# A

**AABB** ……………… American Association of Blood Banks
**AARP** ……………. American Association of Retired Persons
**ACCME** ……………………………Accreditation Council for Continuing Medical Education
**ACGME**……………………………..Accreditation Council for Graduate Medical Education
**ADA** ………………………. Americans with Disabilities Act
**ADJ MKT SHARE** ……………….. Adjusted Market Share
**ADM PHYS RATIO** …………… Admitting Physician Ratio
**ADMIN** ………………………………… Administration
**ALOS** ……………………………… Average Length of Stay
**AMI** …………………………… Acute Myocardial Infarction
**AOC** ……………………………........... Administrator On Call
**AP** …………………………………….... Accounts Payable
**APR-DRG** ……………………………… All Patient Refined Diagnosis Related Group
**A/P SVCS** …………...…….. Anatomical/Pathology Services
**AR** …………………………………… Accounts Receivable
**AS**……………………………………… Ambulatory Surgery
**ATC** …………………… Administrative Training Committee

# B

**BBA** ……...…..……………………….. Balanced Budget Act
**BBI** ……………………………... Behavior Based Interviewing
**BOD** …………………..…………………….. Board of Directors
**BP** …………………………………………… Blood Pressure
**BSC** …………………………………… Balanced Scorecard

# C

**C & A QUAL** ……….…. Clinical & Administrative Quality
**CABG** ……………………… Coronary Artery Bypass Graft
**CAP** …………...…………….. Career Advancement Program
**CAP** ……………………..... College of American Pathologists
**CAP** ……………………… Community Acquired Pneumonia
**CBT** …..…………………….…. Computer Based Training
**CCC** ……………………………..……….… Child Care Center
**CCO** ………………………… Corporate Compliance Officer
**CCP**…………………………...Corporate Compliance Process
**CDC** ……………..……..……… Centers for Disease Control
**CD-ROM** ……..…. Computerized Disc – Read Only Memory
**CE** …………………………………… Continuing Education
**CEO** …………………….………… Chief Executive Officer
**CEU** ……………………..…… Continuing Education Unit
**CFO** ………………..……………….... Chief Financial Officer
**CHF** ……………….……………… Congestive Heart Failure
**CHIPS** ……………………………...… Center for Healthcare Industry Performance Studies
**CLO** ……………...……………….… Chief Learning Officer
**CME** ……………..……….. Continuing Medical Education
**CMI** ……………………………………….... Case Mix Index
**CMS** …………….…. Center for Medicare/Medicaid Services
**CNO** ………………...………………… Chief Nursing Officer
**COBRA** ……………..……. Consolidated Omnibus Budget Reconciliation Act
**COO** ……………………….……. Chief Operating Officer
**COMM**…………………………………… Communication
**COMP** …………………….…………….. Compensation
**COMP** ………………………..………….. Comparative
**COMP** ……………………….………….. Competency
**COMPL** ……………………………………… Complete
**COTH** ……………………... Council Of Teaching Hospitals
**CPO** ……………………..…………… Chief Privacy Officer
**CPT4**……………………… Current Procedural Terminology
**CSRP** ……….……. Customer Satisfaction Research Program
**C-SECTION** …………………………….. Cesarean Section
**CTR** ……………………………….....………... Center
**CTE** ……………………………. Commitment To Excellence
**CUST SAT** ………...……………… Customer Satisfaction
**CV** ……………………………….………….. Cardiovascular
**CV** ……………....…………….……. Coefficient of Variation
**CVICU** ……………..…. Cardiovascular Intensive Care Unit

# D

**DCOH** …………..…………..………….. Days Cash on Hand
**DDI** ………………..….. Development Dimensions International
**DRG** ……………….....………… Diagnosis Related Group
**DSS** ……………………..………… Decision Support Services

# E

**e-Billing** ……………………………..……. Electronic Billing
**e-Health** …………………………….…. Electronic Health
**e-ICU** ……………………….….. Electronic Intensive Care Unit
**e-Mail** ……………………………………….. Electronic Mail
**e-Portal** …………………………………… Electronic Portal
**EA** ……………………….…………. Environmental Assessment
**EAP** ……………………….. Employee Assistance Program
**EBI** ……………….………. Educational Benchmarking, Inc.
**EC** ……………………….……………. Executive Council
**ED** …………………….…………… Emergency Department
**EEO**……………………… Equal Employment Opportunity
**EHS** …………………….……….. Employee Health Services
**EIS** …………………………..…. Executive Information System
**EKG** …………………..………………….. Electrocardiogram
**EMP** ……………………….…. Emergency Management Plan
**EOS** ……………………….…..…. Employee Opinion Survey
**EPA** ……………..……….. Environmental Protection Agency
**ER**……………...………………….…… Emergency Room
**ERISA** …….. Employee Retirement Insurance Security Act
**ETO** …………………………..………..…. Ethylene Oxide
**EVAL** ………………………………………….. Evaluation

# F

**FAC** …………………………………………….. Faculty
**FEC** …………………………... Full Employment Council
**FT** ……………………………………….……… Full Time
**FTE** ………………………………..…….. Full Time Equivalent

# G

**G & D** ……………………..……….. Growth & Development
**G/L** ...………………………………...……… General Ledger
**GPO** ……………………….. Group Purchasing Organization
**GROWTH** ………… Girls Reaching Out With Their Hopes

# H

**HBA1C** …………………………………… Hemoglobin-A1C
**HBI** ..…………………….…..………Horizon Business Insight
**HCA** ……………...………. Hospital Corporation of America
**HCVA** …………………...….. Human Capital Value Added
**HIPAA** ………………………… Health Insurance Portability and Accountability Act
**HLG** ………………...……… Hospital Leadership Group
**HMO** …………………… Health Maintenance Organization
**HR** ………………..……………………. Human Resources
**HRMA** …...…. Human Resource Management Association

# I

**IA** …………………………………… Information Associate
**IA** ………………………………………….. Invoice Accuracy
**ICU** ……………………..…………….. Intensive Care Unit
**IMP** …………………………..………………. Improvement
**IMT** ………….…….. Inspection, Maintenance and Testing
**INTRO** ………………………..……………… Introductory
**IP** ……………...………………...…………..…….. Inpatient
**IRB** …………………………… Institutional Review Board
**IRHC**………………… Independence Regional Health Center
**IS** ……………………..……………… Information Services
**IT** …………………..……………… Information Technology

# J

**JCAHO** …..……… Joint Commission on Accreditation of Healthcare Organizations
**JCI** ……….……………………..…. Johnson Controls, Inc.
**JVS** ………………….……….. Jewish Vocational Services

# K

**K** ……………………………………………… One Thousand
**KC** ………………..……………………………... Kansas City
**KCBJ IP** ………….. Kansas City Business Journal Inpatient
**KCOI** …………...………… Kansas City Orthopedic Institute
**KU** ……………….……….. Kansas University Medical Center
**KUMC** ……….…………. Kansas University Medical Center

# L

**LAN** …………………………………... Local Area Network
**LCL** ……………………….………. Lower Control Limit
**LCME** ……..…. Licensing Committee for Medical Education
**LLP** ………………….……. Listening and Learning Process
**LPE** ……………...…. Leadership for Performance Excellence

**LWDI** …………….…………….. Lost Work Day Incident

# M

**M & I** …………..…………..……. Monitoring and Inspection
**MABSI** ……….....…. Mid America Brain and Stroke Institute
**MAHI** ……………….………. Mid America Heart Institute
**MBN** ………………………….. Missouri Board of Nursing
**MBNQA**…………..Malcolm Baldrige National Quality Award
**MCET** …..…….. Multidisciplinary Continuing Education Team
**MCT** ………………………….. Multidisciplinary Care Team
**MCP** …………….………….. Multidisciplinary Care Process
**MD** …………………….………………… Medical Doctor
**MIR** …………………………….. Medication Incident Report
**MGMT**........................................................... Management
**M** ……………………………..……………… Million
**MO** ……………………..……………………….. Missouri
**MOCSA** ………………………… Metropolitan Organization to Counter Sexual Assault
**MQA** ………………………….…. Missouri Quality Award
**MRA** ……………………….. Multiple Regression Analysis
**MSB** ……………………………………. Medical Staff Board
**MSEC** ………………… Medical Staff Executive Committee
**MVI** ……………….…………………… Market Value Index

# N

**NA** ……………………….……..………… Not Applicable
**NICU** ……………………… Neonatal Intensive Care Unit
**NKCH** ……………………… North Kansas City Hospital
**NNIS** ……… National Nosocomial Infection Surveillance
**NRC** ………………….…….. National Research Corporation
**NRC** ……………………… Nuclear Regulatory Commission
**NSD** …………………………….. Nursing Staff Development
**NSICU** ……….……… Neurosurgical Intensive Care Unit
**NTH** ………………….....…… National Teaching Hospitals

# O

**OA** ……………………………...…………… Order Accuracy
**OB** ………...………………..……...……………… Obstetrics
**OCC** …………………………………………...…. Occupied
**OCPG** ……………… Office of Clinical Practice Guidelines
**OD** ……………………………. Organization Development
**OP**…………………………….…………….……….. Outpatient
**OP** ………………………………….…. Organizational Profile
**OR**…………………………...…...………. Operating Room
**OSHA** ……... Occupational Safety and Health Administration
**OTD** …………………..……...……………… On Time Delivery

# P

**PA** ……………………………….………… Patient Advocate
**PC** ……………………………………….…. Personal Computer
**PCT** ……………………...………………... Patient Care Team
**PCT** ………………………………… Patient Care Technician
**PCP**………………………………….. Primary Care Physician

**PEL** ……………….……….….. Permissible Exposure Limits
**PG** ……………………….……………………. Press Ganey
**PhD** …………………………………….... Doctor of Philosophy
**PHYS** ……………………………………………… Physician
**PI** ……………………………….. Performance Improvement
**PIM** ……………………………… Pathways Image Manager
**PIN** ……………….……….... Personal Identification Number
**PISC** ….…. Performance Improvement Steering Committee
**PM** …………………..…………….. Preventive Maintenance
**PMP** ……..…………… Performance Management Process
**POM** …………………. Plant Operations and Maintenance
**PHO** ………………………. Physician Hospital Organization
**PPM** ……………………………………. Parts per Million
**PPO** …………….………… Preferred Provider Organization
**PRN** ……………………………...………… On Call Staff
**PRO** ...………………… Professional Review Organization
**PROV** …………… Providence St. Margaret's Health Center
**PROF** ……………………...………………… Professional
**PSA** ……………………………..…. Prostate Specific Antigen
**PSC** ………………….…………… Process Level Scorecard
**PSO** ………….………….... Physician System Organization
**PT** ……………………………………………………. Patient
**PTCA** ………………..… Percutaneous Coronary Angioplasty
**PUBS** ……………………………………...……. Publications

# Q

**QA** ………………………….……………. Quality Assurance
**QR** ………………………….…………….. Quality Resources

# R

**RAD** ……………….…… Research and Analysis Department
**RES** ………………………………………………. Resources
**REL** ……………….…….. Recommended Exposure Limits
**RMC** …………………………….... Research Medical Center
**RN** ……………………...…………………... Registered Nurse
**RO** ……………………………………………. Routine Order
**RRC** ………………………… Residency Review Committee
**RTN** ……..……………………………………………. Return
**RTN FOL AMB PROC** ………………… Returns Following Ambulatory Procedures

# S

**SAP** ……………………………………Strategic Action Plan
**SAT** ……………………………………………. Satisfaction
**SATISF** ………………………………………. Satisfaction
**SAS** ………………………….…….. Strategic Aim Statement
**SCHED** …………………………...………… Scheduling
**SCP** ………………………… Supplier Certification Process
**SFA** ..………………………………… Strategic Focus Areas
**SG** …………………………………… Shared Governance
**SJHC** ……………….……… Saint Joseph's Health Center
**SKS** …………………………..… Staff Knowledge and Skill
**SLC** …………………………………… Saint Luke's College
**SLH** ………………..……...…..……….. Saint Luke's Hospital
**SLHS** ………………………… Saint Luke's Health System
**SMMC**…………………… Shawnee Mission Medical Center
**SOM** …………………………….……..School of Medicine
**SPP**…………………..……….. Strategic Planning Process
**SPSS** ………………………………… Statistical Package for the Social Sciences
**SR** …………………………………………………... Senior
**SVC** ………..………………………………………. Service
**SVCS** ………………………………………………. Services
**SWAT** ………………………… Stroke Watch Action Team
**SWOT** ……….... Strength, Weakness, Opportunities, Threats

# T

**TCI** ………………….…………………….. The Cancer Institute
**TEMP** …………………..………………………… Temporary
**TBD** ……………………………………... To Be Determined
**tPA** ………………………….. Tissue Plasminogen Activator
**TSH** ………………………… Thyroid Stimulating Hormone

# U

**UCL** ………………………….………. Upper Control Limit
**UMKC** ……………..….. University of Missouri-Kansas City
**USA** ………………..…………. United States of America

# V

**VBAC**……………………....….. Vaginal Birth after Cesarean
**VHA** ……………………… Voluntary Hospitals of America
**VIP** ……………………………… Very Important Principles
**VP** …………………………………………… Vice President
**VPMA** …………………… Vice President Medical Affairs

# W-Z

**WAN** ………………………..…………….. Wide Area Network
**WC** …………...……………………. Workers' Compensation
**WIC** ………………………… Women, Infants, and Children
**WO**……………………………………...…….. Work Order

## *P.1 Organizational Description*

### *P.1a Organizational Environment*

**P.1a (1)** Saint Luke's Hospital of Kansas City (SLH), founded in 1882, is the metropolitan area's largest hospital, with 582 beds, 3,186 employees, and a staff of 500 physicians who provide 24-hour coverage in every health care discipline. It is a voluntary not-for-profit comprehensive teaching and referral health care organization affiliated with the Diocese of West Missouri of the Protestant Episcopal Church. The Bishop of the Diocese serves as the Chairman of the Board of Directors of the hospital. In addition, SLH is the tertiary care referral center of the Saint Luke's Health System (SLHS), operating under a common "Commitment To Excellence" philosophy. SLH also distinguishes itself as the primary private teaching hospital of the University of Missouri-Kansas City School of Medicine, with numerous graduate, post-graduate, and continuing medical education programs, endowed teaching chairs, and clinical research programs.

The SLHS is a voluntary not-for-profit, fully integrated system consisting of 8 hospitals, 14 primary care facilities, 5 behavioral health clinics, 7 employee assistance program locations, 3 wellness/fitness locations, 5 home health/hospice locations, and 4 affiliated health care facilities. In addition, SLHS employs 100 primary care physicians and relates to over 1200 physicians through various physician/hospital health plan arrangements. Currently, SLHS employs 6333 individuals with approximately 51% located at SLH. Horizontal integration across the System is achieved through collaboration, cooperation, and partnership.

SLHS supports SLH in the following areas: financial management, payor contracting, marketing, planning, public affairs, quality resources, information technology, risk management, human resources, and real estate management. SLH's facilities include the main hospital, Mid America Heart Institute, Mid America Brain and Stroke Institute, ambulatory surgery center, outpatient care center, employed physicians offices, nursing college, medical library/education center, child care center and a health enhancement exercise center.

SLH's primary service area includes Jackson, Cass, Clay, and Platte counties in Missouri as well as Johnson and Wyandotte counties in Kansas. The majority of the inpatient volume comes from these counties. In addition, SLH serves as a tertiary care facility for 60 additional counties located approximately 120 miles from Kansas City. SLH focuses on 113 significant zip codes from which SLH draws 80% of its patient volume.

SLH is unique in the Kansas City area because of its tertiary specialty care capabilities. Examples include:

- The Mid America Heart Institute, which treats complex cardiovascular diseases;
- The Mid America Brain and Stroke Institute, including a nationally recognized program dedicated to preventing and treating stroke;
- A Level I (highest designation) Trauma Center certified by the State of Missouri;
- Stereotactic Radiosurgery Services;
- Blood and Marrow, Heart, and Kidney Transplantation Programs;
- The only comprehensive maternal-fetal diagnostic and treatment center in the KC metro area, receiving referral and high risk maternal transport patients from an eight-state regional geographic area;
- A Level III (highest designation) – Neonatal Intensive Care Nursery (NICU);
- A nationally certified Sleep Disorder Center; and
- Specialists in other disciplines such as orthopedics and oncology, who also attract patients from the service region.

In addition, SLH sponsors its own College of Nursing and offers training programs in radiology technology, pharmacy residency, laboratory medicine, and a spiritual wellness program, all of which directly relate to its mission of education and research.

In order to meet all health care delivery and patient requirements, SLH utilizes a **Multidisciplinary Care Process (MCP)**. Key sub-processes include:

- Initial assessment
- Planning of care
- Intervention of care
- Evaluation of care
- Modification of care
- Resolution (discharge)

The MCP is used for all patients and produces a care plan to achieve the best possible clinical outcomes and high patient satisfaction, both of which are driven by the patient requirements shown in Figure OP-2. Clinical pathways (predetermined, evidence based, disease specific care guidelines) or other care models are used to design and deliver the plan of care, with 60% of all health care delivery managed through a clinical pathway. Care teams have developed 134 clinical pathways for particular patient populations based generally on the type of illness. Other care models include individual physician care plans, accepted protocols and guidelines, and experimental/research protocols.

**Multidisciplinary Care Teams (MCTs)** carry out delivery of health care. These teams typically include physicians, a clinical nurse, a patient care technician, an information associate, and, as appropriate, physical therapists, dietitians, respiratory therapists, social workers, and pharmacists. Care teams individualize care for each patient by developing the care pathway or plan in conjunction with the patient and family. In this way, patient/family input is obtained, expectations can be shared, and all requirements can be incorporated into the path. As an added feature, the path is translated into "patient language" and provided to the patient and family so they can follow the delivery of care from day to day.

**P.1a (2)** SLH's mission directs the organization to serve any patient at any time irrespective of the ability of that patient to pay for the care provided. A significant portion of SLH's annual budget is dedicated to charity care, and is an important factor in SLH's strategic planning and financial management.

SLH's **mission, vision and core values** are shown in Figure OP-1. These are closely linked to those of the System and are used as a basis for strategy and plan development, as well as day-to-day operations. For example, the core values are integrated into the **Performance Management Process (PMP)**. Every employee has specific actions and goals relative to the four values, and is assessed on his/her individual progress in meeting them.

**P.1a (3)** SLH draws upon 1.6 million residents of the eight-county bi-state metropolitan area for its medical staff membership and employee pool. National recruiting is also done for certain highly skilled and/or difficult to fill positions. A diverse skill mix, including professional, clinical, technical, administrative, clerical and other support staff, is employed to provide the highest quality value-added health care services to SLH. SLH employs approximately 3,186 people in full-time, part-time, and PRN positions, which represents 2,459 budgeted FTE's. The skill mix of the staff varies from entry-level positions with no degree requirements to Ph.D. and M.D. level positions. Approximately 60 percent of SLH's workforce has a Bachelor's degree or greater. All physicians who are part of the medical staff are screened and credentialed to perform in their area of expertise based on their training, experience, and Board certification. In addition to private practice physicians who have been credentialed to serve on the medical staff, SLH employs 34 full-time and part-time physicians and 48 contracted physicians to serve in either clinical care positions or administrative/educational positions. SLH has developed, in conjunction with the medical staff, a **Medical Staff Development Plan** in order to guide future physician recruitment placement and identify technology requirements.

Nurses represent the majority of SLH's employee base, with 68% of all staff providing direct patient care. From time to time, in order to meet peak staffing needs, SLH is required to contract for agency nurses using accredited local companies. In addition to physicians and nurses, caregivers include patient care technicians, chaplains, clinical pharmacists, dietitians, social workers, occupational therapists, physical therapists, speech pathologists, and respiratory care practitioners. The remaining 32% of employees support those who provide direct patient care. Support staff work in areas such as the laboratory, radiology, facilities management, information services, financial services, materials management, health information management, environmental services, quality resources, nutrition services, human resources, and administrative services. In addition, SLH supports active, accredited training programs in all the major medical specialties, nursing and laboratory/ radiology technicians. Over 100 medical residents and fellows are on rotation each month and participate in the workflow and care of patients at SLH.

