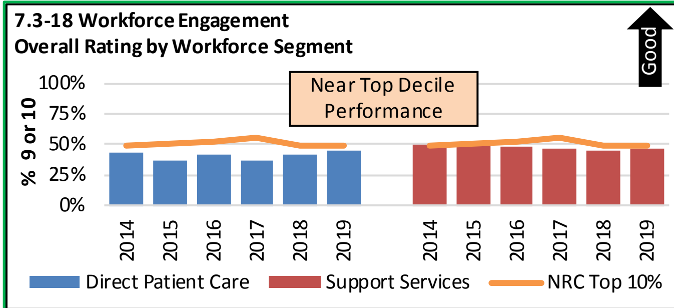


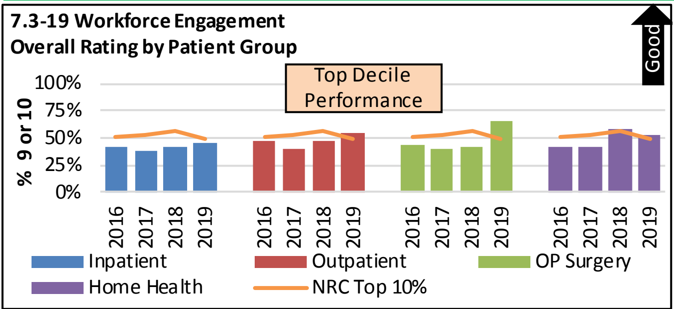
Action taken as a result of the previous survey **(Figure 7.3-16)** is a measure of effectiveness in targeting improvements and communication. Significant improvements in the two most current reporting periods are attributed to focus groups and engaging employees in assisting with action plans (5.2c(3)). This custom question has no benchmarks but is important for us to monitor.



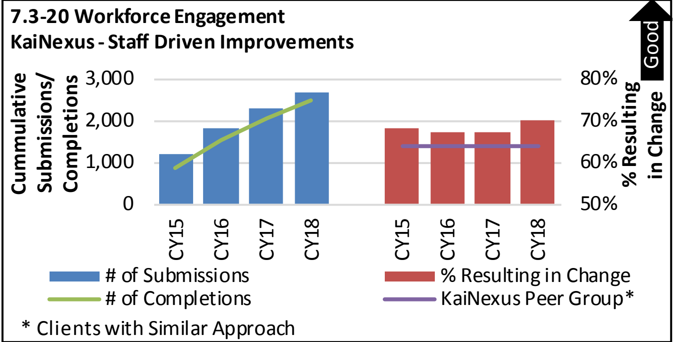
Overall ratings on the employee survey – an indicator of employee satisfaction – are almost to top decile performance organization-wide and for key workforce segments (**Figures 7.3-17, 18).** Results for the outpatient and home health service offerings/patient groups **(Figure 7.3-19)** have surpassed top decile. MGMC also monitors survey results mapped to its key employee requirements of respect and communication **(Figure 7.3-17).** Results show a beneficial trend with continued improvement efforts focused on communication. Employee turnover and tenure provide additional evidence of MGMC's engaged workforce **(Figures 7.3-1, 7.3-2)**.



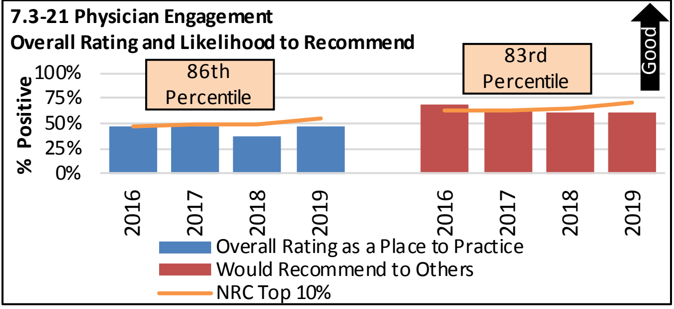




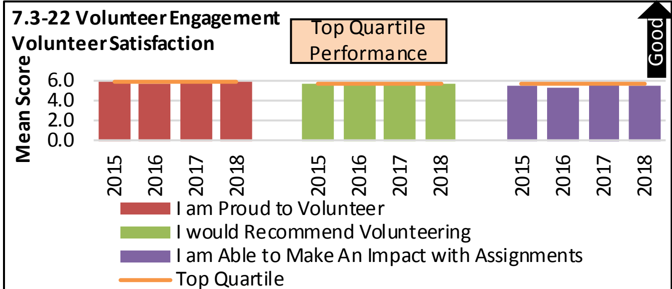
Engaging those closest to the work to improve their work is a key strategy to support employee engagement. **Figure 7.3-20** demonstrates employee participation in submitting daily improvements, indicative of an improvement-focused culture.