SLH strives to maintain a diverse and skilled workforce which reflects the community it serves. In the primary six county SLH service area there is a 25% minority population, which is expected to grow in the future. SLHS has established a diversity program to address this changing ethnic demographic by adding a Vice President of Diversity and monitors organizational performance through its **Diversity Index** in the **Balanced Scorecard (BSC)**. SLH is directly involved in carrying out SLHS diversity objectives. In addition, SLH values its volunteers and auxiliarians who act as important ambassadors for the hospital and who provide significant help and assistance to the workforce with daily tasks. SLH strives to create a sense of community throughout its workforce. It is not unusual for SLH employees to remain with the hospital for long periods of service and to see family members of employees become affiliated with SLH in some way. This sense of community is pervasive among SLH employees and contributes to their loyalty, and ultimately to the delivery of high-quality patient care.

**P.1a (4)** By the nature of its tertiary care services, it is essential for SLH to utilize major technologies in the areas of business and clinical computer systems software applications, clinical applications, transportation, diagnostic laboratory and radiological equipment, advanced patient monitoring systems, and technical innovations necessary to support transplantation of tissue, bone and marrow. SLH has invested $140 million

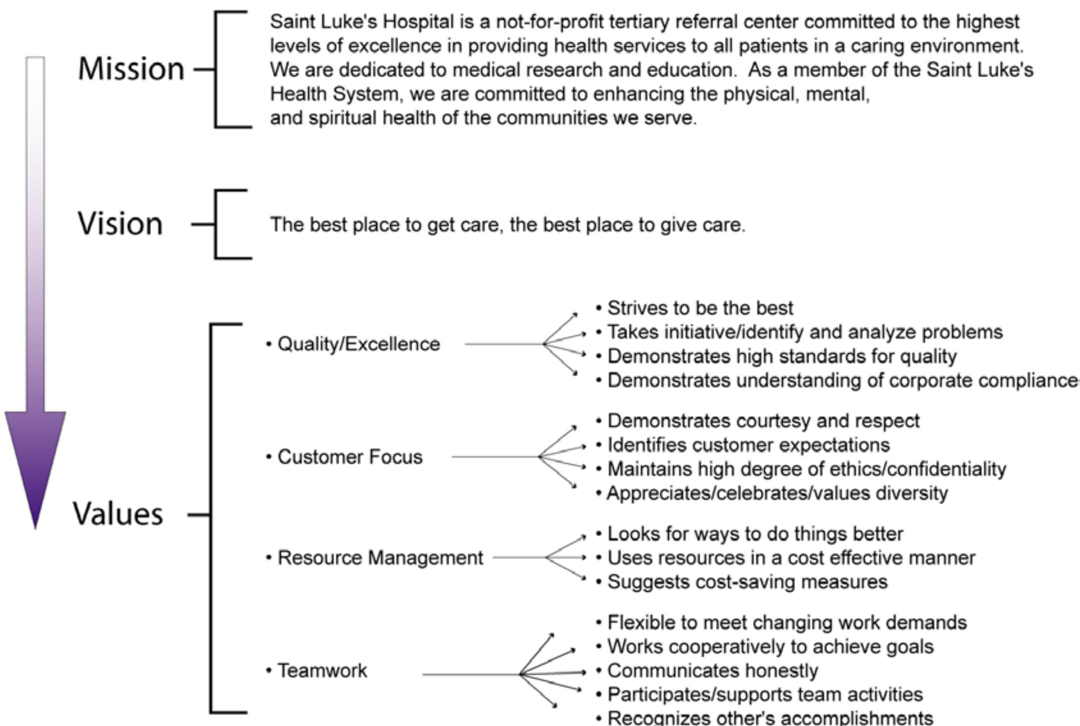



**Figure OP-1 SLH Mission, Vision and Core Values**

dollars over the last five years in facility renovation, information technology, capital equipment, and new technology.

**P.1a (5)** SLH operates in a heavily regulated environment and abides by the standards and regulations established by the following organizations:

- Americans with Disabilities Act (ADA);
- Occupational Safety and Health Administration (OSHA);
- Nuclear Regulatory Commission (NRC);
- Joint Commission an Accreditation of Health Care Organizations (JCAHO);
- College of American Pathologists (CAP);
- American Association of Blood Banks (AABB);
- Accreditation Council for Graduate Medical Education (ACGME),
- Residency Review Committees (RRC),
- Licensing Committee for Medical Education (LCME); and Missouri Board of Nursing (MBN).
- Accreditation Council for Continuing Medical Education (ACCME)
- Health Insurance Portability and Accountability Act (HIPAA)
- Environmental Protection Agency (EPA)

In addition, a number of other local, state, and federal health care and educational requirements impact SLH's operations. This regulatory environment influences SLH process and service design and delivery requirements, and impacts the way in which SLH manages its business and facilities. For example, SLH is in the process of completing a 10-year master plan to update and meet the life safety code within the hospital and improve/update its facilities to maintain compliance with ADA and other standards. SLH continually works to improve its management and business operations and comply with JCAHO standards as they relate to patient care processes, environmental issues, and facility design and operations. On an ongoing basis, over 15 regulatory/accreditation agencies have oversight of SLH performance and impact SLH's response to health care, educational and other needs. In addition, participation in the Medicare program requires compliance with ERISA and SLH is required to comply with accepted auditing standards.

### *P .1b Organizational Relationships*

**P.1b (1)** SLH is governed by a Board of Directors (Board), which is a community-based group of 52 members charged with providing the overall governance for the hospital. Members of the SLH administrative senior leadership team, in an ex-officio capacity, participate, facilitate, and collaborate with the Board at all of its meetings, as well as at its committee and workgroup meetings. Select members of the Board also serve on the SLHS Board, thereby providing a critical link between the System and the hospital's strategic direction and governance. SLH's Chief Executive Officer reports to the Board.

Organizationally, SLH has a close collaborative partnership with the SLHS, which plays a key role in establishing direction and performance expectations for the hospital. Many of SLH's leadership group share administrative responsibilities at the System level and, therefore, help drive System planning, goal-setting, and policy development while at the same time coordinating a strategic direction for other System entities. This allows for a well-integrated System strategy, and strong involvement by SLH leaders in the formation of that strategy. The SLH Chief Executive Officer also serves as the SLHS Chief Executive Officer.

**P.1b (2)** SLH's key customers and requirements are shown in Figure OP-2. Customer requirements are gathered through a **Listening and Learning Process (LLP)** that includes formal methods (primary and secondary research) and informal methods (conversations with customers). These methods make use of qualitative and quantitative research tools such as focus groups and telephone and paper surveys to obtain required information. Further, every employee is expected to continuously monitor and provide input concerning changing customer needs. A formal **Customer Satisfaction Research Program (CSRP)** is used to continually gather customer and market requirements and measure customer satisfaction. Based on research conducted and SLH's ongoing relationships with customers, SLH has identified the key requirements shown for each customer group.

| Customers | Key Requirements |
|---|---|
| Patients and Families | • Reliability<br>• Access<br>• Responsiveness<br>• Empathy<br>• Competency |
| Residents/Students | • Competency<br>• Meet educational needs |

**Figure OP-2 SLH Customer Groups and Key Requirements**

The requirements described are further defined such that all caregivers understand what the key satisfiers are in terms of service delivery. Regression analysis of satisfaction survey results validates focus group and needs survey information to identify key satisfiers on a recurring basis. Key drivers of patient satisfaction have been fairly consistent over time and are carried as BSC measures for this reason. They are:

- Wait Times;
- Responsiveness to complaints; and
- Outcome of care.

It is recognized that within the category of patients and families there are different segments that may have special needs. These include inpatients, outpatients, and emergency department patients. SLH has determined that the key requirements listed in Figure OP-2 apply to all segments of patients and families, although the level of importance may vary from one to another. With regard to geographic/service areas, the hospital has determined that the basic requirements for patients and families are the same due to the fact that patients primarily come to SLH seeking its tertiary services capabilities.

**P.1b (3-4)** Suppliers and partners are important to SLH for two reasons. First, the products and services procured can directly

impact the quality of care and the effectiveness of care delivery, and second, non-labor expenses are a significant component of SLH costs. Suppliers are categorized as follows:

- **Partners** – those organizations or individuals that directly support care delivery and for which there are reciprocating relationships, or dual requirements. Physicians, our most important partner, are managed through a Physician Partnering Process.
- **Key Suppliers** – those suppliers that represent the highest volume of purchasing combined with the criticality of items purchased. It is imperative that SLH have access to the highest quality products and services matched with the most reasonable cost. To achieve that objective, SLH has implemented a Supplier Management Process that includes sub-processes to certify and select suppliers, negotiate contracts, procure supplies, manage receipt and delivery, evaluate supplier performance, and manage supplier communications. SLH maintains ongoing communications with all key supplier and partner groups. Representatives of SLH meet with these groups monthly to discuss supplier performance, improvement opportunities, SLH requirements, issues regarding the supplier's products and services, and to obtain feedback on SLH performance in meeting supplier needs. In addition, more frequent communication is conducted via telephone, e-mail and mail, and partners have access to the SLH intranet.

Figure OP-3 identifies SLH partners and key suppliers and their key requirements. As indicated above, the partner groups have dual requirements. Physician requirements of SLH include reliability, access, responsiveness, competency, and high patient satisfaction; Johnson Controls' requirements of SLH include timely payment of bills and communications. Both of these partner groups are integrated into SLH key processes, including leadership, strategic planning, patient focus, measurement, staff focus, and process management. SLHS is a shareholder and owner of VHA/Novation, the largest Group Purchasing Organization (GPO) in the nation. SLHS accessed 885 VHA/Novation contracts with a total spending of $97 million in 2002. VHA/Novation validates the quality, market share, and availability of the various vendors, and provides SLHS as much as a 6% increase in discounts plus an average 2% rebate for every contract dollar spent, thereby supporting the achievement of SLH objectives. Most key suppliers are accessed through VHA/Novation.

| Key Supplier/Partner | Items Procured | Key Requirements |
|---|---|---|
| **Partners** | | |
| • Physicians | • Care Delivery | • Patient Admissions<br>• Patient Referrals<br>• Competency<br>• High Patient Sat<br>• Resource Mgmt |
| • Johnson Controls | • Facilities Maintenance | • Timeliness<br>• Accuracy<br>• Process Integration |
| **Key Suppliers** | | |
| • Burrows<br>• Amerisource Bergen<br>• Sysco<br>• Cardinal<br>• Source One<br>• Medtronics<br>• McKesson | • Med/Surg supplies<br>• Pharmaceuticals<br>• Food and Nutrition<br>• Lab products<br>• Radiology products<br>• Cardiovascular Svcs<br>• IT Products & Svcs | • Reasonable Cost<br>• Timely Delivery<br>• Accuracy of Receipt<br>• Product/Svc Quality |

**Figure OP-3 SLH Partners and Key Suppliers**

## P.2 Organizational Challenges

### P.2a Competitive Environment

**P.2a (1)** SLH competes in a dynamic, ever-changing health care market. The greater Kansas City health care market is currently dividing into large "systems of care" that compete for patients by providing a broad continuum of services such as primary care, inpatient hospitalization, rehabilitation, home care and end-of-life care. Two major systems of care have evolved in the Kansas City area: SLHS and HCA. SLHS has 3 hospitals located in the metropolitan Kansas City market and HCA has 10 hospitals in the metropolitan area. In total, there are 23 medical-surgical acute care hospitals within the greater Kansas City metropolitan area. Locally, SLH competes for tertiary patients with Research Medical Center (RMC), Kansas University Medical Center (KUMC), Shawnee Mission Medical Center (SMMC), Independence Regional Medical Center (IRMC), Providence Medical Center (PMC), and North Kansas City Hospital (NKCH).

Even though SLH must compete for patients and caregivers, it recognizes that collaborations are a vital component for success. Therefore, in 1999 SLH partnered (minority ownership) with 18 orthopedic surgeons to build an orthopedic specialty hospital in Johnson County, Kansas, the Kansas City Orthopedic Institute (KCOI), thus allowing SLH to retain the best orthopedic surgeons in Kansas City on its staff. In addition, in 2001 SLH partnered with HCA's predecessor to establish The Cancer Institute (TCI), a comprehensive oncology, diagnostic and treatment hospital within the confines of SLH and RMC, in order to attract regional cancer patients to Kansas City, obtain National Cancer Institute designation, and provide local comprehensive cancer care that was previously provided in competing cancer facilities in the Midwest region.

**P.2a (2)** SLH believes that there are a number of principle factors that have helped it achieve success as a market leader and will serve to ensure this success continues in the future. These are shown in Figure OP-4.

**P.2a (3)** SLH key sources of comparative data are shown in Figure OP-5. These data sources provide comparisons within the health care industry to similar types of hospitals across the country, within Missouri, and in some cases, local market area hospitals. Comparisons are generally in the form of industry averages or quartile level performance. While these data are readily available, there is less ability to gather direct competitor performance data other than financial information, and there is

virtually no ability to obtain data pertaining to best-in-industry performance. Additional department and process level comparative data are collected from other sources on a regular basis, but are not listed here due to space limitations.

| Factor | Competitive Advantage |
|---|---|
| Leadership | • Continuity of purpose<br>• Long term vision<br>• Relationship building<br>• Experience |
| Education Mission | • Enhances staff recruiting<br>• Maintains "cutting edge" care<br>• Fosters research<br>• Fosters innovation and learning |
| SLH Foundation Assets | • Supports education and research mission<br>• Enhancement of SLH recruitment process |
| Dedicated primary physician staff | • Loyalty<br>• Enhances education and research mission<br>• Enhances team and relationships |
| Tertiary Care Teaching Hospital | • Large referral base<br>• Enhances staff recruitment<br>• Education resource |
| VHA Member | • Reduces supply cost<br>• Source of benchmarking and comparative data<br>• Educational resource |
| Centers of Excellence | • Attracts national and regional patient volume<br>• Fosters advanced care and research<br>• Enhances physician recruiting |
| Financial Stability | • Sustains long term planning vision of future<br>• "A" Bond Rating<br>• Sustains tertiary care educational mission<br>• Sustains high technology |
| Quality of Care | • Attracts patients and referrals<br>• Enhances recruiting<br>• Fosters innovation and learning<br>• Provides better patient outcomes<br>• Enhances pride of workforce |
| Stakeholder Partnerships | • Diversifies organization geographically<br>• Fosters ongoing productive relationship with physicians and other organizations<br>• Supports and strengthens financial foundation |

**Figure OP-4 SLH Organizational Success Factors**

### *P.2b Strategic Challenges*

SLH identified ten Significant Issues in its 2003-2005 strategic planning process that served as the foundation for its long-term strategies. These are identified in Figure OP-6.

### *P.2c Performance Improvement System*

**P.2c (1)** In order to focus the organization on the need to evaluate performance, seek opportunities for improvement, and share knowledge so that it can learn and grow, SLH uses a three-pronged approach to performance improvement. **On a daily basis**, SLH employees use the **SLH Design, Management and Improvement Model ("PI Model")** to manage and improve key processes. The **PI Model** provides a well defined approach to establishing the key requirements of processes, identifying measures against those requirements, collecting data to understand process performance, assessing the quality of that performance and establishing improvement requirements and actions. To further enhance SLH ability to improve processes, a **Process Level Scorecard (PSC)** was initiated in early 2003. **On a monthly and quarterly basis**, SLH leadership reviews the output of the **Balanced Scorecard (BSC)** measurement system. The BSC provides focus in the five perspective areas at the organizational level and allows leadership to emphasize programs, services, or processes where improvement may be needed. **On an annual basis**, SLH conducts a Baldrige assessment as part of the System's **Commitment to Excellence (CTE) Program**. CTE requires System entities to complete an assessment through the MBNQA or Missouri Quality Award (MQA) programs, or by means of an independent evaluation. Since 1995, SLH has completed eight CTE assessments including three MQA applications, two MBNQA applications, and three independent assessments. SLH has been a recipient of the MQA three times, and was one of only four health care organizations to receive a Baldrige site visit in 2002. This affords SLH an outside objective view of its performance and provides a feedback report detailing opportunities for improvement.

| Source | Data Type |
|---|---|
| Maryland Quality Indicator Project | • Clinical |
| Missouri-PRO | • Clinical |
| Solucient-ACTION | • Operations & Financial |
| CHIPS | • Financial |
| Moody, Standard & Poor, Fitch | • Financial |
| Saratoga Institute | • HR Performance |
| Press Ganey | • Patient Satisfaction |
| NRC | • Consumer Perception |
| CEO Workshop – VHA | • Process Outcomes |

**Figure OP-5 SLH Key Comparative Data Sources**

| SLH Significant Issues, 2003 - 2005 |
|---|
| • Providing an adequate, adaptive and diverse workforce |
| • Simultaneously, serving, strategically planning with and competing with physicians |
| • Preparing for another round of consolidation and/or new competitors in the marketplace |
| • Assuring patient privacy, safety and reduction of medical errors |
| • Managing the cost of providing quality care within current government and private sector allocations |
| • Embracing new technology responsibly |
| • Efficiently managing the indigent care burden |
| • Gaining access to capital for renovation and market expansion |
| • Assuring customer satisfaction |
| • Complying with regulatory requirements |
| • Addressing physician compensation and reimbursement issues |

**Figure OP-6 SLH Significant Issues**

**P.2c (2) SLH** utilizes multiple avenues to identify and share knowledge across the organization. The **90-day Action Planning Process** identifies department-level best practices by BSC perspective. These best practices are shared with the Hospital Leadership Group at monthly meetings. Quarterly, best practice sharing is an agenda item at the SLH quarterly

Leadership retreats. In addition, SLH PI teams exchange learnings at a one-day Quality Teamwork Award competition. Semi-annually, SLHS conducts a "Best Practices Sharing Day." During this event all SLHS entities present 2-3 best practices and, in turn, consider newly learned best practices for implementation in their respective entities.

# CATEGORY 1—LEADERSHIP

## *1.1 Organizational Leadership*

The SLH Leadership system consists of an **organizational structure** designed for agility, rapid decision-making, and interaction between the medical staff, administration and Board of Directors; a set of **Very Important Principles (VIP)** designed to make SLH a mission- and values-driven organization; a **Balanced Scorecard (BSC)** designed to establish focus on strategic objectives and performance expectations; and a **Performance Management Process (PMP)** designed to emphasize empowerment, innovation, and organizational and staff learning throughout the organization.

**1.1a(1)** Organizationally, SLH has a close collaborative partnership with SLHS, which plays a key role in establishing direction and performance expectations for the hospital. Many of SLH's leadership group share administrative responsibilities at the System level and, therefore, help drive System planning, goal-setting, and policy development, while at the same time coordinating strategic direction for the other System entities. This allows for a well-integrated strategy across the entire System, and strong involvement by SLH leaders in the formulation of that strategy. Formal direction from the System comes in the form of an annual strategic plan, which becomes an integral part of the SLH **Strategic Planning Process (SPP)**. Senior SLH leaders set, communicate, and deploy the hospital's mission, vision and values, as well as its short-and long-term direction and performance expectations through the **SPP**, and its associated processes, the **VIP**, **BSC** and **PMP**.

The SLH leadership structure is characterized by a strong collaboration between administration and the medical staff. The medical staff is well represented on each component of the governance structure as administrative and medical staff leaders share BSC Perspective Leader responsibilities. For example, the President-Elect of the Medical Staff and the COO jointly manage the Growth/Development Perspective. In this way, SLH ensures that top-level direction will flow down through the organization administratively and medically, thereby enhancing the opportunity for full alignment of the organization. SLH's key leadership groups include the following components:

**Board of Directors (Board)** - A community-based Board of 52 directors provides overall governance of SLH. The Board operates in accordance with SLH's bylaws and has responsibility and legal authority for overall hospital operation, fiscal accountability, staff/employee performance, and the provision of quality patient care, educational direction, research, and hospital/community health initiatives. The Board is the approving authority for the SLH Strategic Plan.

**Executive Council (EC)** - The EC is led by the CEO and COO and is the main decision-making body for SLH on a day-to-day basis. It is also responsible for establishing strategic direction and defining operational goals, targets, and measures through the management of the SPP.

**Medical Staff Executive Committee (MSEC) and Medical Staff Board (MSB)** - The MSEC is the governing body of the medical staff. It is responsible for coordinating the activities and general policies of the medical staff, as well as the various medical departments and related committees. The MSB serves as a liaison to the medical staff, EC, and the Board on matters such as policy, clinical competence, patient care, and quality.

**Hospital Leadership Group (HLG)** - The HLG consists of all EC members plus departmental managers and other administrative and medical staff leaders, including Johnson Controls. The majority of this group has direct operational authority and accountability over departmental and unit functions, staff competency, corporate compliance, budget development, and daily work assignments. The HLG exists to communicate senior leadership direction and goals, to integrate, team build, seek follow-up information/ suggestions, and promote a singular culture of organizational direction and performance.

**Performance Improvement Steering Committee (PISC)** - The PISC consists of senior administrative leaders and medical staff officers, including the BSC Perspective Leaders, and quality resources personnel. In addition, the CEO of the hospital and the leaders of the Cardiovascular, Women's and Children's, and Cancer service lines are PISC members. The PISC is responsible for ensuring organizational learning, continuous improvement, and innovation throughout the hospital.

In June of each year, the EC and MSEC collaborate to review and validate the SLH mission, vision, and values as part of the SPP. The review is driven by information emerging from the System strategic planning process and an analysis of the annual **Environmental Assessment**. Once validated, these become the cornerstone of the VIP and serve to guide development of the strategic plan. The core values are then communicated and deployed throughout the organization using two formal tools.

1) **PMP** - The core values are the foundation of each employee's job description and the PMP. The PMP produces a set of specific, measurable behaviors that exemplify the core values for each and every SLH employee. These behaviors are documented on a PMP form, which is developed collaboratively by supervisors and employees. Performance reviews and developmental objectives are included in the process so that all employees are measured on their effectiveness in implementing the core values and continually learn and develop the behaviors that are consistent with them.

2) **VIP** - The core values are integrated into the SLH hiring process using the **Behavior-Based Interviewing (BBI) Process** introduced during new hire orientation, and are published on the **VIP Card**. The card is distributed to all employees and contains SLH's mission statement, vision, core values, hospital strategic goals, PI Model, and customer contact requirements. On a daily basis, all employees have ready access to the VIP card, which presents a constant reminder of the principles that are critical to SLH in the delivery of high quality health care. The result is reflected in the culture and daily operations of the hospital.

SLH leaders set direction and performance expectations through the SPP. The process produces **Strategic Focus Areas (SFAs)**, which are those areas that are most critical to SLH future success and link to the five perspectives of the **BSC**, a set of **Significant Issues**, which represent the most important challenges that SLH must overcome to be successful in the future; **Strategic Aim Statements**, which represent long-term strategic objectives; and **Strategic Action Plans**, which provide more detailed direction to hospital departments. Measures and goals are established for each of the Strategic Aim Statements and are incorporated into the BSC, thereby establishing performance expectations for the organization as a whole. These are then deployed throughout the organization by incorporating the hospital's annual operating goals and key measures into department-specific goals through the **90-Day Action Planning Process**. Hospital goals are further translated into personal commitments and documented on the PMP form for each employee that identifies individual responsibilities and goals relative to the Strategic Aim Statements (in addition to the core values).

In addition to addressing values, direction and performance expectations, senior leaders employ a systematic approach to assure a continual focus on creating and balancing value for patients and other customers. This approach includes the following components:

- **Plan for Care and Services Manual** - This manual, updated annually, was developed by a multidisciplinary Plan for Care Committee in collaboration with the EC and HLG, and was published and distributed in August 1998. This document describes values, performance expectations, and a focus on patients.

- **Leadership Retreats** - As part of the SPP, SLH leaders conduct retreats to evaluate patient and customer needs and requirements to assure that the hospital remains focused on the most important aspects of its health care service delivery, and that these considerations are integrated into strategy and plan development.

- **Administrator On Call (AOC)** - The AOC program provides 24 hour, 7-day coverage, with a member of the EC serving as the AOC. The AOC takes action to resolve customer concerns as quickly as possible. AOC reports are generated weekly and reviewed individually by EC members via e-mail. Data are aggregated, reported,

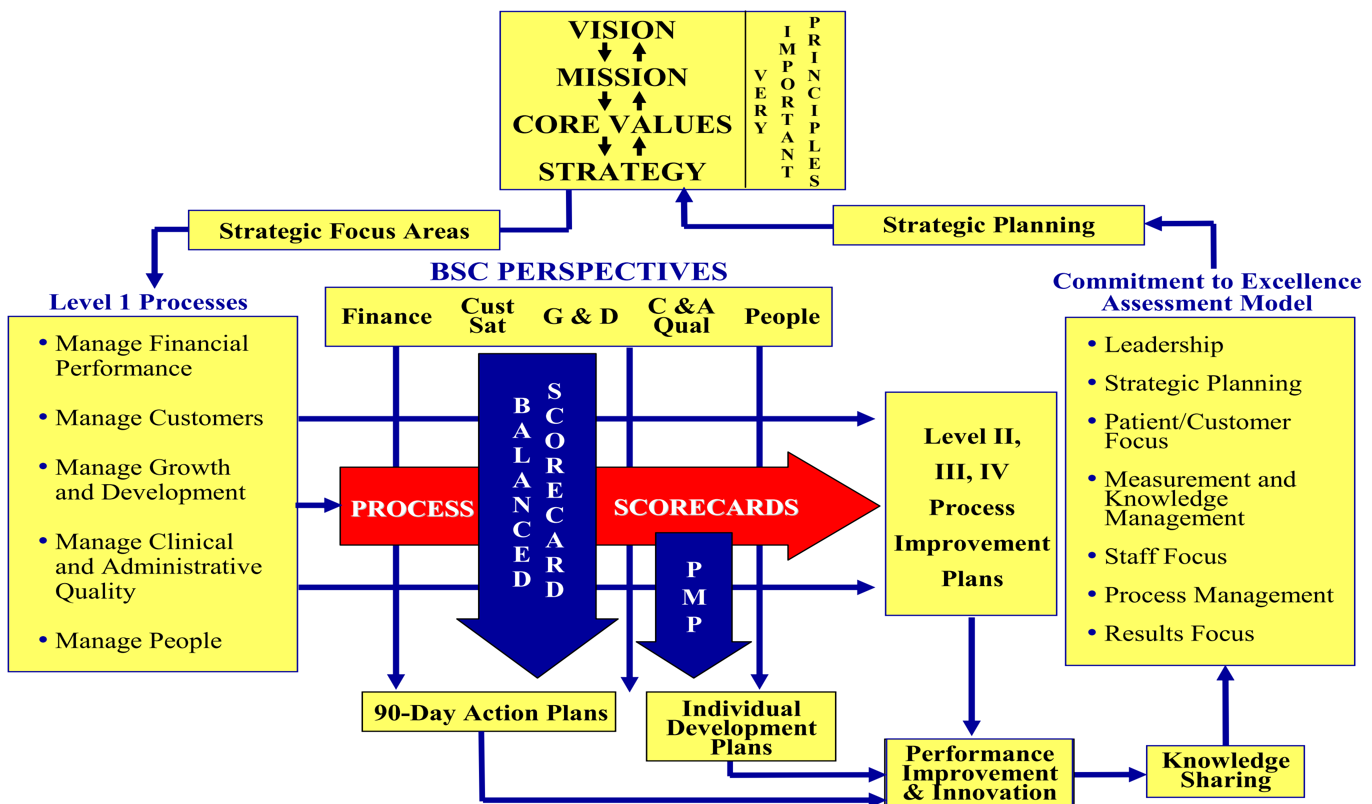



**Figure 1.1-1 SLH LPE Model**

reviewed and analyzed by the EC to identify trends.

- **"Open door" policy** - Senior leaders promote an open door policy, as well as carry pagers and cellular telephones, to ensure immediate access for patients, physicians, and other stakeholders.

- **Administrative Rounding** - Senior leaders interface with patients, employees, and medical staff via administrative rounding and participation in departmental functions and activities on a regular basis. A standard set of questions is used during rounding, which provides the EC input into the quality of care being delivered.

- **Customer Satisfaction Research Program (CSRP)** - The CSRP, provides SLH leaders significant information pertaining to market, patient, and customer needs, requirements and satisfaction, including information on key satisfiers. This permits a focus on the high value areas for various customer groups.

**1.1a(2)** SLH strives to be an agile and continuous learning organization in which a culture of innovation and information sharing is expected, encouraged, and modeled by leadership. This is operationalized through the **Leadership for Performance Excellence (LPE) Model** (Figure 1.1-1). SLH leaders drive a focus on performance improvement using this approach through creation of an organizational process model and a process level measurement system, application of the **BSC process**, and the Baldrige-based **Commitment to Excellence (CTE) Assessment Model**. Processes are identified and defined such that they link directly to the Strategic Focus Areas, and are managed and improved on a regular basis. The BSC is linked to the SFAs through the SPP and permits progress to plan revisions and drives improvement. CTE assessments are accomplished annually and permit an overall evaluation of SLH performance. These activities are integrated as shown in the model and produce a continuous focus on learning, innovation, and knowledge sharing. The LPE model permits SLH to act with agility through frequent performance reviews and improvement action planning. SLH **core values** drive the LPE model by stressing the importance of taking the initiative, continuously improving work practices, taking risks, analyzing processes and problems, sharing information, participating on teams and practicing ethical behavior. As previously indicated, employees are responsible to demonstrate these behaviors and are evaluated on their ability to do so as part of the PMP. To aid employees in being successful in this regard, leadership implemented the **PI Model**, which guides employees in their efforts to seek continuous improvement and innovation, and to take the initiative to improve their own work processes on a regular basis.

SLH leaders have also placed a significant emphasis on training and professional development. Numerous opportunities are provided to ensure that the medical staff and employees have necessary job skills, as well as the skills needed to successfully implement the core values. For example, the PMP includes development plans and objectives designed to enable employees to be empowered and seek continuous improvement and innovation. A framework to promote a culture of clinical and technological advancement has also been established by SLH leadership. This framework includes the establishment of centers of excellence, medical education endowed chairs, shared governance within the nursing department, visiting professors, resident and medical student education, allied health education programs and Saint Luke's College of Nursing. In addition, SLH, the primary private teaching hospital for the UMKC School of Medicine, educates others, and therefore, must strive to remain on the cutting edge of innovation and knowledge. SLH also provides learning experiences for outside groups via on-site visits, conferences, clinical tutorials, and public forums.

Senior leaders also recognize the value of networking and benchmarking, both internally and externally. Leaders work with a variety of other learning organizations through Voluntary Hospitals of America (VHA), a 1000+ hospital cooperative and other comparable collaborating hospitals. These organizations provide SLH with an opportunity to share information and benchmark best practices. SLH's CEO and Medical Director for Quality participate in a **VHA-sponsored CEO-to-CEO workgroup**, composed of some of the largest health care organizations in VHA, whose purpose is to drive organizational improvement in the area of the clinical 7th Scope of Work, to reduce medical error rates, benchmark with each other, and learn and network best practices. In addition, learning and networking opportunities occur through physician and nurse membership in local, state, and national medical societies, committees, and workgroups.

SLH is able to act with agility because leaders cultivate a culture of empowerment throughout the hospital, make a heavy investment in technology, provide timely information across the

| | High Impact | Medium Impact | Little to No Impact |
|---|---|---|---|
| The process materially contributes to the strategic success of the Hospital and/or System | | | |
| The function/department/ activity success is achieved through this process | | | |
| The process is a high priority for maintaining regulatory compliance | | | |
| The process failure will negatively affect a related process which exhibits one or more of the above characteristics | | | |
| The process is highly visible to our key customers | | | |
| If the process is allowed to deteriorate, it would be exceptionally costly to reinstate | | | |
| The process has a high cost associated with its daily operation | | | |
| The process has a strong relationship to driving one or more Scorecard measures | | | |

**Figure 1.1-2 SLH Prioritization Grid**

organization, and maintain an organizational structure that is conducive to efficient decision-making at the point of greatest impact. SLH embraces change through tools such as the LPE Model, SPP and the PI Model, and encourages the identification of change requirements.

**1.1b** The SLH governance system ensures management accountability for SLH's action through the oversight provided by the Board, the sharing of BSC Perspective Leader responsibility by both administrative and medical staff leaders, and the frequent performance reviews that are held. Fiscal accountability is addressed through a systemic review of financial performance. The Board reviews financial performance monthly and has a financial committee that monitors SLH financial performance in detail on a quarterly basis. The EC meets weekly, and on the fourth Monday of each month it conducts an extensive financial and operational performance review, with monthly financial, quality and other performance related reports being provided to the HLG and Medical Staff Board. Ernst and Young conducts an external audit annually, and the charge audit department conducts internal audits on a regular basis to determine the accuracy of charges.

**1.1c(1-2)** SLH senior leaders review organizational performance, competitor performance, progress to plan, and complete a needs assessment on a regular basis. The EC conducts a quarterly BSC review during which performance in the BSC measured areas is assessed. The entire scorecard is presented first to give an overall picture of performance in the five perspective areas. Performance for each measure is indicated by color code where blue indicates performance above goal, green indicates performance at goal, yellow shows performance at moderate risk, and red shows performance at risk. For each measure, the performance goal that is established reflects the performance objective of the strategic plan. The color shows if current performance is at, above, or below that goal, so the BSC review serves as a progress to plan review as well as an overall organization performance review. In addition, a drilldown for each measure is presented in the form of run charts depicting upper and lower limits based on stretch goals and risk levels for those measures, and where the quarterly performance places it. The run charts also include comparative performance based on previously identified benchmarks for each measure.

The HLG and PISC, including the BSC Perspective Leaders, each hold monthly performance reviews that are focused on the **90-Day Action Planning Process**. This process produces a BSC Department Report Form, which identifies the monthly progress in selected BSC measures. These reviews permit a close look at the progress of the specific actions identified as part of the strategic plan, how they are impacting performance in the key measures, and identification of necessary improvement actions to help keep plans on track.

| Key Process | Measure | Goal |
|---|---|---|
| Corporate Compliance | • # Investigations<br>• % Employees trained | • 0<br>• 100% |
| Accreditation<br>Health care requirements<br>Laboratory policies and procedures<br>Transfusion practice<br>Graduate Medical Education programs<br>College of Nursing | • JCAHO survey<br>• CAP survey<br>• AABB survey<br>• RRC survey<br>• Certification results | • Full Accreditation<br>• Full Accreditation<br>• Full Accreditation<br>• Full Accreditation<br>• Full Accreditation |
| Legal Consultation | • Physician contract review | • 100% compliance |
| Licensure | • % of staff maintaining licensure | • 100% compliance |
| Risk Management | • Patient falls<br>• Infection rate<br>• OSHA recordables | • 0<br>• 0<br>• 0 |
| Ethics | • % employees trained<br>• # violations<br>• % independent board members | • 100%<br>• 0<br>• 75% |

**Figure 1.2-1 SLH Public Responsibility and Ethics**

**1.1c(3)** If a significant year-to-date unfavorable variance occurs in any of the BSC measures, as indicated by yellow or red performance, an improvement activity may be initiated. BSC Perspective Leaders evaluate the performance in question and determine what action may be required. In making this judgment, they employ a prospectively designed Prioritization Grid (see Figure 1.1-2) to help them make decisions and align improvement activities with the goals/strategies of the organization.

**1.1c(4)** SLH uses a variety of methods to evaluate and improve both leadership effectiveness and that of the leadership system. Individual leadership skills are addressed through the PMP, as every leader and manager participates along with all employees. Leadership is also evaluated by means of the biannual Employee Opinion Survey, through employee forums, and via the monthly Employee Feedback Group. Each of these provides opportunities for employees to provide feedback to leadership about their performance or input on ideas or innovations for improvement.
Senior leadership also conducts an annual internal assessment of the effectiveness of their contribution to improving performance based on the outcome of the BSC reviews and year-end performance. Additionally, the Board conducts an annual self-assessment during which it evaluates its effectiveness in 10 areas.

Finally, the leadership system and the performance of the EC and Board are evaluated as part of the SPP. This review is based on overall organization performance and

input received from various patient and other customer surveys.

## *1.2 Social Responsibility*

**1.2a(1)** SLH key processes, measures and goals pertaining to its responsibilities to the public and ethics are summarized in Figure 1.2-1. SLH core values provide the framework that drives the hospital to comply with and support all public responsibilities. Operating with integrity and maintaining full compliance are modalities of the core values and are stressed continuously through the PMP.

A formal Corporate Compliance Process is in place to specifically address regulatory and legal requirements, and is supported by a Corporate Compliance Plan (CCP) and a Corporate Compliance Officer (CCO). The plan provides the structure for monitoring, auditing, and managing legal issues.

A VP or other senior leader leads the effort to achieve and surpass accreditation and assessment requirements. When new and/or updated requirements are received and reviewed, they are shared with all key leadership groups. Multidisciplinary teams are formed to ensure that necessary processes exist to address changing requirements of the accreditation process and measures are tracked to evaluate SLH's level of success.

**1.2a(2)** SLH has a variety of methods in place to integrate public concerns with health care services. Members of the SLHS leadership team, often accompanied by a physician, meet with business leaders across the community periodically throughout the year. These meetings provide the opportunity to enter into an active dialogue with key members of the community to help leaders make difficult decisions about health benefits and to learn what health care issues the community faces. Prior to these meetings SLH publishes and distributes two documents: *Quality in Action* and *Spirit of Care: 2003 Community Report*. These publications provide community leaders valid, publicly available information relating to health care quality and service in the Kansas City area and educate them so as to facilitate a beneficial exchange during the meetings. In addition, this represents a proactive method of alleviating concerns that may be developing.

SLH also hosts educational forums with insurance brokers in the Kansas City area to educate them on similar information as referenced in the previous paragraph. In those sessions, leaders also learn from these brokers, who represent major area employers in their selection of health plan benefits for their workforce, what the key issues and concerns are that face employers and how SLH can best address those issues.

In addition, SLH participates in numerous civic organizations, and System leadership promotes employee participation in community-based organizations. Such participation provides the opportunity to establish relationships with the community and receive feedback from key stakeholders, all of which assists SLH in anticipating concerns and developing programs that meet community-defined needs. Further, SLH has proactively developed a variety of protocols to deal with community concerns such as a comprehensive disaster plan/protocol.

**1.2b** SLH has long emphasized ethical behavior and its Organizational Ethics Statement served as the foundation for the development of a System-wide ethics policy. SLHS was one of the first organizations in the region to develop an organizational ethics statement at the Board level that explains to Board members, employees, medical staff, volunteers, and others affiliated with the organization how the System operates based on its core values. The statement and supporting policy have been distributed to all key stakeholders and serve as a basis on which decisions are made. To emphasize its ethics focus, SLH has formed an Ethics Advisory Committee and is a member of the Midwest Bioethics Center. The SLH Ethics Advisory Committee helps the hospital maintain high ethical standards related to clinical care and organizational ethics. This group, composed of Board, staff, and community/religious representatives, meets on a regular basis to hear from representatives of various community organizations and internal stakeholders regarding ethical issues facing the hospital. The committee serves those who need a place for discussion, support in facing choices, consultation, and/or assistance in resolving conflicts. A patient, his/her family, a patient's friend, or any health care provider directly involved with a patient may request a consultation with the committee by contacting the chaplain or patient advocate. A Patient's Bill of Rights is posted in strategic locations throughout the hospital and is included in the *Guide to Patient Services* located at each bedside. Patients are notified of the existence of these rights during the admission process. The Midwest Bioethics Center is one of the country's leading consortiums addressing ethical issues related to health care. Staff at all levels of SLH, as well as members of the Board, participate in policy-making discussions at the center.

Ethical behavior is also incorporated into SLH core values and the CCP, which establishes procedures for monitoring, auditing, and managing ethical and legal issues. The plan encourages employees to report any concerns regarding legal/ethical practices of the organization and requires employees to report

| Community Support Activity | Measure |
|---|---|
| Charity Care | • Dollars committed |
| Community Health Programs<br>• VHA CEO-to-CEO Workgroup<br>• KC Orthopedic Institute<br>• The Cancer Institute<br>• NurseLine<br>• Brush Creek Community Partners<br>• Project GROWTH<br>• Project Challenge–Women's Cardiac Care<br>• Metropolitan Organization to Counter Sexual Abuse (MOCSA)<br>• Federal Women, Infants and Children Program<br>• Kansas City Corporate Challenge | • Program Specific Participation and Effectiveness Indicators |
| Leadership/Staff Participation | • # Organizations served |

**Figure 1.2-2 SLH Community Support**

any known violation. Reported issues are investigated and feedback is provided to the reporter if he or she leaves a name. The CCP and its requirements are thoroughly reviewed during new employee orientation and during PMP reviews. These activities heighten awareness of the plan and encourage utilization as exhibited by the number of issues reported. The CCO and various compliance committees are components of the process, and the CCO has direct access to leadership and the Board of Directors.