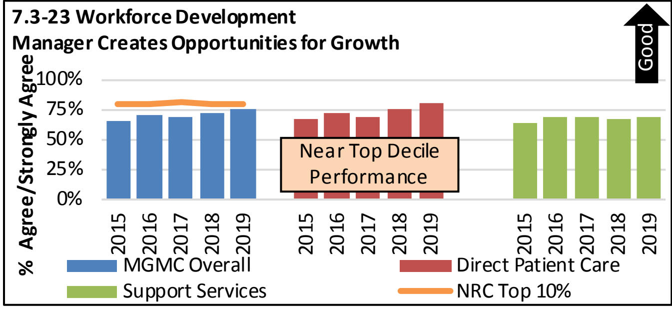
MGMC also annually surveys physicians to gauge their engagement **(Figure 7.3-22).** MGMCs' performance at the 86th percentile is nearing top decile performance. *Additional results and segmentation AOS.*



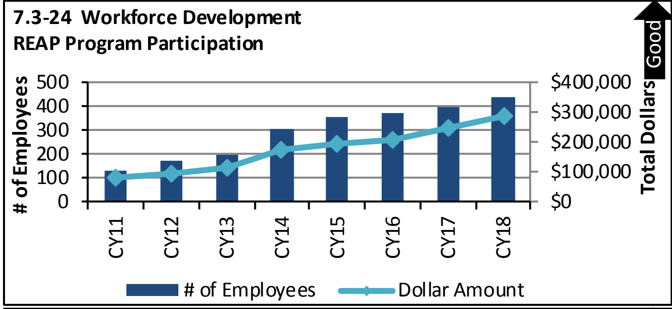
Volunteer engagement is determined via the annual volunteer survey **(Figure 7.3-22).** Results for overall engagement and for the key engagement driver of purposeful work demonstrate sustained top quartile performance. Additional results AOS.

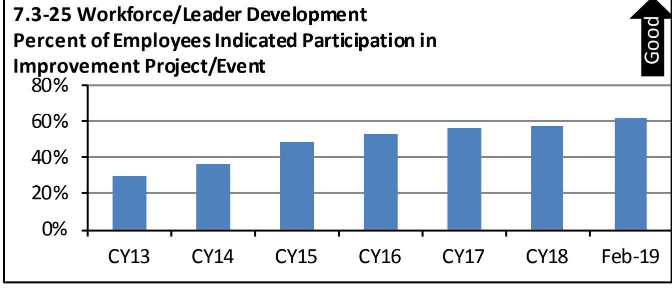


7.3a(4) MGMC monitors specific questions on the annual employee engagement survey as an indicator of workforce development **(Figure 7.3-23).** Results show a beneficial trend with near top decile performance overall and for key workforce segments. In 2017 as part of the performance review proces, leaders began working with staff to create personal and professional development plans.



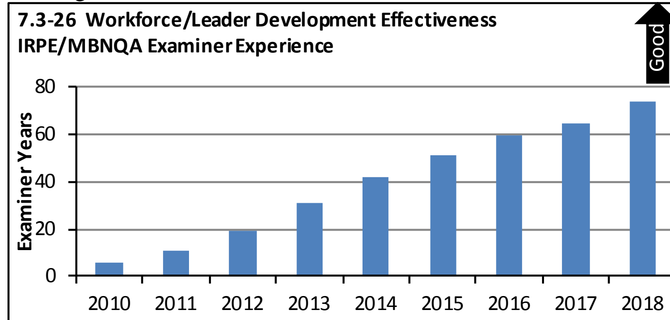
In addition to percent of RNs and advanced certifications (**Figures 7.3-7, 8**), MGMC also monitors dollars paid out for the REAP program (**Figure 7.3-24**), and percent of staff who particpated on a RIE or VSM event (**Figure 7.3-25**) as measures of workforce development. These internal measures have demonstrated continued growth (no benchmarks are available).