**1.2c** SLH core values define SLH's leadership expectation of engaged organizational citizenship and support of its community. Community needs are identified by numerous ongoing tools such as formal community health needs assessments, Board input, formal and informal meetings with community leaders, CEO-to-CEO engagement both locally and nationally, participation by SLH staff in local, state, and national groups, ongoing review of scientific literature, development of stakeholder partnerships with suppliers, community groups, and other institutions, and open-ended comments from customer satisfaction surveys. This information is considered during EC reviews and as part of the SPP, allowing for services to be implemented or modified in direct response to the data obtained from these sources.

Community support activities currently underway include a financial commitment to charity care, community health, benefit programs conducted by the hospital, and leadership and staff participation as volunteers on numerous boards and committees. SLH community support activities are summarized in Figure 1.2-2.

To track community support activities, SLH maintains a community benefit reporting system that delineates what projects the hospital supports, both from a volunteer and financial standpoint. Community benefit activities are reviewed for two key purposes: 1) to ensure that organizational resources are utilized to meet identified community needs; and 2) to determine if there are emerging needs.

# CATEGORY 2—STRATEGIC PLANNING

## *2.1 Strategy Development*

The SLH three-phased, seven-step **Strategic Planning Process (SPP)** integrates direction setting, strategy development, financial planning, strategy deployment and plan management for the hospital. The strategic plan is developed using the first four steps of the process during April through October each year; the plan is deployed using the next two steps of the process from November through January; and the plan is managed using the final step of the process throughout the year. The outcome of plan management feeds back into the process when the next year's plan development begins. The SPP is characterized by a series of **Leadership Retreats** conducted by the BSC Perspective Leaders, with the participation of the HLG, that are integrated into the process at the point of most significant impact. These retreats are designed to focus on analysis of data pertaining to the five BSC perspectives. The SPP is integrated with the performance review approach, is fully deployed, has been in place for a number of years and has been revised on numerous occasions as a result of annual evaluation and improvement cycles.

**2.1a(1-2)** The plan development phase of the SPP (Figure 2.1-1) produces the SLH Strategic Focus Areas (SFAs), Strategic Aim Statements (SASs), Strategic Action Plans (SAPs) and short- and long-term goals. The strategic plan reaches out three years into the future, based on SLH's ability to forecast market changes and the time needed to plan for capital improvements, but has short-term components that support the longer-term strategies.

**Step 1 - Develop Significant Issues** – The process begins with the first two retreats, the **Customer Retreat** and **People Retreat** held in June. During the customer retreat the HLG reviews customer segmentation, validates or refines the needs and requirements for existing customer groups, establishes needs and requirements for new customer groups that may be identified, reviews customer-related performance data, and identifies issues that need to be addressed during development of the SASs and SAPs. Data collected through the **Listening and Learning Process** and the **Customer Satisfaction Research Program** are used by the HLG to reach their conclusions. During the People Retreat, staff strengths and weaknesses are addressed through evaluation of data produced by the **Performance Management Process (PMP)**, work system effectiveness data, information obtained through informal surveys, employee satisfaction and motivation data produced by the **Employee Satisfaction Determination Process**, and employee well-being performance indicators.

In June of each year, a System **Environmental Assessment (EA)** is published that provides a comprehensive data set pertaining to external and internal factors important to strategy development for the System as a whole and for each of the hospitals within the System. The EA includes:

- a detailed analysis of **emerging market trends** that addresses the economic environment, general public, patients, employers/payors, providers and employees;
- **a profile of SLH key customer groups** that includes patient demographics and reimbursement data, a community health assessment, a community hospital perception, market density/potential, area employer demographics, a payor analysis, identification of top primary care and physician specialty groups in the market area, referring physician preferences, physicians supply and demand data, an analysis of admitting/employed physicians, and an employee review;
- **SLH customer-related data**, including patient profiles and volume, patient revenue mix, product line performance, eligible market share, and patient/visitor

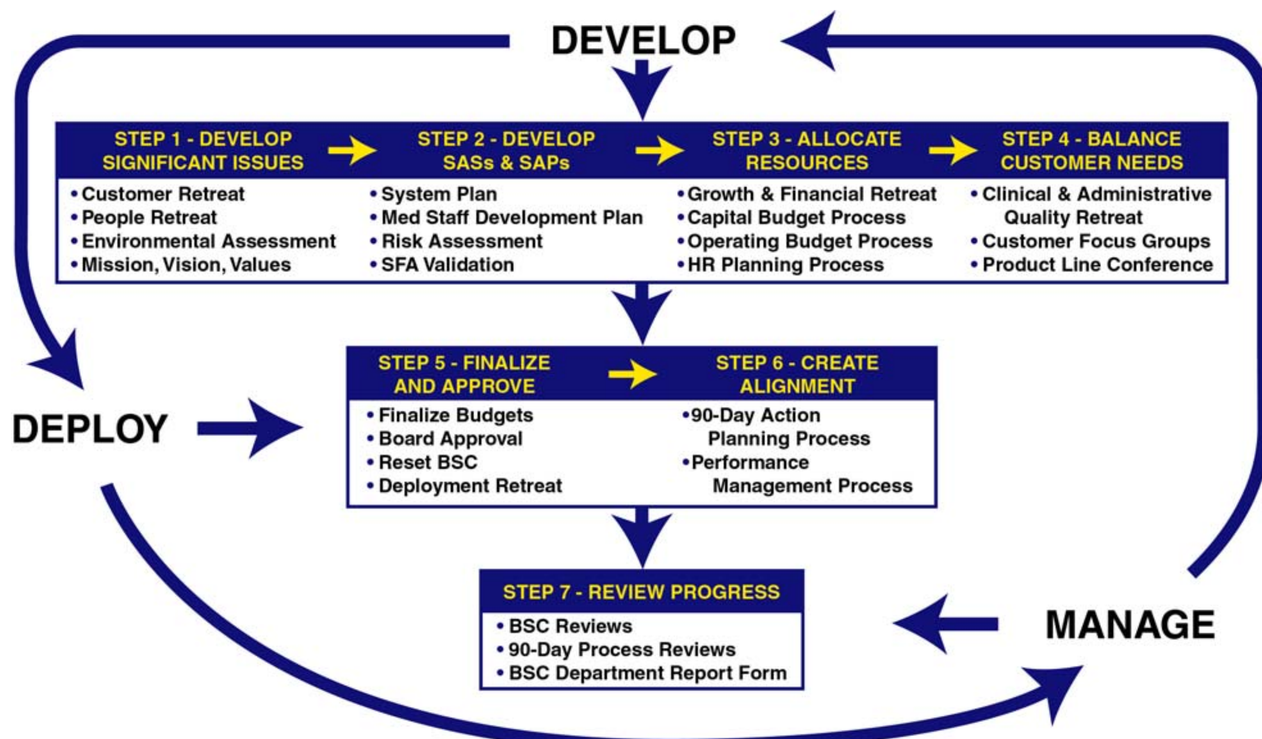



**Figure 2.1-1 SLH Strategic Planning Process**

satisfaction, employer/payor satisfaction, payor volumes, employed physician performance, identification of the top admitting and referring physicians, employee compensation/benefits/retention data, employee satisfaction, and diversity indicators; and

- **competitor profiles,** including an area market share breakdown, Medicare market utilization, and an overview of each primary competitor.

The EC and MSEC conduct an analysis of the EA as soon as it becomes available. This is followed by a review and validation of the SLH mission, vision, and values, and then development of a set of **Significant Issues** that capture those critical challenges the hospital faces and must address if it is to be successful in the future.

**Step 2 - Develop SASs and SAPs** – In July, the System produces its strategic plan for the coming year. The EC reviews the System strategic plan to identify appropriate linkages and to ensure that SLH is aligned to System requirements. Once this is complete, the SFAs are validated and appropriate direction is given to each of the BSC Perspective Leaders to review and refine their SASs based upon the work that has been accomplished to date. In setting the goals in each of the statements, the Perspective Leaders focus on SLH and competitor and/or benchmark performance, with an objective of exceeding competitor performance in key areas and achieving performance that ranks among the best performers or in the top quartile nationally. The statements are provided to the EC and MSEC, who then collaborate on development of a preliminary list of SAPs. An important activity conducted by the MSEC in conjunction with this is the creation or revision of the **Medical Staff Development Plan**, which is designed to identify medical technology needs and opportunities, as well as medical staff requirements for the future. In addition, the EC and MSEC call upon the Information Systems Department to provide input on technology changes that might impact SLH services, and Materials Management to provide input on supplier/partner strengths and weaknesses. The groups also identify potential risks associated with the various actions they identify and, where appropriate, direct a **risk assessment** of potential action plans. Upon completion of these activities, the preliminary list of SASs and SAPs is developed.

**Step 3 - Allocate Resources** – SLH begins the resource allocation process with its **Growth and Financial Retreat** in July. During this retreat financial and market data are reviewed using information provided by the **Market Segmentation Process** and the financial performance analyses. The CFO develops five-year financial projections for review during this retreat, target areas for growth are identified, along with growth projections, and opportunities to redirect resources are assessed.

The HLG and MSEC then begin the capital planning process, which leads to identification of capital requests from SLH departments, and the HLG develops budget assumptions based on the SASs and SAPs that had been formulated earlier in the month. In August, the capital requests are aggregated and prioritized, and human resource plans are developed by HR to support the action plans. In addition, a top-down, bottom-up operating budget development process is initiated to support the plans being developed.

**Step 4 - Balance Customer Needs** – In order to ensure that all customer needs are balanced and the highest value provided to key customer groups before plans are finalized, SLH conducts a **Clinical and Administrative Quality Retreat** in September. Health care service delivery and support process performance data are evaluated during this retreat using information gathered through application of the **PI Model** to the delivery of health care, and in delivery of support services. In October, customer focus groups are held to validate and refine needs and requirements and to ensure that the needs of all customer groups are balanced. A joint planning conference is held with the System to review and integrate product line and entity strategic plans, and by the end of October the EC finalizes the SASs and SAPs.

**2.1b(1)** The SLH 2003-2005 Strategic Plan is summarized in Figure 2.1-2. Displayed are the SFAs and SASs, which constitute SLH key strategic objectives and their associated measures.

| Strategic Focus Area | Strategic Aim Statements | Strategic Action Plans | Measures |
|---|---|---|---|
| Financial | • Achieve Financial Stability | • Improve processes related to payment denials | • Total Margin<br>• Operating Margin<br>• DCOH<br>• Cost/CMI Adj Disch |
| Customer | • Improve Customer Satisfaction | • Conduct visioning sessions | • Wait Time<br>• Overall Sat<br>• Response to Complaints<br>• Outcome of Care<br>• Adm Phys Ratio |
| Growth & Development | • Increase Market Share | • Complete facility renovations | • Community Market Share<br>• Eligible Market Share<br>• Profitable Eligible Market Share<br>• PCP Referral |
| Clinical & Admin. Quality | • Improve Clinical Quality | • Exceed benchmark expectations for regulatory bodies | • Maryland Quality Indicator Index<br>• Pneumoccoal Screening and/or Vaccination<br>• Patient Safety Index<br>• Infection Control Index<br>• Med Staff Clinical Indicator Index<br>• CHF ALOS<br>• CHF Readmission Rate<br>• Net Days in Accounts Receivable |
| People | • Achieve Workforce Availability, Proficiency, and Commitment | • Support Diversity Council leadership development process | • Human Capital Value Added<br>• Retention<br>• Diversity<br>• Competency<br>• Employee Satisfaction<br>• Job Coverage Ratio |

**Figure 2.1-2 SLH 2003-2005 Strategic Plan**

**2.1b(2)** The SASs address all of SLH's Significant Issues as SAPs are established within each of the SASs that focus on these issues.

SLH uses customer focus groups to ensure that its strategy balances the needs of all customer groups. These focus groups are conducted in October and include a review of customer requirements, SASs and SAPs. Customers are asked to comment on the validity of the requirements identified, and on how well the strategy statements address their needs and concerns. Based on the outcome of these focus groups, customer requirements and/or strategy statements are refined as appropriate.

## *2.2 Strategy Deployment*

**2.2a(1)** The deploy phase of the SPP consists of Steps 5 and 6.

**Step 5 – Finalize and Approve** – The capital and operating budgets are finalized by the EC, and the plan and budgets are presented to the Board of Directors for approval in November.

Once the Board has approved the plan and budgets, the Quality Resource Department and the EC collaboratively reset the BSC scoring criteria and targets. A **Deployment Retreat** is then held with the HLG to review the final plan, assign responsibilities for plan actions, and review current year performance. In addition, the SPP is evaluated and opportunities for improvement are identified.

**Step 6 - Create Alignment** – Once the plan is finalized, the **90-Day Action Planning Process** is initiated. This process requires

that each SLH department identify supporting action plans with a target for completion within the first 90 days of the plan year. In December, department-level plans are refined and the HLG reviews them to ensure they are aligned with the hospital strategic plan. In January, strategic and 90-day action steps are incorporated into the PMP as personal commitments as explained in Item 5.1. This ensures that plan alignment occurs not only at the department level, but also at the individual level. Resources are allocated in support of all action plans in accordance with Step 3 of the SPP using the capital and operating budget processes and HR planning.

**2.2a(2)** SLH action plans are shown as part of the strategic plan.

**2.2a(3)** SLH develops human resource plans based upon its SASs and SAPs. A "Workforce Planning and Assessment Tool" is used to complete four key components of the HR planning process: a supply analysis, a demand analysis, a gap analysis, and a solution analysis. The results of the solution analysis are incorporated into the human resource plan.

**2.2a(4)** The manage phase of the SPP occurs throughout the year following Step 7.

**Step 7 - Review Progress** – SLH reviews plan progress to ensure that it has opportunities to make adjustments in order to keep plans on track. This step is integrated with the SLH performance review process. The **Balanced Scorecard Process** produces the measures used to track progress relative to the SASs and SAPs. The **90-Day Action Planning Process** is used to ensure that the action plan measurement system achieves organizational alignment and covers all deployment areas. Each quarter, departments complete a **BSC Department Report Form**. This form displays the monthly performance for each of the strategic plan measures, and lists the highlights and next actions relative to the 90-day plans. The highlights summarize the progress made on the current 90-day plans, and the next actions identify the anticipated plans for the next 90 days. Department leaders provide this report to the BSC Perspective Leaders, PISC and responsible administrator for review and evaluation. This allows hospital leadership to continually assess progress to plan, and ensures that each department is focused on achievement of plan objectives and the key measures associated with the strategy.

**2.2b** SLH performance is projected to 2004 for the key measures in each of the SFAs as shown in Figure 2.2-1. These are based on current plans and are compared to 2002 SLH performance and the comparison currently used for each.

| Key Measure | 2002 SLH | 2002 Comp | 2004 Proj |
|---|---|---|---|
| Operating Margin | 14.9 | 10.3 | 4.8 |
| Overall Patient Satisfaction | 92.7 | N/A | 93.1 |
| Profitable Market Share | 8.5 | N/A | 9.3 |
| Patient Safety Index | 5.8 | N/A | 7 |
| Retention Rate | 88.7 | 83.5 | 86 |

**Figure 2.2-1 SLH Performance Projections**

# CATEGORY 3—FOCUS ON PATIENTS, OTHER CUSTOMERS & MARKETS

## *3.1 Patient, Other Customer, and Health Care Market Knowledge*

**3.1a(1)** SLH has identified its key external customer group as patients and their families. Patients are segmented based on the site of care: inpatient, outpatient, and emergency department patient. Physicians exhibit many of the characteristics of customers but are a key partner group for SLH, and are treated as such in an effort to build strong and binding relationships through the Physician Partnering Process. Employees are a key internal customer and are addressed in Category 5. Residents/students are another key internal customer group due to the importance of SLH's education mission. The SLH market area is defined geographically, as described in the Organizational Profile, but is segmented by product lines for determining needs and requirements, and for tracking performance.

| Customer | Listening/Learning | Frequency |
|---|---|---|
| Patients and Families<br>• Inpatients<br>• Outpatients<br>• Emergency Patients | • Formal inpatient/outpatient/emergency satisfaction survey (Press Ganey)<br>• Follow-up calls after discharge<br>• Patient Advocate<br>• AOC<br>• Focus groups<br>• NurseLine feedback<br>• Complaint management<br>• Outreach services & visits | • Weekly<br>• Daily<br>• Daily<br>• Daily<br>• Two/year<br>• Daily<br>• Daily<br>• Daily |
| Residents/ Students | • Program (teaching) evaluations<br>• Performance evaluations<br>• Daily interaction<br>• National testing<br>• Published research data<br>• Satisfaction surveys | • Annual<br>• Monthly<br>• Ongoing<br>• Annual<br>• Ongoing<br>• Annual |

**Figure 3.1-1 Customer Listening and Learning Methods**

Customer groups, their associated requirements, and SLH market segments, are determined by SLHS and SLH leadership and finalized during the **Strategic Planning Process (SPP)**. The annual **Customer Retreat** is used to analyze customer groups and segments. The **Customer Segmentation Process** involves a review of data produced by the **Listening and Learning Process**. Both formal and informal methods of obtaining data are considered with an emphasis on determining if the information available suggests that segmentation should be altered. Questions asked in making this determination include:

- are needs emerging for a particular group of customers that are significantly different than the group as a whole;
- are satisfaction results indicating that there are different key satisfiers for a particular group of customers; and
- are services that are provided different enough that establishing a separate segment would add value.

Responses to these questions help SLH leaders decide if additional segmentation is warranted, and if any changes should be made.

Market segmentation is evaluated during the **Growth and Financial Retreat**. The **Market Segmentation Process** involves an in-depth analysis of the factors provided in the **Environmental Assessment (EA)**. This process involves a review of the health care market, movement of customers within the market, customers of competitors, new players in the market and new product line offerings or services that are emerging. The objective is to determine if the existing market strategy is still valid, to adjust that strategy as needed to improve business opportunities, and to determine if the market should be segmented differently for data collection and tracking purposes. As part of this process, SLH seeks information from customers of competitors through a variety of means. These include "ghosted" patient focus groups where the sponsoring institution is not identified, networking within the community, formal participation by SLH leadership and employees in local business and civic groups, and from the SLH physicians who also admit patients to competing hospitals. Data from these sources are channeled into the evaluation to help determine how to better target the market and the need for new programs and services.

3.1a(2) SLH serves a wide variety of customers, both internally and externally, and therefore needs a robust system of gathering data in order to understand customer requirements and the relative importance of those requirements. For this reason, SLH has developed a formal **Listening and Learning Process (LLP)**. The LLP consists of both formal and informal listening and learning methods as shown in Figure 3.1-1. Three important approaches are used extensively by SLH to help define patient's needs:

- **Approach 1** – Market Research and Analysis Department (RAD) conducts an annual patient satisfaction data regression analysis to determine the most significant indicators of overall satisfaction. These significant indicators, once determined, are verified through the focus group and PA activities.

- **Approach 2** – On a weekly and quarterly basis, information obtained from open-ended questions on each patient type survey is coded and classified by key requirements and/or issues for SLH leadership to review and analyze.

- **Approach 3** – Complaints that are tracked and trended by the PA Department are categorized and analyzed quarterly by key requirements and/or issues in the same manner as the open-ended questions.

SLH evaluates data from these three approaches to verify the key requirements, observe how they may be changing over time, and make adjustments in service features to accommodate those changes. SLH Key Customer Requirements are shown in the OP. This process also results in the determination of the most important satisfiers for patients and families. SLH has identified three key patient satisfiers that tend to remain constant from year to year, and tracks these on the BSC:

- Wait time
- Outcome of care
- Responsiveness to complaints

Other important satisfiers tend to change more frequently and are identified as "significant indicators." These are tracked and emphasized for a one-year period, allowing specific focus and service improvement efforts.