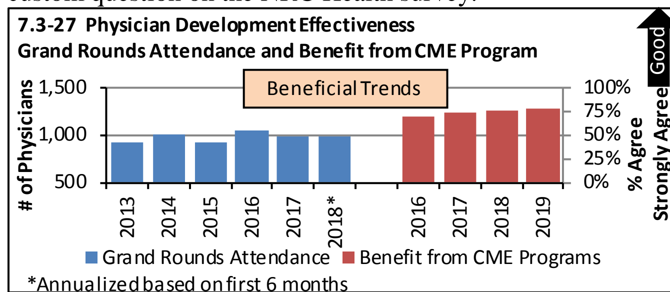


MGMC is proud to support leadership development through state and national Baldrige examiner training programs (**Figure 7.3-26**) and has logged more than 65 years of examiner

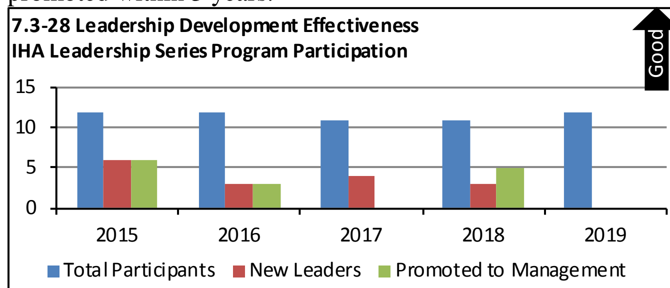
experience to date demonstrating its commitment to the Baldrige Excellence Framework.



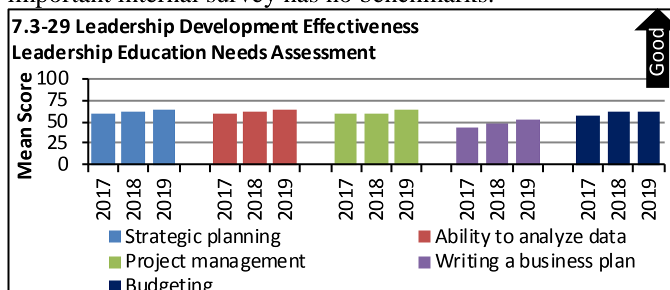
MGMC invests in educational support for its physician workforce by offering a certified Grand Rounds program weekly (**Figure 7.3-27**). Continuing Medical Education credits are provided, and results of this offering demonstrate strong attendance and benefit. There are no benchmarks for this custom question on the NRC Health survey.



MGMC invests in employee development through ongoing succession planning. **Figure 7.3-28** demonstrates employee participation in the IHA leadership development series. On average, eligible employees who participate in this program are promoted within 3 years.



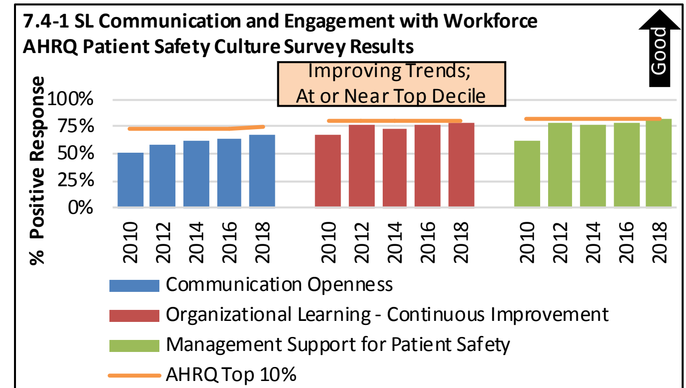
The annual leadership needs assessment survey is done to systematically assess leader development needs and to support an annual Leadership Institute (LI) learning and development calendar. On the survey, leaders rate their expertise from novice to expert, with an increasing score indicating greater expertise. **Figure 7.3-29** demonstrates steady improvement in key leadership competencies supported by MGMC programs. This important internal survey has no benchmarks.