3.1a(3) RAD is responsible for annually assessing and evaluating all marketing research tools; i.e., written surveys, focus group moderators guide, etc., as to their reliability and validity. This evaluation is conducted both internally and externally with key customers using the PI Model. SLH partners with Press Ganey to ensure survey quality for inpatients and outpatients, and Press Ganey conducts its own survey assessment annually. Internally, RAD visits with SLH leaders, and conducts an in-depth staff session discussing possible new questions needed in conjunction with the regression findings. The PAs also use the PI Model to evaluate and improve their patient listening and learning approaches. Finally, SLH participates extensively with other VHA member hospitals to exchange information in order to remain as current as possible with its listening/learning strategies.

### *3.2 Patient and Other Customer Relationships and Satisfaction*

3.2a(1) SLH believes that building and sustaining good customer relationships and fostering those elements that produce loyalty can only be achieved by personalizing the delivery of its health care services. To personalize service to patients and families and build these relationships, SLH does three things: creates a **patient path** to explain how care is to be delivered in a patient-friendly format; assigns an **Administrator on Call (AOC)**; and provides **Patient Advocates**. The patient path allows patients and family members to have a clear explanation of how care is to be delivered. It is personalized for the patient and the particular treatment to be provided, is developed in collaboration with the patient and the family, and is provided when the plan of care is developed. The AOC is a member of the EC and is on call 24 hours a day, seven days a week. He/she is available at all times to patients or other customers. The AOC listing is routed throughout the hospital to key entry points, such as the Communications Department, where incoming calls are received. The AOC also carries a pager and cell phone to ensure rapid response to customer needs. All patients have in-room telephones so they can call for information or seek resolution of a problem or complaint. All issues logged by the AOC are entered into a PA database. This information is immediately

acted upon, compiled, and weekly reports are disseminated to the members of the EC.
PAs visit patients on their first, fifth, and tenth day, and more frequently if needed. They serve as a liaison between patients and their families and the hospital. To facilitate communication with Hispanic patients, a Spanish-speaking PA is on staff. The advocacy program was improved in 2003 to include employment of a Russian translator to facilitate patient scheduling. Patients are made aware of the PA through a brochure and access card provided at admission. The goal of the PA is to proactively address each concern as it is presented by the patient, his/her family, or the staff. The PA responds to compliments and concerns, investigates complaints, gathers information, and follows through with appropriate personnel. In doing so, the PA transcends departmental lines and interacts with staff at all levels within the organization. The PA Department is available to all patients, visitors, and employees.

To build relationships with our physician partners, SLH has established Centers of Excellence, such as the Mid America Brain and Stroke Institute established in 2001, to provide physicians the opportunity to practice in a "leading edge" environment. SLH and its Foundation are highly committed to medical education and research so as to attract top-quality medical staff. Residency and Fellowship programs are made available in major specialties. As a result, members of the SLH medical staff have opportunities to conduct research, publish, and gain national recognition. In 2003 the Doc One program will be expanded and integrated with NurseLine to facilitate improved physician access. Other enhancements include a medical concierge service and enhanced referring physician communications.

**3.2a(2)** In 1995, a work redesign team was given the task of creating a patient-focused model that would reflect SLH's commitment to providing outstanding clinical care and enhance attention to customer service. The redesign team analyzed written patient satisfaction comments from the previous year and information collected during patient and staff focus groups. Service requirements established by other health care institutions were also considered. The culmination of this information provided the foundation for a list of customer contact requirements known as the *Commitment to the Four Core Values*. These commitment statements were then incorporated into a new patient-focused care delivery model and all health care team members were asked to sign a statement of understanding. These commitment statements have evolved and have been redesigned by a team into the customer contact requirements shown in Figure 3.2-1.

**Saint Luke's Hospital of Kansas City**
**Customer Contact Requirements**

1. Greet patients/guests by introducing myself; address patients/guests by last name unless otherwise told.
2. Ask sincerely, "How may I help you?"
3. Knock, request permission to enter the room, and explain what I am going to do.
4. Complete initial assessment on all patients within eight hours.
5. Acknowledge all patient/guest requests, and be accountable for follow-up.
6. Address all complaints within 24 hours or less.
7. Introduce any replacement caregiver.
8. Promote family-centered care; listen thoughtfully to all patients/guests, and provide timely communication to the appropriate person(s) for action.
9. Respect and acknowledge diversity, culture, and values of my patients, their family, visitors, and my co-workers.
10. Maintain confidentiality of all information.
11. Know, or have access to, legal and regulatory requirements and standards of care related to my specific responsibilities.
12. Thank my customers for choosing Saint Luke's Hospital.

**Figure 3.2-1 SLH Customer Contact Requirements**

All new employees are educated on the customer contact requirements during hospital orientation. In addition, they are listed on the **VIP Card**, which is provided to all employees. Customer contact requirements also are included in various training forums.

Customer focus is one of SLH's four core values and adherence to the customer contact requirements is part of this value. Employees are evaluated annually on how they meet this expectation. Customer contact performance feedback is collected informally on a daily basis and formally on a quarterly basis via the customer satisfaction survey. Analysis of this survey is utilized to identify improvement opportunities. In addition, SLH provides its customers with a comprehensive selection of tools to access information about their health, organizational services, seek providers, make suggestions, and file complaints. Figure 3.2-2 summarizes SLH's key access and service informational mechanisms.

**3.2a(3)** SLH responds to complaints 24 hours a day, seven days a week. All employees are empowered and expected to resolve complaints. In the event an employee is unable to resolve a patient concern, the employee will forward the concern to the PA Department, to Nursing Management, or to the AOC. Patient concerns are brought to the attention of these individuals through one-on-one visits, telephone consultation, and pager access. When the call is received, an interview is immediately held with the patient to ascertain the issues and identify potential solutions. Calls from patients who have been discharged from the hospital, or from outpatients, are routed to the PA Department for investigation. The person who receives the call assumes the investigation, follow-up, and resolution responsibilities. Complaints are addressed within 24 hours. Any delays in resolution are communicated to the patient with an interim status report, and the patient is provided with additional information pertaining to the resolution. All patient/customer complaints are recorded in the *Patient Advocate Department Patient Case Report* database using a software collection tool. The report emphasizes acknowledgement and resolution of a complaint, information from every department involved, and actions taken.

Information from the *Patient Advocate Department Patient Case Report* is tabulated and analyzed for specific root causes, trends, and other key data. Reports indicating types of requests by

| Public | Patient | Provider | Others |
|---|---|---|---|
| --Media<br>--Website<br>--Nurse Line<br>--Personal<br>--Physician Newsletter<br>--Message to Web Master<br>--Time to Feel Good (TTFG) | --Media<br>--Website<br>--1-800-#<br>--NurseLine<br>--Administrator on Call<br>--Physicians<br>--Printed information<br>--Patient Advocate | --Newsletter<br>--Conferences<br>--Telemedicine<br>--E-health<br>--Regional Relations<br>--Message to Web Master | --Printed materials<br>--Website<br>--Physicians/employees<br>--Conferences<br>--Media<br>--Message to Web Master |

**Figure 3.2-2 Key Access and Service Information Methods**

category and corresponding analysis and trends are sent to all appropriate administrators, nurses, and department managers. Information derived from this process is used to identify performance improvement projects. Each Friday RAD compiles and distributes written patient satisfaction comment data to improve processes and to facilitate an improved understanding of current and future customer requirements. Managers use this information to plan future services, pinpoint customer requirements, and establish department and individual performance goals.

**3.2a(4)** See 3.2b(4).

**3.2b(1)** SLH has a formal **Customer Satisfaction Research Program (CSRP)** with the following goals:

- achieve survey consistency among research tools
- identify satisfaction benchmarks to use for comparison
- report satisfaction trends over time
- recommend viable alternatives to improve operations, personnel, and product/service offerings.

CSRP measurement is practical and oriented to the customer's perspective. The research measures satisfaction with SLH, with hospital procedures, overall outcome, and with the customer's perception of their last encounter with SLH. The measurement and analytical techniques all meet strict statistical sampling and correlation testing rules. Customer values are determined by correlating scores on individual questions to the scores for overall satisfaction. This approach is the most statistically valid method for performing market research. The CSRP measures satisfaction levels using a five-point Likert Scale. All customer satisfaction questions are categorized by the five key patient requirements shown in OP. The CSRP measures satisfaction levels for various patient segments and uses a variety of sampling techniques. Every 15 days, random samples of the following customer groups are surveyed: inpatients, outpatients, and emergency patients. In addition to more detailed questions, each CSRP survey asks three "core questions":

- What is your overall satisfaction?
- Would you recommend SLH to your friends or family?
- Do you have any suggestions for improvement?

Results of the surveys are tabulated and distributed weekly and formally trended and reported on a quarterly basis. Each department and product line uses the data to manage services and/or as the trigger for performance improvement. Results of the surveys are compared with other System entities, local Press Ganey Metro Peers, and national Top-15 Press Ganey.

The open-ended questions included on the survey provide responses that are returned to leadership verbatim. This rich customer feedback is most useful in understanding customer needs. Hospital-wide and department-specific data are prepared for dissemination and review. Leadership involves employees in review of these data via results posting, discussion, and departmental meetings. Department-specific performance improvement teams focus on opportunities to improve patient satisfaction for the patient population they serve. Furthermore, the PA calls every patient who requests a follow-up call.

SLH also conducts focus groups semi-annually for selected patient categories, such as emergency department patients, cardiac patients, etc. SLH focus groups are held each spring or fall to uncover issues not well captured by the paper surveys, to ascertain how to achieve top performance ratings, and to add depth of understanding to the survey responses and discuss business development opportunities as well as to identify requirements related to new program or service offerings. Focus group findings are forwarded to leadership, managers, and product line work teams for next action steps.

Referring and Admitting Physicians are included in an annual survey or a focus group; both designed to rate their level of satisfaction with SLH services.

**3.2b(2)** A variety of methods are used to obtain immediate post-discharge feedback related to health care services rendered, as well as to assess the general well-being of the patient. The primary method of contacting patients post-discharge is by a formal follow-up phone call. Follow-up phone calls to patients at preset intervals are often reflected in the clinical pathway used to manage the patient's care.

**3.2b(3)** SLH obtains information about customer preference relative to direct competitors from the National Research Corporation (NRC). NRC obtains customer perception data about local programs annually by conducting the nation's largest consumer assessment of health plan, health system, hospital, and physician performance. Prior to conducting the survey, NRC works with its health care clients, such as SLH, to ensure that the survey contains relevant questions. The NRC syndicated panel survey is thoroughly pre-tested in an actual field situation to ensure respondents' question comprehension. NRC's attention to quality helps ensure validity of the data and provides reliable health care consumer information and feedback to SLH.

Press Ganey information identifies patient satisfaction norms for Kansas City area peer hospitals each quarter, as well as national norms (averaged results from the top 15 performing hospitals in the Press Ganey national group). This relationship was established in January 1998 as an improvement to SLH's data collection process. Press Ganey works nationally with over 1,000 hospitals and ensures valid and reliable peer norms for core questions regarding inpatient and outpatient services.

3.2b(4) Customer access, satisfaction, and relationship processes are evaluated routinely using patient and customer feedback and hospital performance indicators as the primary tools. Data are analyzed and reviewed in an effort to identify improvement opportunities using the PI Model. Process improvement teams are formed periodically to address specific issues, while RAD conducts an annual assessment of the survey tools and techniques as described in Item 3.1a(3), in addition to maintaining an active list of improvement ideas from patients.

# CATEGORY 4—MEASUREMENT, ANALYSIS, AND KNOWLEDGE MANAGEMENT

## *4.1 Measurement and Analysis of Organizational Performance*

4.1a(1) As illustrated in the SLH **Leadership for Performance Excellence (LPE) Model** measurement system requirements to track daily operations are driven by the requirements of the **PI Model**. Key process data sets (measures) are selected as part of the program/service/process design phase of the model and support activities throughout the hospital. When process measures are selected, data collection methods to support those measures are identified and collection procedures are established. These vary depending on the process and the specific measures selected. Process level measures are aligned with the BSC measures through the **90-Day Action Planning Process and BSC Department Report** process, and are aligned within the various departments through the consistent use of service delivery and measurement approaches. Department leaders are responsible to ensure that process level management is a routine activity throughout SLH and hold process owners accountable to follow established procedures. Process level measures are used to make determinations about the effectiveness of daily operations and work processes and include both outcome and in-process measures. This permits process owners to monitor performance on a continuous basis, make adjustments as needed to ensure consistent, high quality service delivery, and identify improvement opportunities. As needed, improvement initiatives are undertaken to drive higher levels of performance. Process level measures are integrated at the department and/or work unit level and are reviewed periodically by department heads to allow tracking of overall performance.

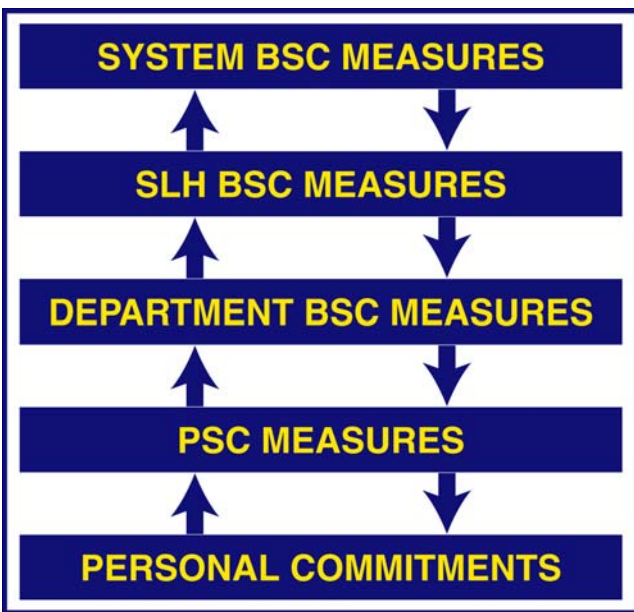


**Figure 4.1-1 SLH Measurement Architecture**

To further enhance SLH's ability to manage daily operations and align the measurement system, a **Process Level Scorecard (PSC)** process has been initiated and integrated with the PI Model. This began in early 2003 with establishment of an organizational process model, which was aligned with the BSCperspectives, and identification of three levels of processes within SLH. Once complete, the PSC approach is expected to provide stronger alignment between the BSC and key process measures, and an improved capability to integrate performance data at all levels of the organization.

As shown in the **LPE**, the **BSC Process** is the method used by SLH to track overall organization performance. The BSC is a comprehensive, fact based management tool and framework that supports a strategy-focused organization. The BSC provides for strategic alignment, linkage, and synergy across SLH and the System, thereby facilitating the achievement of strategic outcomes. The BSC is focused on key performance indicators that enable senior leaders to make determinations with respect to the organization's overall health. The BSC serves to align the entire System as illustrated in the SLH Measurement Architecture (Figure 4.1-1). BSC measures are selected at the System level, with a number of those required to be incorporated into the entity-level scorecards. SLH includes the System measures in its BSC and adds specific measures of its own during strategic planning. Similarly, SLH departments create their scorecards using the hospital BSC perspectives and required measures, where beneficial to the organization. The BSC will link to the PSC at the department level as BSC measures are rolled down and PSC measures are rolled up.

SLH utilizes the BSC Process as the primary tool to align organizational level analysis with key performance results. Analysis of data sets included on the BSC produces a display of SLH performance in areas most critical to its success. This analysis shows an understanding of that performance so as to permit identification of improvement priorities on a regular basis

as indicated in the **LPE** model, and is then used as an input to the **SPP** to help determine **SASs** and **SAPs**.

Organizational data sets (measures) are selected annually as part of the **SPP** and are based on specific organizational needs such as customer, operational, regulatory, or industry. These data sets reflect the five **SFAs** (or the five BSC perspectives) and are incorporated into the matrix of the balanced scorecard for organizational/product line/department needs. Data needs are aligned through the BSC process with input and direction provided by the Perspective Leaders and reporting through the PISC/MSEC/EC to the Board. The BSC Departmental Report Form and department level scorecards serve as the primary tools to ensure alignment. BSC data are integrated from across the organization through an aggregation and analysis process to merge department performance results to create overall organization results in the form of totals, averages, or indexes.

**4.1a(2)** The use of comparative and benchmark data is an important part of the analysis step in the PI Model. SLH utilizes these data in three areas: Competitive-strategic information, Comparative (local/ regional/ national) data, and Benchmarking. Each of these comparative data types is used for a specific purpose. Competitive strategic information is gathered for use in the SPP; comparative results data are used to determine SLH's relative performance and help set future goals and targets; and benchmarking information is used to design and improve patient treatment techniques, as well as other hospital processes.

Needs and priorities for competitive strategy information are driven by the SPP and are incorporated into the **EA**. In the comparative results area, if a measure is selected for inclusion in the BSC, it automatically becomes a priority for comparative data, which is used to establish the stretch targets for the BSC. Further, SLH seeks to maintain its performance at the department level in the top 25% of peer group hospitals. Therefore, key measures are compared against other health care organizations or other industry leaders whenever possible. To obtain comparative results information, SLH researches third-party providers to identify those that have a demonstrated ability to obtain data relative to SLH key results areas and provide information about organizations that compete with or are similar to SLH. Based on these criteria, SLH has chosen those shown in the OP as the primary sources of comparative results data. In addition, SLH compares itself to other SLHS hospitals.

With regard to benchmarking, SLH has established a strong culture of seeking external process improvement information to support the design of new products, services, and service delivery processes, as well as the improvement of current operations. Seeking information from other organizations is a step in the "design" and "improve" phases of the PI Model. Process owners are encouraged to seek benchmarking information as an inherent part of continuous improvement. Process owners identify high-performing health care providers or standout companies from other industries that excel in the particular process being designed or improved. Suggested criteria include organizations with nationally recognized health care processes, national or state quality award recipients, and recipients of industry-wide recognition.

**4.1a(3)** The PISC is charged with the responsibility of ensuring that the overall performance measurement system is evaluated and revised as necessary to support organizational needs, and uses the PI Model to carry this out. The PISC conducts an annual review of the measurement architecture, including all organization and department level measures to determine if they are providing the necessary information to give a clear picture of the organization's effectiveness. During this review, each measure is analyzed to determine if it should be retained, and consideration is given to potential new measures. In addition, the PISC oversees the measurement system on a continuous basis and makes adjustments more frequently as needed based upon changes in organizational strategy or action plans, initiation of new programs or services, or unexpected market changes.

**4.1b(1)** SLH conducts a number of analyses to support the quarterly BSC review. The results of these efforts are published in a BSC report, which is provided to senior leaders and available for more widespread distribution. The report includes the overall scorecard, with quarterly performance highlighted in color coded boxes indicating performance above (blue), or at goal (green), moderate risk (yellow), and at risk (red). This permits senior leaders to quickly determine where performance is relative to the goals established by the strategic plan.

To obtain the BSC information, performance data are gathered and analyzed from across the hospital. These data are plotted on run charts so trends can be identified, and in key clinical outcome and operational performance measures, control limits are established to allow determination of process stability. This information is available for drill-down analysis during the BSC reviews and is included in the BSC report. Comparative or benchmark data are also included. SLH annually acquires Medicare data from Solucient in order to measure health care outcome performance and works closely with Mercer/Solucient to turn DRG hospital based information into index scores for reporting purposes. CMS data that are released include Medicare discharge volumes, DRG severity index, average length of stay index, mortality index, and DRG Resource index per market analysis. With this information, SLH can measure its performance against local/regional competitors.

Human resource performance is analyzed by trending data and obtaining comparisons from the Saratoga Institute. Financial performance is analyzed by tracking variance to budget on a monthly basis, including an analysis of volume indicators, revenues, and expenses for personnel, supplies, and other operational areas. These are analyzed by month, year-to-date, and compared to the previous year's results.

When determining market-related performance, SLH calculates a **Market Value Index (MVI)**. This computation is based on inpatient market share as determined by the Kansas City Business Journal, the NRC Perception Rating, and the "Would

Recommend" ratings obtained from the Press Ganey survey. The MVI indicates the perceived value SLH has in its market area in relation to its competitors. In addition, SLH tracks and trends eligible and profitable market share.