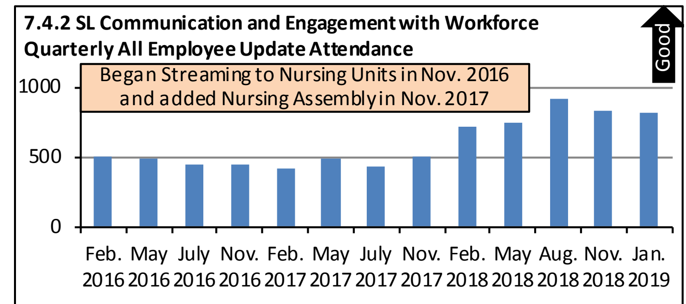
7.4 LEADERSHIP AND GOVERNANCE RESULTS

7.4a Leadership, Governance and Societal Responsibility

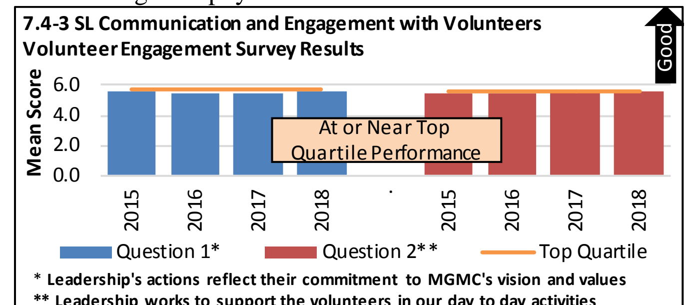
7.4a(1) MGMC administers the AHRQ Patient Safety Culture Survey to employees every other year (next surey will be conducted in the fall of 2018). This survey helps gauge employee satisfaction and engagement with SL communication, organizational learning and support for patient safety (**Figures 7.4-1**). Results related to SL communication with customers Figure 7.1-32 Leader Rounding. Full survey results AOS.

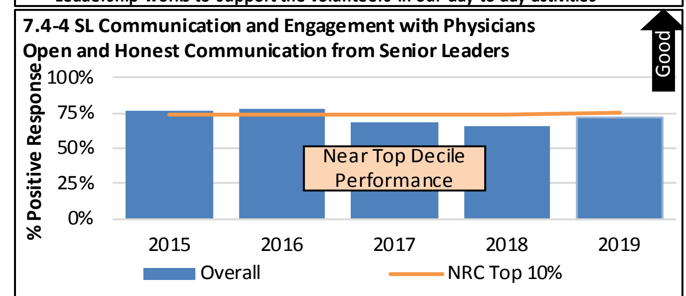


Attendance at Employee Updates (**Figure 7.4-2**) is tracked as a measure of effective two-way communication. Strategies to improve attendance, particularly in the patient care division where it is more challenging to leave the work unit, have been successful.



Communication and engagement with volunteers (**Figure 7.4-3**) and physicians (**Figure 7.4-4**) are monitored through their annual surveys, and results are used for improvement such as SL rounding with physicians.





Leadership created laser **focus on action** in 2017 with the implementation of the Big Dot Goal philosophy and has experienced sustained and breakthrough improvement in these 4 key strategic priorities to date (see 7.5b). Results for leader rounding with patients are presented in (Figure 7.1-32).

7.4a(2 MGMC uses the IHA board survey as a key indictor of governance accountability **(Figures 7.4-5, 6).** MGMC sustains performance better than the benchmark across all key areas of governance. Additional key measures of governance accountability are displayed in **Figure 7.4-7**.

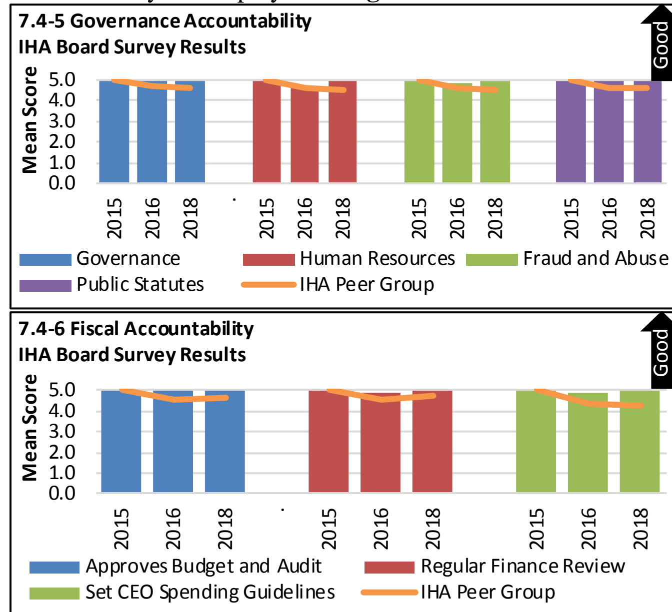


Figure 7.4-7 Governance Accountability				
Internal	**Measure**	**2016**	**2017**	**2018**
Board Certification	Certification/Re-Certification	100%	100%	100%
Conflict of Interest Disclosure	Disclosure	100%	100%	100%
External	**Measure**	**2016**	**2017**	**2018**
Moody's	Rating Review	A2	A2	A2
Financial Audit	Unqualified Opinion	Clean	Clean	Clean

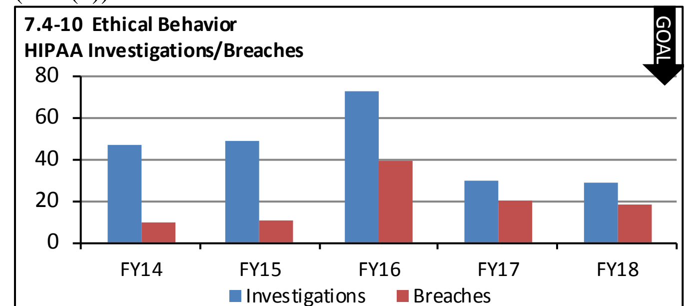
7.4a(3) Key measures and results of legal, regulatory, and accreditation are listed in **Figure 7.4-8**.