In addition, SLH produces both weekly and quarterly patient satisfaction reports for inpatient, outpatient, and emergency areas as part of its **Customer Satisfaction Research Program.**

To support SLH's strategic planning, the EA is produced. The EA contains four sections: market assessment, internal assessment, medical education/research, and emerging market trends. For this report, numerous internal and external data sources are used and linked to analyze and report information by market, product line, payor, etc. These data sources include Solucient National Planning Data, CMS, NRC, CHIPS, newspaper and business periodicals, and internal files such as DSS and financial reports.

**4.1b(2)** Communication of the results of organizational-level analysis occurs through the PISC monthly meetings, the weekly meetings of the EC, MSEC and the monthly meetings of the HLG and the MSB. The PISC utilizes the BSC quarterly report card to review findings; this information is then communicated in a flow-up (Board) and in a flow-down (all departments) manner. Specific key measures such as infection control data, clinical indicators, CMS 7th Scope of Work, are shared in detail with departments/ groups/teams and others as required. In addition, SLH uses e-mail, newsletters, department/unit specific monthly meetings, storyboards and written notices to communicate with the entire organization.

## *4.2 Information and Knowledge Management*

**4.2a** Figure 4.2-1 depicts the SLH IT Systems architecture that is the foundation of access to data by staff, suppliers, partners, patients and customers. The architecture is categorized into four broad areas: Clinical Information Systems, Administrative and Financial Systems, Executive Information Systems and Decision Support Systems, and finally e-Portals.

The Clinical Information Systems are comprised of automated solutions that include Patient Demographics, Clinical Protocols, Orders and Results (Laboratory, Radiology, Pharmacy), History/Physicals, Transcribed Reports, Electronic Signature, Nursing Care, Discharge Summary, Charge capture for services rendered, Incident Reporting, and Cardiac and Radiology electronic imaging. Patient information has been automated to allow for the HIPAA compliant reporting of patient results to patient care areas, and, most importantly, to the physicians' offices, both on-campus and across the 120-mile service area of SLH. Physicians and other caregivers have the option of looking at information through the enterprise-wide online remote access system or having hard copy information automatically delivered to areas selected by the caregiver. This is accomplished via the use of the Clinical Browser, a system that was implemented using a multidisciplinary team process of physicians working with the Information Technology groups. This web-based solution allows access to patient information via a secure Intranet, thus expanding the capabilities of SLH physicians to care for their patients not only at the campus, but also while at home or traveling.

Because of the automation that SLH utilizes, SLH physicians are able to communicate with a patient's primary care physician by electronically distributing major events involved with individual patient encounters. SLH physicians can forward to the primary

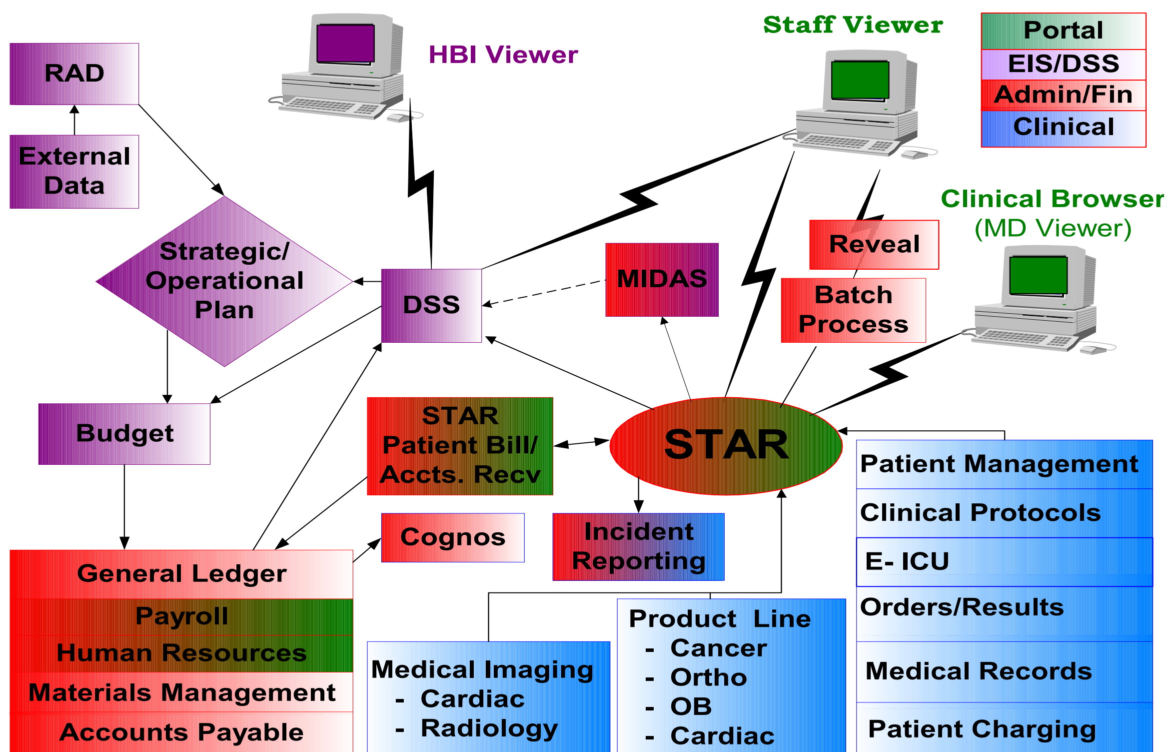



**Figure 4.2-1 IT Systems Architecture**

care physician a patient's discharge summary, key clinical findings, and signal patterns of EKG information and other cardiac imaging using the extensive communications network. This is a major benefit to patients in that their records are now available to their physicians at the time they return to their community, allowing the delivery of care to continue uninterrupted. SLH has teleradiology and telecardiology capabilities at two of the SLHS rural facilities. This allows, in some situations, for patients to stay in their rural hospital and be cared for by a SLH physician using this remote technology.

In an effort to fulfill the Leapfrog requirement of full-time, board certified intensive care specialists in the ICU, SLH is in the initial stages of development of an e-ICU which will meet the Leapfrog standard for ICU care. Numerous studies have demonstrated improved clinical outcomes including lowered error rates, lowered patient injury rates, lower death rates and lower costs when ICU's are staffed by full-time intensivists. The e-ICU is the provision of technology-enabled remote care provided by off-site physicians.

The Administrative and Financial Systems are comprised of Accounts Receivable Management, Incident Reporting, Medical Information Data Analysis System (MIDAS), and traditional financial systems including HR/Payroll, Materials Management/AP, General Ledger, and Financial Reporting. Access to Administrative and Financial Systems output data is accomplished via REVEAL, a PC-accessible end-user system that provides daily and monthly online reporting of operations information.

The Executive Information System (EIS) and Decision Support System (DSS) are automated solutions that translate much of the data from the clinical, administrative, and financial systems into information that supports key business decisions and strategic planning functions. These systems work in conjunction with data contained in the Budget, Research Analysis Department, and key internal data sets such as BSC data. DSS integrates patient-level resource consumption, demographics, clinical, and billing data with general ledger financial data. This information is used to assess performance relative to internal financial and operational goals. DSS is an integral part of SLH's combined budgeting process that produces flexible budgets and operational performance monitoring. Monthly flexible budget reports are available via REVEAL. Access to other key output data such as BSC, DSS, and RAD Data Sets is accomplished via the McKesson HBI (Horizon Business Insight) product. HBI serves as the EIS for SLH, with selected daily, monthly, and quarterly statistics, and interfaces with the billing, patient management, and DSS systems. This is a web-enabled system that provides e-mail alerts to executives regarding measures that vary from pre-specified parameters.

The e-Health strategy utilizes the web as an interactive tool for communication of information and data between the enterprise and its staff, suppliers and partners, and patients and customers via e-portals. SLH has implemented: a single point customer access e-portal to provide on-line health information; a single point physician access e-portal to allow physician timely alerts and clinical test results, and is staged to support physician order entry; a single point employee e-portal for update of employee demographic information, annual benefits enrollment, and viewing of current and historical payroll information; and a patient e-portal that includes eAccount Manager, a tool that allows patients access to their billing information as well as the ability to pay bills via the internet and communicate with billing staff about bill status via e-mail. Additionally patients have the ability to pre-register for services via the patient e-portal.

SLH uses a number of methods to ensure that hardware and software are reliable, secure, confidential, and user friendly. These include policies and procedures, technical security measures, and user education and awareness. During orientation, all employees acknowledge their responsibility for protecting patient information by signing confidentiality agreements. These agreements cover the proper access and use of confidential information. Annually, managers review the confidentiality requirements with their employees. The confidentiality agreement covers all automated and manual information that is collected and utilized by SLH. Physician access is also controlled using signed confidentiality agreements that are maintained by the Medical Staff Office. Contractors also are required to sign a confidentiality agreement to ensure that only those who need access will be granted access to data.

Technical security measures include hardware and software tools that enforce the security policies, such as limiting employees' access to patient information based on their physical location, their job responsibilities, and their department. Because passwords are the most commonly used method of restricting access to information, employees are instructed on how and why to select "strong" passwords. A strong password is the combination of a personally selected password and a personal identification number (PIN) that ensures uniqueness of that individual to the computerized system. In addition, secure "token" security access is utilized for SLH admitting physicians and other users to provide HIPAA compliant access from remote locations.

SLHS uses state-of-the-art firewall strategies that are on the leading edge of technology, providing SLH patients, employees, and business partners with more secure and reliable access to required data. The Internet/Extranet approach has two firewalls in place to isolate SLH and other System entities from outside networks. Check Point Firewall-1 protects SLH from the Internet; Cisco Private Internet Exchange protects SLH from its private connections (Extranet). Both firewalls are industry leaders in the marketplace and provide full firewall protection to conceal internal network architecture from the outside world.

All automated clinical and administrative information systems are backed up to tape on a nightly basis, using an automated process to back up and verify data. Data transactions for mission-critical systems are journalized to tape at hourly intervals throughout the day to maximize data recovery efforts in the event of a hardware or software failure. Tapes are stored off-

site, using a rotation system consisting of eight daily tape versions, five monthly tape versions, and five quarterly tape versions. The off-site tape storage location is a remote underground facility that is bonded and secured. To ensure business continuity, IS is also piloting a disaster recovery backup process with Computer Associates. Early stages of this plan have already been executed.

In addition, the SLH Data Center monitors all information systems for data integrity and network errors on a 7-by-24 basis, using automated monitoring and management tools supplied by Platinum Technologies. System and network errors are flagged immediately and remedied through a structured problem resolution methodology that identifies appropriate tier level support responsibilities. To ensure the least amount of business interruption, various system redundancy strategies have been deployed. All hardware systems are configured with redundant power, disk storage, and data controllers. Mission-critical messaging and data interface engines utilize clustering technology for complete system fail-over in the event of hardware or software failure.

The organization monitors targeted population usage rates (i.e., staff, physicians, and residents) to ensure that the computer systems are being utilized. These data are regularly reported to EC, MSEC, and MSB. A drop in utilization would trigger a drill down into the causes (i.e., lack of user friendliness).

SLH employs several approaches to ensure that data and information availability mechanisms are current with health care service needs and directions. SLH actively participates in SLHS's long-range (5-year) Information Technology (IT) plan, based on the strategic goals of the System. The PISC identifies key trends for the future needs of data and information and helps to prioritize those needs through this process. This plan includes both hardware and software enhancements based on the latest computer developments. Also, users of key systems provide direct input into SLHS software/hardware product selection as well as enhancements to be operationalized. Finally, through IT vendor partnership arrangements, SLHS serves on key vendor product enhancement task forces to influence and prioritize needed future product enhancements to the IT systems that SLHS utilizes.

**4.2b(1)** There are multiple approaches deployed to manage organizational knowledge. Both formal and informal mechanisms encourage and support the exchange of knowledge at all levels of the organization. The collection and transfer of staff knowledge is accomplished through multiple mechanisms listed in Figure 4.2-2.

Best practices are shared at all levels, and in addition SLHS conducts a Best Practices sharing day twice each year.

**4.2b(2)** Organizational knowledge is heavily dependent on the data and information supplied and evaluated. Key to ensuring integrity, timeliness, reliability, security, accuracy and confidentiality of all data, information and ultimately knowledge are staff and data management systems. To assure that staff exhibit these properties, SLH begins with the selection of individuals exhibiting the core values through the interviewing process and PMP. The organization provides employees with the mechanisms to "do the right thing" by setting project and performance expectations and boundaries. This sets the platform for work systems that assure integrity, reliability, accuracy and timeliness. Tools, such as training, internal team facilitation,

| Kowledgeholder | Method to Collect/Transfer |
|---|---|
| **Staff Member** (individual) | • Departmental or unit meetings<br>• Staff reports<br>• Suggestions to manager<br>• Preceptor programs<br>• Informal communication among peer groups<br>• Suggestions to teams/council<br>• E-mail<br>• Newsletter<br>• Bulletin boards |
| **Teams/Councils** | • Stakeholder input to team<br>• Team to Team sharing (SLH Team Quality and Medication Team Reports)<br>• Team to sponsor reporting<br>• Storyboards<br>• Presentation of team learnings or design changes (published in Rounds, Horizons or discussed at departmental meetings). |
| **Organizational** (leadership) | • Staff focus groups<br>• Staff surveys (patient safety, employee sat)<br>• Staff to leadership meetings<br>• Hospital leadership group meetings<br>• Best practices learned from conferences or literature<br>• Leadership retreats |
| **Patients** | • Patient advocate<br>• Nurse caring for patients<br>• Administrator on call<br>• Patient satisfaction survey process<br>• Use of customer contact requirements<br>• Physicians/residents<br>• Printed material<br>• Video |
| **Physician** | • Communication within medical staff structure<br>• Input into teams/committees as a member or stakeholder<br>• Development of evidence-based pathways or guidelines<br>• Rounding to outlying areas<br>• Presentations such as Grand Rounds, or educational conferences |
| **Key Suppliers** | • Checking references/resources provided by partner<br>• Training of staff by supplier (IS, medical equipment)<br>• Monthly and quarterly meeting |
| **Students/ Residents** | • Rounding<br>• Educational conferences<br>• Posters<br>• Caring for patients |

**Figure 4.2-2 Management of Organizational Knowledge**

and the measurement architecture assure security, confidentiality, accuracy and integrity. Retention of skilled staff is key to assuring reliability and integrity of organizational knowledge. Continued evaluation using core values, as well as recognition and reward of employees, are two methods used to retain staff. Similarly, data management systems are selected, developed and maintained to maximize these properties. As Information Systems are selected, hardware and software sources are screened. Specifications are defined through the development of definitions, identification of needed data elements, and user requirements. This structure provides for integrity, reliability and accuracy of the data elements. Training is also provided to end-users to access data and reports, as well as the usage of the reports. This training brings security, integrity, confidentiality and accuracy to the organizational knowledge base. Lastly, the output is validated through the use of data validity checks and statistical analysis to assure reliability and integrity of the reports.

# CATEGORY 5—STAFF FOCUS

## *5.1 Work Systems*

SLH uses matrix systems architecture to manage work and jobs. The foundation of this architecture rests on the traditional organizational structure of a tertiary care teaching hospital in which work is aligned according to product lines (i.e., cardiovascular disease or cancer), clinical departments (i.e., internal medicine or pediatrics), administrative departments (i.e., finance or human resources), nursing units (i.e., intensive care units or blood and marrow transplant units), cross functional work teams (i.e., patient fall team or medication error reduction team), and multidisciplinary committees (i.e., safety committee). Each of these has an assigned governance structure, responsibility, reporting system, and specific task accountability. In addition to this structural alignment within the organization, workflow (i.e., patient care delivery or support process delivery) is accomplished using a variety of processes depending on whether the workflow involves a specific health care delivery team, specialty care, or education, research, administrative or support process. Management of this complex matrix of work processes and job functions is accomplished using a variety of tools including the Performance Management Process (PMP), coworker or customer feedback, prospectively designed policies, procedures, protocols, or clinical pathways, employee, physician, student survey instruments, a rigorous practitioner credentialing and recredentialing process, and the use of rewards and recognition to encourage staff performance and commitment to the organization.

**5.1a(1)** To promote cooperation, initiative, innovation and a healthy organizational culture, SLH has placed specific emphasis on the use of multidisciplinary teams and committees to enhance communication and decision-making, and a Patient-Focused Delivery Model, which is based on a Multi-disciplinary Care Team (MCT). This team, comprised of physicians, residents, students, clinical nurses, patient care technicians and information associates, was created in order to direct work, assign accountability, focus individual patient care and foster innovation through the use of prospectively designed clinical pathways, protocols and policies. These care teams continually assess, plan, evaluate, intervene and modify individual patient care delivery for their assigned patients. Team members are accountable and responsible to their patients and families, the attending physician, and other team members. The skill mix of the MCT is unit specific and is defined in part by patient activity and service intensity, length of stay requirements, and overall patient needs.

Workflow for staff not directly involved in patient care is organized by function. Many of these areas (such as Human Resources, Quality Resources, and Materials Management) have been reorganized into flatter, more customer-focused structures. Staffs in these areas are aligned with specific MCTs or product line business units.

Innovation within the complex matrix of SLH's health care delivery services is encouraged through the solicitation of employee suggestions, ideas, and feedback by both formal and informal methods, ongoing formal education of the workforce and physicians, including daily educational conferences and unit specific inservice education, new technology acquisition, ongoing clinical research programs, and use of external stakeholder partnerships to foster community cooperation and encourage acquisition of new knowledge and techniques.

**5.1a(2)** SLH capitalizes on diversity by ensuring that it has a diverse workforce in place, and through its focus on teams and knowledge sharing. The diversity of the workforce is reflected in the make up of teams and work groups, thereby allowing for diverse ideas, cultures, and thinking to be expressed in team activities and daily work. In addition, the knowledge sharing methods described in Item 4.2 ensure that a diverse cross section of the work force is included in data gathering activities and communication flows. This permits an understanding of knowledge, biases and concerns from employees of all backgrounds and at all levels.

**5.1a(3)** Administrative leaders share responsibility as BSC Perspective Leaders with medical staff leaders to manage the functions of the five perspectives thus facilitating cooperation, communication, alignment, innovation and a robust organizational culture.

**5.1b** In the PMP for each employee, primary customers at all levels are identified as part of the job description so that each employee knows his/her roles and customers prospectively. In addition, the PMP defines the four core values of the organization and then delineates the shared expectations, position-specific competencies required, and the employees' personal commitments needed for each core value to meet the organizational, department, or unit goals and to assure alignment

of individual employee performance with the organizational measurement system. At least annually, each employee participates in a formal coaching session with his or her supervisor where feedback and performance recommendations are provided to the individual by core value. A similar process occurs for senior leaders, employed physicians, and residents in training.

To support SLH's pay-for-performance strategy, managers and directors use the PMP to set compensation through an evaluation scoring system that corresponds to a merit matrix, thereby rewarding employees on the basis of performance while also taking into consideration the individual employee's compensation compared to the local market. The compensation program and the PMP provide the tools for making equitable pay decisions, for rewarding individual performance that supports the mission and annual operating goals, for identifying developmental opportunities, and for targeting pay levels at market rates.

In addition to individual recognition through the PMP, a combination of reward and recognition methods are linked to SLH core values, as shown in Figure 5.1-1.

**5.1c(1)** Key competencies and skills required for each position at SLH are captured on the PMP form, and these are formally reviewed at least yearly through the performance management process. Characteristics, skills and abilities needed by potential staff are identified based on SLH strategic initiatives, competitive forces in the local market, newly acquired technologies, and performance improvement efforts. All patient caregiver jobs are designed using core competencies, to include the age specific core competencies required by specific regulatory agencies such as JCAHO, CAP and AABB. New positions are defined using the PMP and are developed by directors in collaboration with other departments to encompass customer expectations. Once a candidate is selected, HR performs an extensive background check including a reference check, criminal record check and drug screening, along with appropriate verification of licensure and education.

**5.1c(2)** New employees are recruited using a variety of sources, including print advertisements, word of mouth from current SLH employees (the most common), the internet, career fairs, national/regional conventions, community agencies, the employee referral bonus program, search firms, and through internal transfer and the System transfer process. HR representatives and hiring managers throughout the hospital use Behavior-Based Interviewing (BBI) by core value to assure that individuals selected for employment are a good match with the hospital's mission, culture and values, and to assure a smooth transition to their new role.