Figure 7.4-8 Legal, Regulatory, Accreditation				
	Measure	2016	2017	2018
TJC	Full Accreditation	Full	Full	Full
CARF	Full Accreditation	Full	Full	Full
DNV - Stroke Certification	Successful Certification	100%	100%	100%
CMS	Requirements Met	100%	100%	100%
Magnet	Accreditation	n/a	n/a	Full

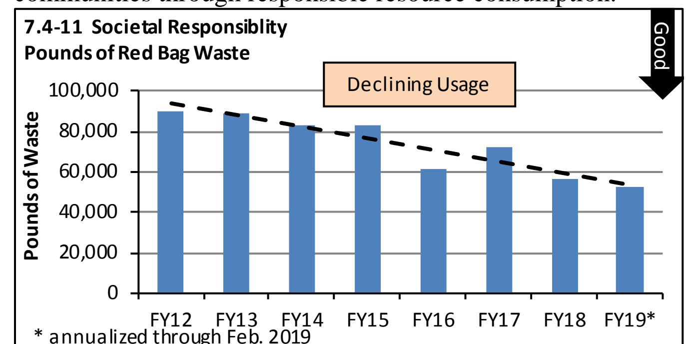
7.4a(4) Key measures and results of ethical behavior in governance and senior leadership are listed in **Figure 7.4-9**.

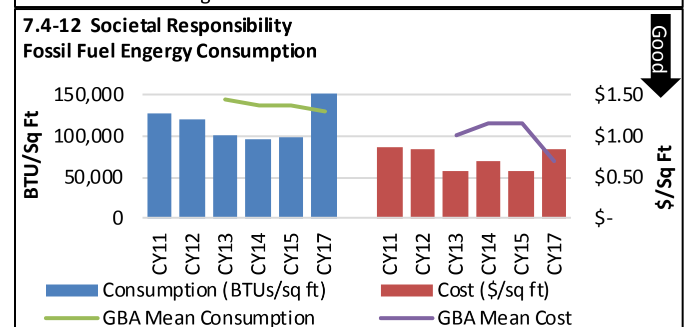
Figure 7.4-9 Ethical Behavior				
	Measure	2016	2017	2018
BOT Compliance with Open Meetings	% compliance	100%	100%	100%
WF Trained on Code of Conduct	% trained	100%	100%	100%
Workforce trained on HIPAA / Confidentiality	% trained	100%	100%	100%
HIPAA Fines	Number	0	0	0
OIG Sanctions	Number	0	0	0

Protecting patients' personal health information through secure access to systems and upholding the Code of Conduct is an expectation of all workforce members. Ongoing monitoring of compliance through HIPAA investigations (**Figure 7.4-10**) is tracked and reported to CMS. MGMC's ongoing systematic monitoring process identified one incident in 2016 that impacted a number of access points. This led to greater securities and increased workforce awareness and training (1.2b(2)). None of these events resulted in sanctions or fines.



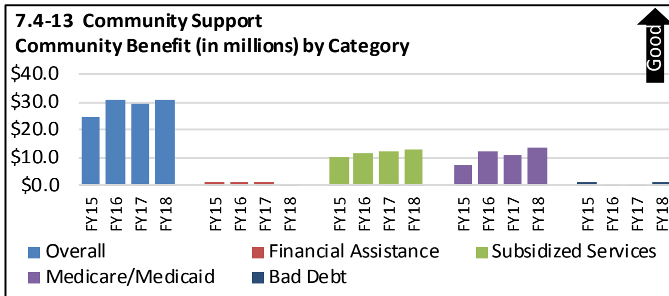
7.4a(5) Society Key measures of societal responsibility include reduction of red bag (infectious) waste (**Figure 7.4-11**) and sustaining/decreasing fossil fuel consumption (**Figure 7.4-12** most current available data). We now use natural gas to produce domestic hot water (versus steam), which has a higher efficiency factor; however, this has increased consumption and costs, which MGMC planned for. Through LEED Silver designation, we continues to demonstrate a commitment to the communities through responsible resource consumption.