Physicians are recruited using a master staffing plan, with consideration given to SLH strategic initiatives, newly acquired technology, educational and research requirements, and scheduled retirement of older physicians. Physician applicants to the medical staff must undergo an extensive background check, including their malpractice history, and are credentialed and privileged in accordance with JCAHO, state licensure requirements, and medical staff bylaws, rules, and regulations.

SLH retains qualified staff by using a multilevel approach that includes such initiatives as maintaining a competitive compensation package (annual salary/benefit survey), sustaining employees' desire to maintain their competency (educational support), maintaining SLH as an "Employer of Choice" (one of the top 100 employers for working mothers), soliciting suggestions and feedback from employees (Employee Feedback Groups) career advancement programs or ladders, team building, multiple team and individual reward and recognition programs, and other empowerment activities. SLH monitors its efforts in retention through the retention measure, which is on the BSC.

Diversity is recognized by SLH as an important part of its life and function. SLH serves a diverse community and strives to reflect the community in its employee base, employs an increasingly diverse workforce, monitors its efforts through its diversity metric noted in its BSC, and supports an active Diversity Council at the System level. Diverse ideas, cultures and thinking are important in SLH's culture in order to sustain its urban mission as a tertiary educational healthcare institution.

| Core Value | Organizational Level | Department Level |
|---|---|---|
| Quality/ Excellence | Employee of the Month<br>Employee of the Year | Clinical Excellence Awards |
| Resource Management | Employee Suggestion Program<br>Volunteer Recognition Award | Deployment of selected employee ideas for expense reduction |
| Customer Focus | "Angel for an Angel" Award | Spot recognition awards for customer service |
| Teamwork | SLH Team Quality Award | Spot recognition awards for teamwork |

**Figure 5.1-1 SLH Reward and Recognition Programs**

**5.1c(3)** SLH models its senior administrative leader succession plan after the System plan. All openings in leadership positions are announced across the health system via email distribution prior to contracting with executive search firms. Senior leaders are mentored on an individual basis to prepare them to step into other leadership roles with a seamless transition. Development of highly qualified individuals who are capable of additional responsibility has allowed SLH to maintain a core of senior leaders that are capable of sustaining the vision and mission of the organization. Over 80% of the members of the hospital's current Executive Council have been promoted from within the organization. Senior medical staff leaders are developed over a 10-15 year period by advancing recognized individuals through the governance structure of the medical staff until they obtain the skills necessary to become medical staff officers (5 year commitment). Each year a new officer is selected by a nominating committee and elected by the entire medical staff. That new officer then systematically rotates through each of the

five officer positions during the following five years, and thus serves as a leader of each of the five BSC perspectives over that 5-year period.

At the staff level, succession planning is accomplished through the PMP where personal commitments are set each year based on the employee's individual development plan. The personal commitments are reinforced through career ladders found in many departments and units, e.g., Nursing, Pharmacy, Surgical Services, Information Services and the Child Care Center. All open positions are posted internally, and any internal candidate who is qualified is encouraged to apply. Internal candidates fill approximately 30% of all openings.

## *5.2 Staff Learning and Motivation*

5.2a(1) SLH education, training, and development programs support its mission, vision, core values, SFAs and SAPs. Reflecting the importance SLH places on organizational and personal learning, a Chief Learning Officer (CLO) position was established in early 2003. The CLO is responsible for centralizing the determination of training needs, training delivery options, reinforcement of skills and knowledge, and knowledge and best practice sharing. Efforts are currently under way to enhance SLH's already strong performance in each of these areas. SLH education, training, and development programs are categorized in four critical areas as shown in Figure 5.2-1. Responsibility for managing SLH training offerings is deployed to the sponsoring groups where the expertise resides for the various subject areas.

Every offering begins with an understanding of how it supports one or more of the SFAs. Requirements to support SLH SAPs are developed as part of the planning process with the use of the Workforce Planning and Assessment Tool. The Administrative area focuses on development and learning needs generated from feedback obtained through the PMP, as well as from executive directives and the planning process. Information on training needs is passed from SLH leaders and HR to the sponsoring organizations so that appropriate action can be taken to identify a training offering and plan its implementation.

Continuing education and professional development is addressed in the Clinical Education area and is the responsibility of Nursing Staff Development (NSD). Clinical Medical Education (CME) addresses physician training requirements.

5.2a(2) Key organizational education, training, and development needs include the following:

**Technological Change** – the IS training department is responsible to provide new technology training as needed and conducts ongoing desktop training support as part of its course curriculum. IT training is directly linked to the People and Financial SFAs.

**Management/Leadership Development** – to ensure that SLH leaders have the opportunity to develop their skills and capabilities HR, OD, and the Diversity Departments conduct designated training in the following areas: sexual harassment, PMP, turning poor performers into productive ones, current developments in HR law, BBI, DDI leadership, and diversity. These standard offerings directly support the SLH People SFA and are revised based on PMP feedback and direction from senior leaders.

**New Staff Orientation** – all new staff, both clinical and administrative, go through an orientation program. Clinical Orientation includes training on the following: philosophy of nursing, legal issues of practice, delegation issues, code blue review, pain management, patient safety, physical assessment/critical thinking, advanced directives, and body mechanics. New Employee Orientation includes training in the following areas: PI Model, diversity, safety, information technology, PMP, corporate compliance, spiritual wellness, and health enhancement. The Corporate Compliance Plan (CCP) is introduced by the AOC, and all employees are required to read the plan and sign an acknowledgment of understanding. Each employee's commitment to the CCP is reaffirmed each year during the PMP. New employees are also provided with "A Guide to Organizational Ethics" that has been endorsed by the Medical Leadership Council of SLHS as well as the BOD and is designed to be a guide to making patient care and business decisions.

**Safety** – this training is a requirement for all SLH employees during orientation and on a recurring basis and directly supports the Clinical and Administrative Quality SFA. Required safety modules include general safety, electrical safety, emergency preparedness, fire safety, and back safety. Training is offered in a variety of delivery methods based on the varying needs of SLH departments, including interactive video, computer-based, and paper/pencil. In addition, specific safety courses are offered to employees based on their job requirements.

**Performance Improvement** – PI education begins in orientation with an explanation of the PI Model. In-depth half-day training on the use of the PI Model is open to all SLH employees and physicians desiring to learn the mechanics of the model. Additionally, specialized training is offered, through the Quality Resources Department, to teams, committees, and departments as needs are identified. Examples of training provided include Balanced Scorecard, "PI Tool Time" at Nursing Quality Council, and just-in-time training for PI Teams. PI training and education directly supports the Clinical and Administrative Quality SFA.

**Diversity** – this training is linked to the People SFA and is provided to every new employee during orientation. The SLHS Diversity Department and the Diversity Education Committee are responsible to develop new or additional training based on input from leadership, feedback from the PMP, or input from the Diversity Trainers.

5.2a(3) Each year, Directors/Managers compile a prioritized list of department training needs, including desired delivery methods

based on PMP outcomes. An Education Opportunity Feedback Form is used by these leaders to submit this information. Once compiled, the list is sent to HR where the Administrative Training Committee (ATC) reviews the inputs using defined criteria. The training request must first be linked to one of the SFAs in order to be considered. Once that linkage has been established, requests are positioned on an Impact/Cost Grid. High impact, low cost requests receive the top priority for approval.

MCET and NSD assess needs of the clinical staff through a variety of methods including multidisciplinary surveys, written program evaluations, competency issues, incident reports, new patient care guidelines, new equipment, regulatory requirements, and feedback from the PMP. Clinical education needs are also developed through hospital-wide teams and organization task forces or committees that are initiated by MCET and NSD.

| Area | Purpose | Examples | Sponsors |
|---|---|---|---|
| Administrative | • Enhance position specific competencies<br>• Support mission, vision, core values, strategies | • Orientation<br>• BBI<br>• Diversity<br>• Leadership Level<br>• Baldrige Mgmt<br>• Computer Use<br>• PI Training | • HR<br>• Org Dev<br>• Sr Leaders<br>• IS<br>• QR<br>• Diversity Council |
| Clinical Education | • Enhance clinical competencies<br>• Support mission, vision, core values, strategies<br>• Provide continuing education<br>• Promote professional development | • Multidisciplinary Grand Rounds<br>• Inservice Training<br>• PCT Training<br>• JCAHO Preparation<br>• Career Advancement Program<br>• Nursing Orientation | • MCET<br>• NSD<br>• Clinical Education Specialists |
| Continuing Medical Education | • Enhance clinical competencies<br>• Support mission, vision, core values, strategies | • Multidisciplinary Grand Rounds<br>• Formal Educational Offerings<br>• Training Program Core Curriculum<br>• Visiting Lecturers | • Medical Education<br>• Program Directors |
| Resident Training Programs | • Train/educate future caregivers<br>• Support mission, vision, core values, strategies | • Defined Core Training Curricula<br>• Visiting Lecturers<br>• Clinical Care Experience | • Residency Program Director and Teaching Faculty<br>• UMKC SOM<br>• Medical Education |

**Figure 5.2-1 SLH Education, Training, and Development Areas**

5.2a(4) Training delivery methods are selected based on employee needs as determined from staff input, resources available, feedback from the Education Opportunity Feedback Forms, and the desired learning outcome of the program. For both Administrative and Clinical areas a diverse delivery approach is used to include classroom activity, inservices/CE, self-study packets/modules, video/audio tapes, posters/printed material, role playing, one-on-one mentoring or coaching, group/team interaction, computer-based training, and internet access. CME programs use didactic lectures, case-based discussions, panel discussion and the Audience Response System to deliver training. CME currently has accredited programs in a video and CD ROM format.

5.2a(5) A number of methods are used to reinforce knowledge and skills on the job. These include observation and teaching during administrative rounds, mentoring/coaching, CME follow-up activities, peer review, and direct observation from managers and supervisors. The PMP provides a formal tool by which job-specific, core values-related, and action plan-related training can be reinforced during coaching sessions. Managers and supervisors are required to determine if personal PMP commitments have been achieved and if knowledge has been gained during their coaching/mentoring sessions with employees. They review those areas and reinforce the requirements as they develop training and development needs for the next cycle. Each April they assess the learnings of the previous year and determine how it affected behavior among their staff.

5.2a(6) Training is evaluated using the Kirkpatrick Model. All training delivered at SLH has at least a level 1 evaluation that measures how favorably the trainee responds to the material presented. Many of the courses in all four areas use level 2 measurement that determines if learning has occurred, and some use level 3 measurement to determine if behaviors change back on the job. In addition, SLH applies level 4 measurement to determine if training has had a positive impact on overall performance.

5.2b SLH leadership uses a wide range of formal and informal motivational methods to promote professional development of its employees. Informal methods include performance feedback, skill sharing, and mentoring. In addition, residents and students have active coaching on a daily basis and observe staff physician role modeling along with formal and informal evaluations. On a formal basis, SLH utilizes the PMP, which emphasizes coaching and individual development through the setting of "personal commitments" each year that include learning goals. The PMP is both a motivator and a coaching tool with three key components in a continuous cycle: planning, coaching and review.

Leaders are encouraged to identify staff that have the potential to advance within the organization. Those individuals who have demonstrated potential are placed in advanced positions and given the opportunity through formal educational offerings or through informal mentoring to develop their leadership skills. In addition, this process is performed at the medical staff levels where potential leaders of the medical staff are identified and provided with the opportunity to advance within the governance structure of the medical staff. Even at the resident and student levels, leaders are chosen based on merit and capability.

### *5.3 Staff Well-Being and Satisfaction*

**5.3a(1)** Ensuring the safety and health of employees begins during new employee orientation when a nurse conducts a pre-employment health assessment. Based on that assessment, recommendations are given to the new employee on how to promote a healthy lifestyle. At general orientation, all employees receive extensive training and education related to risks of exposure to bloodborne pathogens, tuberculosis and other infection control issues, as well as other hazards inherent in the health care environment. Employee wellness at SLH is promoted through the *Lifewise* program at the Center for Health Enhancement, the Baby Building program for expectant parents, and the *It's Time to Feel Good* campaign. An important component to the employee wellness program is the state-of-the-art questionnaire *HealthTrac* that includes follow-up from a physician, interventions for those employees identified as high-risk, and guidance for a healthier lifestyle.

The promotion of health and productivity extends to the environment in which work-related injuries are assessed and treated. Employees are strongly encouraged to report all injuries and illnesses to the EHS. The goal is to foster an atmosphere of accessibility and helpfulness. All injuries are assessed by a registered nurse. A physician and a nurse practitioner, both trained in occupational medicine, are also located in the EHS clinic and treat all employee injuries.

Staff participation in improving the work environment is considered to be critical to improving safety. Employees are encouraged to correct safety issues at the work unit level when appropriate. In addition, employees serve on subcommittees of the Safety Committee, and identify safety issues by trending issues and illnesses, evaluating the issues, making recommendations, measuring outcomes, and conducting ongoing program reviews. SLH uses a variety of methods to communicate and promote its philosophy of health and safety, including regular safety education and training, fire drills, safety newsletters, walk-through inspections and hazardous materials identification, ergonomic reviews, and infection control programs. Methods for dealing with, preventing, and reporting workplace violence are addressed during orientation through an interactive session with the security staff and a video, are reflected in hospital policies, and are offered on an ongoing basis to current employees. Safety requirements are enforced in clinical paths, the PI model, and the PMP.

An Ergonomic Team serves as an adjunct to the Safety Committee. This committee serves to oversee the overall ergonomic program. This includes assuring that ergonomic education and training is disseminated to all new and existing employees.

The work place environment is monitored using twenty-seven metrics divided into seven environments of care functions. These metrics are tracked monthly and compared to annual prospectively developed targets. Due to the diversity of the metrics architecture, the work environment is segmented, allowing senior leadership to monitor more closely the different work areas.

**5.3a(2)** SLH prepares for natural or man-made disasters and emergencies that can significantly disrupt the environment of care through a four-phase planning process captured in the Emergency Management Plan (EMP): mitigation, preparedness, response, and recovery.

The Emergency Management program for Saint Luke's Hospital is coordinated by the Emergency Management Subcommittee of the Safety Committee.

**5.3b(1)** SLH uses a variety of tools and methods to determine employee well-being, satisfaction and motivation. These include formal surveys, open forums with senior leaders, targeted focus groups, "rounding" by senior leaders, an "open door" policy, team activity, employee "stay" interviews with long-tenured employees to capitalize on successful retention strategies, "exit" interviews with employees who left SLH both voluntarily and involuntarily, and the Peer Review Grievance Process where specially-trained employees volunteer to serve as members of peer review panels to hear employee grievances. Since the inception of the peer review grievance process, SLH has experienced a decrease in EEO charges and employee lawsuits. Aggregate results from many of these methods are presented to the EC and HLG members on a regular basis, and this information is used to design new programs and establish policies and benefits for employees. For example, multi-disciplinary teams have conducted formal employee opinion surveys on a regular basis since 1993.

**5.3b(2)** SLH offers its employees a wide variety of services and programs through its "flex" benefit package. This benefit package represents 34% of total compensation and exceeds the local market (25% of total compensation). Employees may choose from a variety of health insurance options and types of providers (HMO or PPO). Other benefits/services include: Paid Time Off/Extended Sick Leave; liberal leave of absence policies; an on-site Child Care Center that also sponsors a summer day camp for school-age children; Baby Building (an educational program for expectant employees and their spouses); adoption assistance; flex-time; opportunities to job-share; recreational activities; use of an on-campus health club; a subsidized cafeteria and free parking. SLH also recognizes the emotional needs of its employees. Stress management

programs, crisis intervention training and debriefing, an Employee Assistance Program (EAP), therapeutic massage, and access to Spiritual Wellness for all employees help foster a healthy work environment for all. Many of the services offered are specifically designed to enhance the work environment for female employees who comprise 80% of SLH's workforce. In recognition of its efforts in this area, *Working Mother Magazine* named SLH one the "100 Best Hospitals for Working Mothers" in 1998.

In 1996, SLH, in partnership with SLHS, created a Diversity Council comprised of physicians, administrators, department managers, clinical and support staff, and community volunteers. The purpose of the Council is to highlight SLH's goal to foster a diverse workforce and to deal effectively with issues surrounding diversity. The Council launched a diversity-awareness educational program in 1997 for all SLHS employees that has been incorporated as a regular part of employee orientation. The Council has also sponsored informal "diversity dialogues" during the lunch hour, and has supported the creation of employee networks to foster communication between hospital administration and employee groups with specific interests. The Diversity Council is facilitated by the SLHS Vice President for Diversity and accomplishes its work through a committee structure with participation by employees at all levels of the organization. Through the ongoing interchange of people and ideas, SLH is tailoring the needs of its workforce to its patients and its community.

**5.3b(3)** As noted previously, SLH uses both formal and informal tools to survey its workforce (employee, physician, students and other caregivers). In 1999, a formal survey was administered which consisted of 200 questions divided into 50 indices which reflected SLH core values such as customer focus, quality, community involvement, team performance, job satisfaction and diversity. An important result of the 1999 survey was the development of a cultural competency program for managers that is currently being revised by the Diversity Council. Follow-up surveys incorporating the action steps taken in response to the 1999 survey were randomly given to select groups of employees representing all shifts in October 2000 and May 2001 using keypad technology. In October, 2002 SLH introduced an employee survey tool that is aligned with the Baldrige model, and will be administered in the fall of each year. Action steps identified from the results are being implemented in 2003. SLH uses multiple regression analysis (MRA) as a statistical method to identify key factors from the survey tool. MRA identifies those questions that have the greatest impact on the employees' overall satisfaction. SLH uses other results besides formal survey methods to make judgments about employee satisfaction as discussed in Item 5.3b(1). Unfavorable trends in any of these measures trigger additional research to determine root cause.

**5.3b(4)** The 62 indices created from the survey tool allow senior leadership to easily identify strengths and opportunities for improvement and to drive change in an efficient way. In addition, senior leaders use the BSC People Perspective to monitor employee satisfaction and motivation by tracking the six measures noted below. These BSC measures reflect the key drivers of employee commitment, and are tracked on a quarterly basis:

- employee retention calculated based on employee turnover; turnover is also correlated with patient satisfaction;
- diversity as measured by the percentage of culturally diverse managers and professional staff compared to the local labor market;
- human-capital-value-added which represents employee productivity;
- employee satisfaction as measured by the annual survey of SLH employees using the Baldrige-aligned survey tool;
- job coverage ratio calculated based on the vacancy rate of five key clinical positions (new in 2003); and
- competency as measured by successful completion of performance appraisals.

These measures reflect SLH's commitment to retain productive employees, particularly in key clinical roles, who have a voice in improving their work environment and who are mentored by diverse leaders. Correlating the results of the People Perspective to the other 4 perspectives on the BSC allows SLH leaders to evaluate the impact that many different organizational initiatives, decisions, and factors are having on its workforce.

# CATEGORY 6—PROCESS MANAGEMENT

## *6.1 Health Care Processes*

Saint Luke's strong emphasis on continuous improvement and patient/stakeholder satisfaction motivates physicians and employees to focus on process design, management and improvement in order to produce the consistent delivery of high quality health care services and achieve high levels of patient/stakeholder satisfaction. The Service Design, Management and Improvement Model (Figure 6.1-1), is used to achieve these results. The PI Model, as it is known, contains five basic phases – Plan, Design, Measure, Assess, and Improve – and is fully deployed across all hospital departments. It has been in place for many years, and has undergone a number of evaluation and improvement cycles. Every employee is provided an introduction on the use of the PI Model during orientation training, process owners and PI team members receive detailed follow-up training on the use of the PI Model, and it is prominently displayed as part of the VIP Card to reinforce its importance.

**6.1a(1-3)** SLH determines its key health care services and service delivery processes through its market analysis conducted in conjunction with strategic planning and through use of the plan and design phases of the PI model. Health care services are

focused on the needs of the community and are delivered in a manner that coordinates care from the physician's office to the inpatient stay to a post-acute setting or the home. Key health care processes and their requirements are shown in Figure 6.1-2. Value for SLH, patients and other customers is obtained from these processes by fulfilling the mission of providing excellence in health services, by generating revenue that supports SLH's ability to promote community health, and by affording increased access to health care. Improved health care outcomes are achieved through a detailed approach used by all SLH caregivers in carrying out these processes. SLH uses the first two phases of the PI Model, "Plan" and "Design", to propose, design and implement new health care programs/services and their associated delivery processes. A requirement for a new program or service is typically generated as a result of the Strategic Planning Process (SPP) or as a result of submission of a proposal by a new program/service sponsor. If generated through the SPP, new requirements are typically driven by factors evaluated during the process such as: national health care trends; monetary policy; demographic, market and customer needs assessment; vendor requirements; or technology and health care advancements. As market, customer and healthcare requirements change, SLH physicians and senior leaders, by way of continuous educational initiatives, engaged Board, strong community focus and participation in external organization, utilize the planning and budgeting process to identify new customer needs and requirements. The planning and budgeting process contains the necessary decision-making structure to identify new requirements, prioritize them based on linkage to the hospital's key strategic objectives and challenges, and direct a design effort.