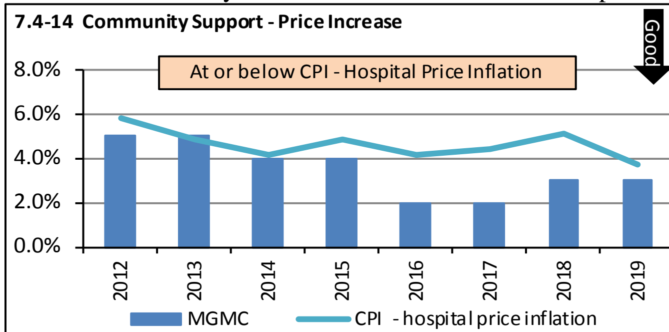


Source GBA = Grumman/Butkus Associates, Sustainable Design Engineers

Figure 7.4-13 demonstrates MGMC's finanical support for its key communities through providing free and reduced services. The subsidized services category includes (but is not limited to) Home Care support to patients who are part of the Transitions of Care program (offsets potential readmissions (Figure 7.1-1).



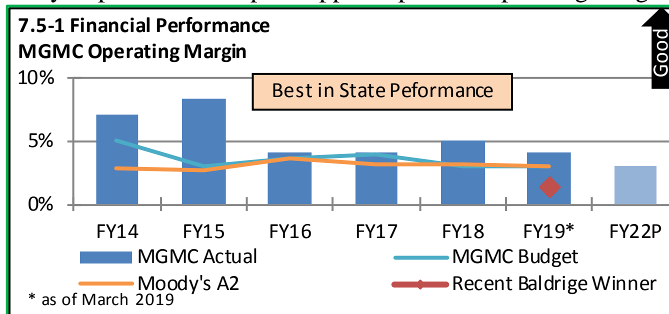
MGMC is committed to providing sustainable health care for the long term. **Figure 7.4-14** demonstrates MGMC's ongoing commitment to improved efficiencies that lead to price increases consistently below that of the CPI rate for hospitals.



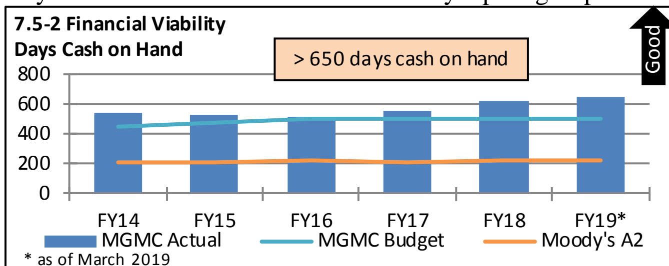
7.5 FINANCIAL, MARKET, AND STRATEGY RESULTS

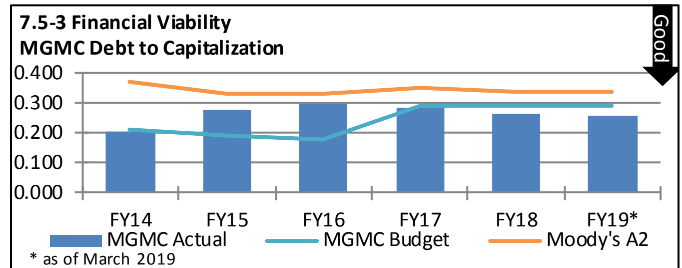
7.5a Financial and Market Results

7.5a(1) Key financial measures aligned with MGMC's five-year financial and SP are reported in **Figures 7.5-1 through 7.5-4.** MGMC maintains a strong operating margin, a Big Dot Goal, compared to Moody's A rated hospitals, key competitors, and the state urban hospital performance of 1.7%. The drop in FY16 was planned due to the completion of the five-year, $130 million master facility project. Performance is expected to remain in the 3% range per the long-range financial plan (Figure 2.1-3), which exceeds Moody's A rated hospitals and performance of others in the state. Our focus on waste reduction, including the three 100 Day Workouts and ongoing Daily Improvement help to support a positive operating margin.

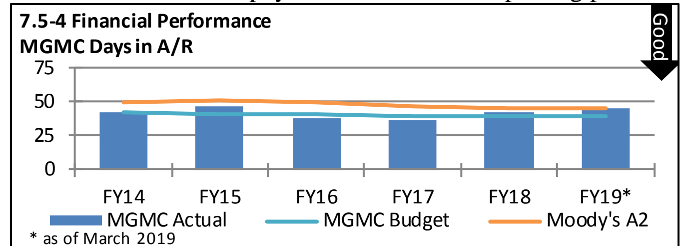


Results for days cash on hand and Debt to Capitalization (**Figures 7.5-2, 7.5-3**) demonstrate strong financial viability. Days cash on hand is three-fold its Moody's peer group.

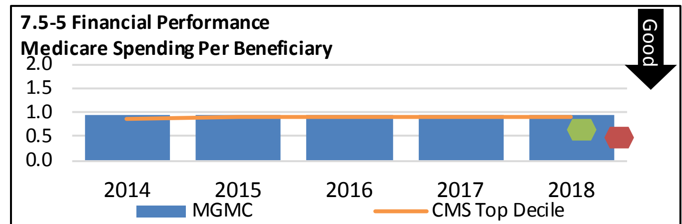




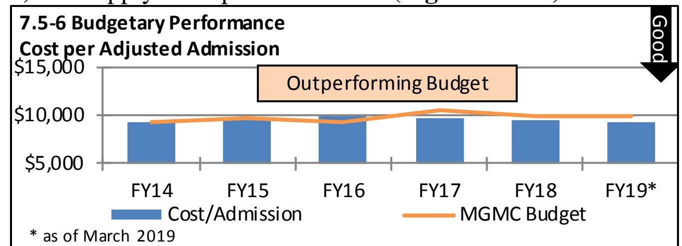
Days in A/R (**Figure 7.5-4**) demonstrate favorable results following the Business Office Revenue Stream Value Stream Mapping event that identified a number of improvements to eliminate waste in the payment collection and posting process.

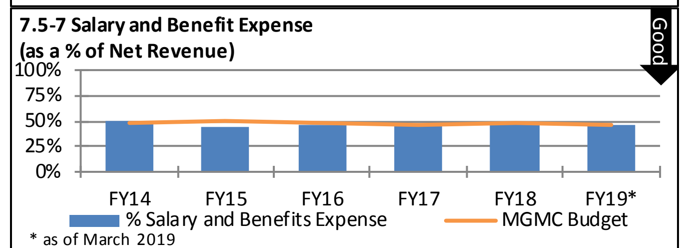


Spending per Medicare Beneficiary (**Figure 7.5-5**) is a key measure in the CMS VBP program and supports efficient and effective care coordination.



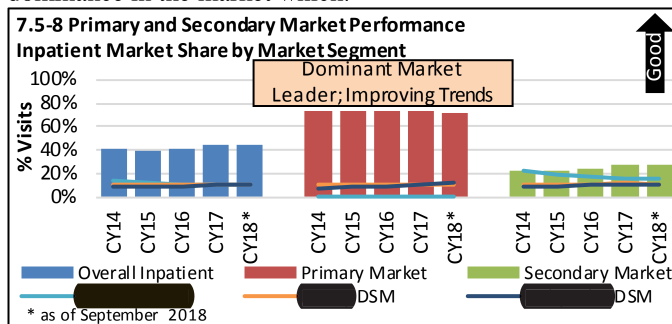
MGMC closely monitors costs across its operations. Despite its tight labor market, and increases in medical supplies and technology across the country, we consistently meet or outperforms budget for cost per adjusted admission **(Figure 7.5-6),** salary and benefit expense per net revenue **(Figure 7.5-7)** and supply costs per net revenue **(Figure 7.1-49).**

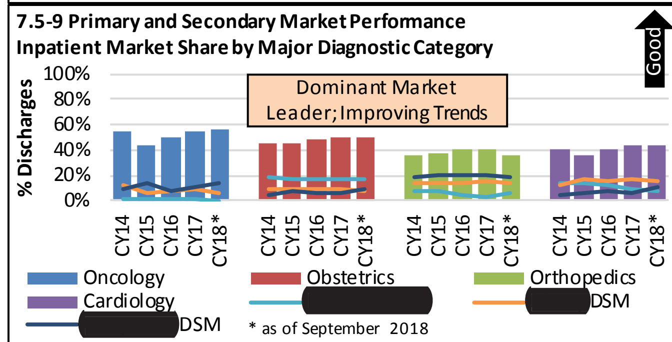




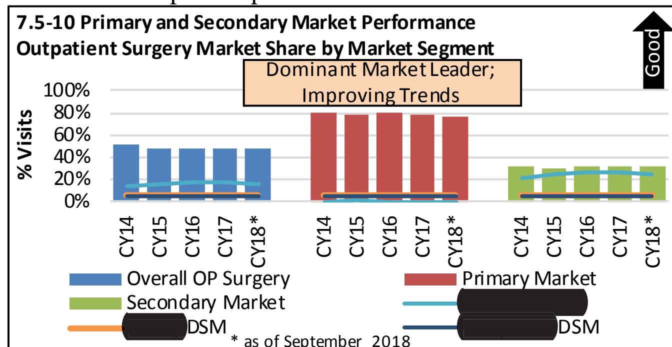
Budgetary performance: As indicated throughout **7.5a(1)** and in **Figure 7.1-49**, MGMC consistently outperforms budget for key measures of financial performance.

7.5a(2) Marketplace Results Overall and primary/secondary market share (**7.5-8**) and segmented market share by Major Diagnostic Category (**Figure 7.5-9**) demonstrate our dominance in the market which.





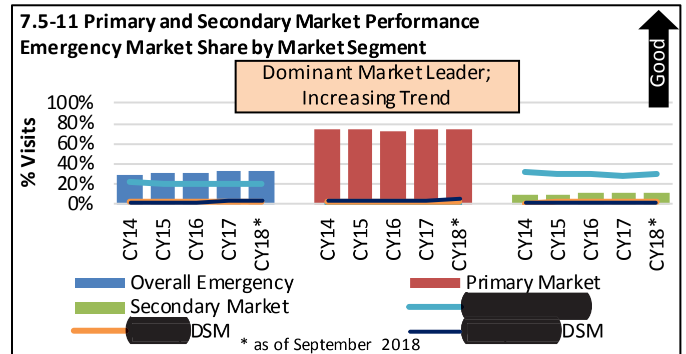
In 2016 the SPTF identified the need to monitor outpatient market share (**Figures 7.5-10**) due to projected shifts to outpatient services. Since then, the BI team reviews these services, engages physicians, and implements action plans for sustained or improved performance.



ED (**Figure 7.5-11**) and Home Health market share (**Figure 7.5-12**) are important to the SP due to the expected shift from IP to OP services. Market share is monitored and benchmarked to key competitors to support strategic priorities. An increase in ED market share from the [redacted] market is the result of greater confidence and loyalty in MGMC after their hospital was acquired by a key competitor.

MGMC has expanded the capacity and capability of its behavioral health services (**Figure 7.5-15**). Additionally, a recent expansion of rehab services created additional capacity, resulting in a net revenue increase of >$600,000; more importantly, it has improved access for patients.

Figure 7.5-15 New Markets and Intelligent Risks			
Market/Service	**2016**	**2017**	**2018**
Behavioral Health Beds	10	12	17
Behavioral Health Providers	2	3	4
Rehab Average Daily Census increase patients	n/a	12/day	14/day



For Home Health, MGMC is the leader in its primary market. However, Home Health market share for MGMC is lower than for other service offerings because of the many small competitors in the market.

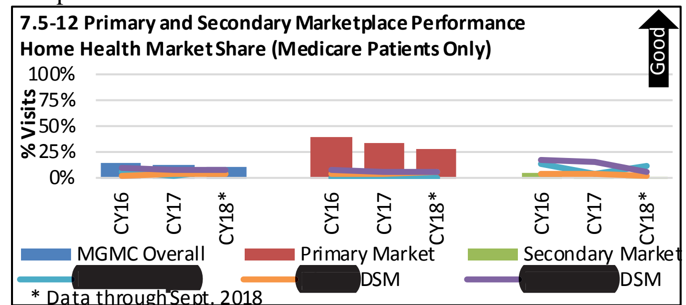


Figure 7.5-13 demonstrates growth and sustained volume in key service offerings. Budget adherence, as well as SL SP Review and the Leader Business Review supports sustainability. Growth in Home Health/Hospice (budget to actual) is a direct reflection of the increased care coordination efforts served by the Transitions of Care program.

Figure 7.5-13				
Service	**FY16**	**FY17**	**FY18**	**FY19D**
Inpatient Discharges (All)	9,450	9,087	9,617	9,403
Outpatient Services	159,258	155,641	153,228	150,492
ED Visits	27,833	28,125	28,059	27,881
Home Health/Hospice	14,680	15,274	17,260	16,217

7.5b Strategy Implementation Results

Results for the achievement of our organizational strategy and action plans (**Figure 7.5-14**) is measured using the systematic Leadership Evaluation Manager (LEM) tool. This tool measures achievement of the Big Dot Goals annually and is cascaded from SL to all leaders. A cycle of learning in 2017 with the introduction of the Big Dot Goal philosophy created laser focus on priorities and resulted in breakthrough achievement of action plans.