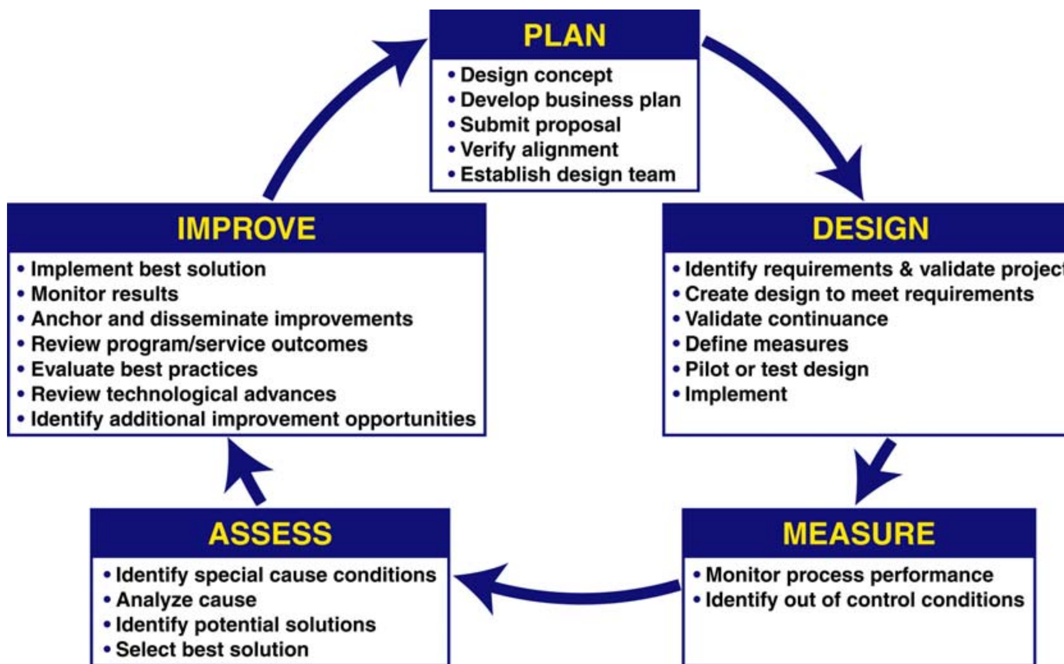



**Figure 6.1-1 SLH Service Design, Management, & Improvement Model**

Outside the planning process, sponsors may initiate a new program/service concept proposal whenever they see a need arise. Sponsors may be physicians, members of the EC or HLG, Board members, employees, students, and even volunteers. Sponsors follow the "Plan" phase of the PI Model, when developing a proposal. They are responsible for defining the program/service concept, developing a business plan with the appropriate operational and financial considerations, and submitting the proposal to the EC for consideration. Included in this proposal is an explanation as to how the new program/service will address the customer needs and requirements, support the hospital's mission and vision, and create value to both the organization and customers. The EC evaluates the concept and business plan, verifies that it aligns with the SLH vision, mission, values and strategies, and determines if a design effort should be initiated.

Once the decision is made to proceed with a design effort, a team is established. The team is comprised of stakeholders of the program/service, including physicians, employees, customers and suppliers, as appropriate. The team proceeds with the "Design" phase of the PI Model. Initially, the team is responsible for identifying the requirements of the new program/service and then validating that the proposal should continue. This entails developing an in-depth understanding of customer and market requirements and establishing the features of the program/service needed to address those requirements.

The PI Model requires the teams to create a detailed design of the new program or service, as well as its delivery process, based on the requirements information. In developing the design, the team strives for highly effective health care outcomes and seeks to control costs by reviewing learnings from past SLH design projects, researching best practices, benchmarking other organizations, and obtaining stakeholder input. Stakeholders are viewed as "subject matter experts" and play a critical role in helping the team design the most effective and efficient program/service and delivery process. New technology opportunities are also sought by means of an evaluation of specialty and service line requirements, research initiatives, vendor input, review of information from the VHA Clinical Advantage Program, and an ongoing literature search. A financial feasibility analysis is also conducted, and at the conclusion of the design development, the team once again validates that the project should continue. Once the decision is made to proceed, the team moves to develop key success

measures for the new program/service and delivery process. These include both in-process indicators of delivery effectiveness, as well as outcome measures to indicate overall program/service effectiveness. Both types of measures are driven by the key customer and organizational requirements of the program/service and delivery process. Once the key success measures have been identified, the team develops a methodology to pilot or test the new program/service and its delivery method as required by the PI Model. Generally, SLH will pilot the program/service in a small, selected area to determine the overall effectiveness and feasibility of introducing it. The results of the pilot drive the decision to move forward with implementation.

**6.1a(4)** Patient expectations are originally factored into the design of the health care service in the Design step of the PI Model and again when measures are identified to evaluate the performance of services and delivery processes. However, SLH personalizes its health care service delivery by addressing the individual needs of patients and families when they enter the health care delivery process. During the initial intake and assessment of the patient, the patient's and family's expectations and desires are obtained through a consultation with members of the care team and are integrated into the care plan design. This includes incorporating the patient/family's health care preferences into the **Multidisciplinary Care Process (MCP),** which is used to design and deliver the care plan. Four primary tools are used to accomplish this process:

1. The patient evaluation by the physician allows for an in-depth medical, social, and family assessment of the patient, as well as a full explanation of the risks, benefits, and options that are available for care (e.g., use of radiation vs. chemotherapy vs. surgery for breast cancer).

2. Upon admission to SLH, caregivers complete the Initial Assessment, which is a multidisciplinary intake form, summarizing the patient's medical history and current physical condition. This intake form allows caregivers to identify special patient needs or expectations and is used to determine the initial plan of care. This form is then utilized throughout the hospital stay by numerous caregivers that help guide care and treatment options, as well as communicate patient expectations.

3. Approximately 60% of SLH patients are placed on a clinical pathway, a predetermined (by physicians and nurses) treatment protocol designed to standardize care and reduce variation. Some pathways include a standardized order set to facilitate care delivery. Pathways are also reconfigured for patients in a separate document called the "patient path". This is a patient friendly format that allows both the patient and family to understand and track what will occur during treatment. The nurse or physician reviews the treatment plan with the patient and family, the anticipated length of stay in the hospital, and any other particular patient needs/expectations that may impact care. Special needs or patient expectations are used to modify the pathways to incorporate additional care or services.

4. Finally, SLH makes use of its many **patient listening and learning and relationship building methods,** described in Category 3, to identify patient information/expectations/preferences in order to modify and improve care.

**6.1a(5)** On a day-to-day basis, caregivers monitor the clinical pathway/care plan to ensure that it is being followed. In addition, caregivers and support personnel collect data to track performance against the predetermined key measures of success that were identified during design in accordance with the **"Measure"** phase of the PI Model. Performance requirements, including regulatory accreditation, patient safety, and payor requirements, were developed during the design phase and integrated into the measurement system. The measurement approach, therefore, allows SLH to determine if these requirements are being met. Included in the measurement approach is establishment of baseline performance, expected performance of the service or delivery process, and outcome goals or objectives of the process. This permits caregivers and support personnel to determine if process performance is meeting expectations as they carry out the **"Assess"** phase of the PI Model. If a problem is identified, SLH process owners analyze the process to determine root cause and generate solutions. In addition, customer complaints, the Corporate Compliance hotline, and various quality assurance monitors (e.g., laboratory testing, radiation therapy monitoring) are used to ensure that requirements are being met.

The key performance measures for SLH health care service processes are shown in Figure 6.1-2. These are provided as examples of the measures used by SLH personnel to control and improve processes. Space does not permit identification of the many measures used on a day-to-day basis. In-process data are collected regularly to ensure the effectiveness of health care delivery. In 2003, SLH began the development of process level scorecards. The process scorecards serve to link daily operations in process measures and BSC outcome measure(s) and are utilized by process owners to monitor overall process performance. Patient advocates and caregivers seek patient/family input on a daily basis and care plans are modified as needed based on the information gathered. Suppliers regularly provide technical support and advice on how to maximize use of the technology they provide to SLH, and offer feedback on ways to improve. Health care outcomes and patient and family concerns are aggregated, analyzed and trended to allow SLH personnel to continually improve health care processes.

**6.1a(6)** SLH has developed a number of methods to minimize errors and costs associated with rework. Quality assurance initiatives are in place throughout SLH and consist of activities such as laboratory testing, radiation therapy monitoring, pharmacy medication monitoring, and use of control charts to analyze data. In addition, the metrics architecture, including the organizational BSC; department-level measures and process scorecards, provides an objective, cost-effective means to identify where problems exist. Based on performance

indicators, SLH appoints specific single-issue PI teams to audit/inspect key processes as needed. The decision to initiate these team audits is the responsibility of the appropriate perspective leaders and the PISC. These decision-makers use the **Prioritization Grid** to determine appropriateness and timing of the team. Finally, SLH performs standard audits of various types, such as drug errors, adverse events, and patient falls. To reduce the costs associated with these audits, SLH is developing additional computer applications and enhancing its automation capabilities.

| Health Care Processes | Key Requirements | Key Measures |
|---|---|---|
| **Admitting**<br>• Scheduling<br>• Precertification<br>• Registration | • Timeliness<br>• Accuracy | • Wait Times<br>• Admissions Audit Results |
| **Multidisciplinary Care**<br><br>• Initial Assessment<br>• Planning<br>• Intervention<br>• Evaluation<br>• Modification<br>• Resolution | • Timeliness<br>• Accuracy<br>• Reliability<br>• Access<br>• Responsiveness<br>• Empathy<br>• Competence | • Infection Rates<br>• Medication Errors<br>• Mislabeled/unlabeled specimens<br>• Patient falls<br>• 7th Scope of Work Clinical Outcomes<br>• Unplanned Returns<br>• Medical Staff Clinical Indicators<br>• Cost per Day<br>• Length of Stay<br>• Potentially Avoidable Days<br>• JCAHO Core Measures |
| **Care Support Services**<br>• Laboratory<br>• Radiology<br>• Pharmacy<br>• Nutrition | • Timeliness<br>• Accuracy<br>• Competency<br>• Appropriateness | • Turnaround Time<br>• Stockout Rates<br>• Nutrition Assessment<br>• Discrepancy Rate<br>• QA Measures |

**Figure 6.1-2 Health Care Processes, Requirements, and Measures**

6.1a(7) SLH evaluates health care service delivery systems and processes at the key process level by applying the **"Improve"** phase of the PI Model. Caregivers and support personnel are responsible to review overall process performance on a regular basis to seek improvement opportunities. Reviews occur on a monthly or quarterly basis and include the outcome measures associated with the process, as well as patient and stakeholder satisfaction data. Where needed, improvement opportunities are sought by researching best practices and technological advancements, as well as process analysis.

From an organizational perspective, health care service delivery systems and processes are evaluated through the BSC process. Process improvement requirements can either flow down from the System scorecard, or flow up from unit or department levels. Perspective leaders initiate process analysis activities when performance indicators suggest a need. Process owners and Quality Resource Department personnel comprise a PI team to conduct these activities using the **"Improve"** phase of the Model to carry out their work. They are required to report progress to the perspective leader who is responsible to monitor performance, provide assistance and resources, establish timelines, and report results to the PISC. The PISC, in turn, communicates information to the MSEC, EC, and ultimately the BOD. If a significant process change is required, the perspective leader formally charters a process redesign team to initiate a process redesign effort. Improvements that are identified through this process are shared throughout the hospital by means of storyboards, newsletters, e-mail, Medical Staff departmental meetings, HLG, and unit-level meetings.

### *6.2 Support Processes*

6.2a(1-6) SLH key business and support processes, key requirements, and measures are shown in Figure 6.2-1. These processes are designed, managed, and improved using the appropriate phases of the **PI Model**. The key requirements for these processes are established in the **"Design"** phase, then revised as necessary based upon customer input, process performance, and changing organizational needs. In all cases, customer and operational needs drive the establishment of process requirements. Information is obtained directly from stakeholders in one-on-one interactions or through formal surveys, informal surveys, and focus groups. Within specific processes, regulatory requirements drive some of the key requirements. These processes are controlled and improved using the **"Measure", "Assess", and "Improve"** phases, and are evaluated on a regular basis. Performance of the key business and support processes is monitored and managed by each process owner through regular data collection using in-process measures, outcome measures, and input from customers of the process. Performance is evaluated and improvements made when necessary to correct variations in service delivery and overall process effectiveness. Measures are selected to permit an understanding of performance as it relates to key process requirements. Prevention-based methods to minimize costs associated with inspections and audits include the increased use of automation and outsourcing.

| Business/Support Processes | Key Requirements | Key Measures |
|---|---|---|
| • Education | • Competency<br>• Meet Student Needs | • First Time Pass Rates<br>• First Time Cert Rates<br>• Student Satisfaction |
| • Research | • High Volume<br>• Knowledge Creation<br>• Competency<br>• Productivity | • # Ongoing IRB Studies<br>• Active Grants<br>• Foundation Funding<br>• External Grant Total $<br>• # Papers/Pubs/Presentations |
| • Supplier Management | • Low Cost<br>• Timeliness<br>• Accuracy<br>• Availability | • Cost/Patient Discharge<br>• Backorders/Lines Ordered<br>• Returns<br>• Distributor Fill-Rates |
| • Revenue Cycle Management | • Cost<br>• Quality<br>• Timeliness<br>• Efficiency<br>• Patient Friendly Billing Team | • Cash Collections to Target<br>• Charge Process Audit<br>• Net Days in Accounts Receivable<br>• Discharges Not Final Billed<br>• Accounts per Collector<br>• Calls Received vs. Statements Sent<br>• Customer Satisfaction |
| • Physician Partnering | • Physician Participation<br>• Improved Productivity<br>• Ease of Access | • Admitting Physician Ratio<br>• Variable Cost per Case<br>• IP Tests/Discharge<br>• Physician Satisfaction<br>• PCP Referral |
| • Human Resource Management | • Competency<br>• Timeliness<br>• Low cost | • Intro Period Separations<br>• New Employee Satisfaction<br>• Time to Fill<br>• Time to Start<br>• Cost per Hire |
| • Facilities Management | • Timeliness<br>• Competency<br>• Safety | • Work Order Turnaround<br>• Performance Appraisal<br>• Customer Satisfaction<br>• Safety/Environmental Measures |
| • Health Information Management | • Timeliness<br>• Accuracy<br>• Productivity<br>• Meet Physician Needs | • PIM Scan Time<br>• Time to Complete Coding<br>• Time to Complete Transcript<br>• Coding Errors<br>• Filing Errors<br>• Lines Transcribed/minute<br>• Physician Satisfaction |
| • Hotel Services Management | • Timeliness<br>• Quality | • Response Time<br>• Cafeteria Sales<br>• Patient Satisfaction |

**Figure 6.2-1 Key Business and Support Processes**

# CATEGORY 7—ORGANIZATIONAL PERFORMANCE RESULTS

## *7.1 Health Care Results*

7.1a Since SLH is a tertiary care, level one trauma center it provides care to the sickest types of patients. The high severity of illness impacts all health care outcomes such as mortality, length of stay, and infections. Sicker patients tend to stay longer and require more resources to be expended in their care. These factors come into play when comparing SLH performance

against that of other organizations. Figure 7.1-1 shows that SLH patients are considerably sicker than any other area hospital with a severity index of 257 compared to the metro average of 100. At the same time, SLH's mortality and length of stay results show that it is among the best performers, despite the high severity index.

| | RDRG Severity Index | | | ALOS Index | | | Mortality Index | | |
|---|---|---|---|---|---|---|---|---|---|
| Hospital | 1999 | 2000 | 2001 | 1999 | 2000 | 2001 | 1999 | 2000 | 2001 |
| SLH | 293 | 290 | 257 | 99 | 98 | 96 | 88 | 91 | 82 |
| HOSP B | 175 | 173 | 180 | 107 | 87 | 80 | 105 | 84 | 76 |
| HOSP C | 186 | 197 | 201 | 127 | 98 | 99 | 126 | 101 | 102 |
| HOSP D | 242 | 228 | 214 | 97 | 98 | 102 | 119 | 113 | 122 |
| HOSP E | 113 | 116 | 120 | 109 | 109 | 117 | 90 | 83 | 78 |
| HOSP F | 124 | 113 | 109 | 115 | 99 | 112 | 106 | 88 | 135 |
| HOSP G | 141 | 142 | 127 | 137 | 109 | 115 | 117 | 101 | 118 |

Source: Solucient Sachs*

Figure 7.1-1 Medicare Marketplace Comparison – Top Competitors

Consumers' Checkbook, a non-profit consumer education organization evaluates 4,500 hospitals across the country and publishes a report on the top 50 performing hospitals each year. The 2002 report, published in the May-June issue of the AARP magazine, ranks SLH 35th in the nation as shown in Figure 7.1-2. SLH exceeds the national average in each of the rated areas, and most by a wide margin.

| | SLH | National Average |
|---|---|---|
| Medical Mortality | 13.1% | 15.3% |
| Surgical Mortality | 1.8% | 2.5% |
| Physician Rating | 86% | 33% |
| Accreditation Score | 92 | 91 |
| Overall Score | 7669 | 5418 |
| **SLH Rank = 35 of 4,500 hospitals in U.S.A.** | | |

Source: AARP

Figure 7.1-2 Consumers' Checkbook Ratings – Top 50 Hospitals in USA – 2002

SLH participates, through the VHA's CEO Workgroup, in measuring and comparing its performance with other top performing institutions in the 7th Scope of Work areas of Acute Myocardial Infarction and Surgical Infection. Figures 7.1-3 through 5 demonstrate SLH's superior performance compared to the ten best peer institutions across the country. In 2002, SLH was the top performer in two of these measures, and second best in one.

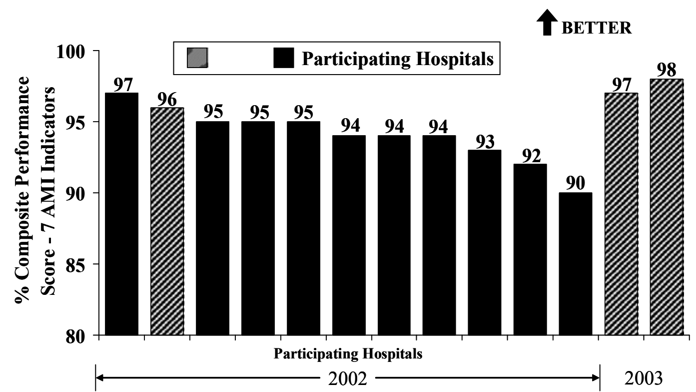



Figure 7.1-3 AMI 2002-2003 VHA Green Light Project

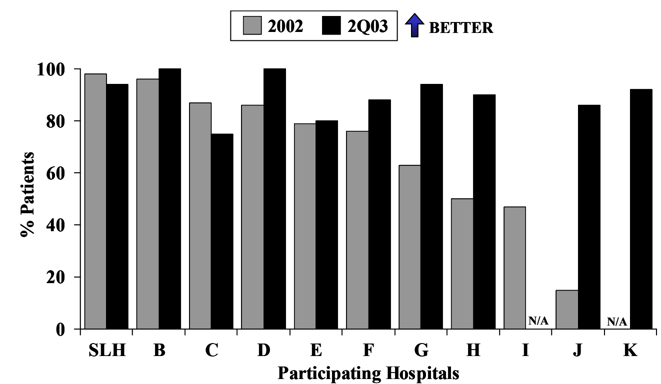



Figure 7.1-4 VHA Surgical Infection Project – CABG/Cardiac Surgery: Antibiotics Received Within 1 Hour of Incision

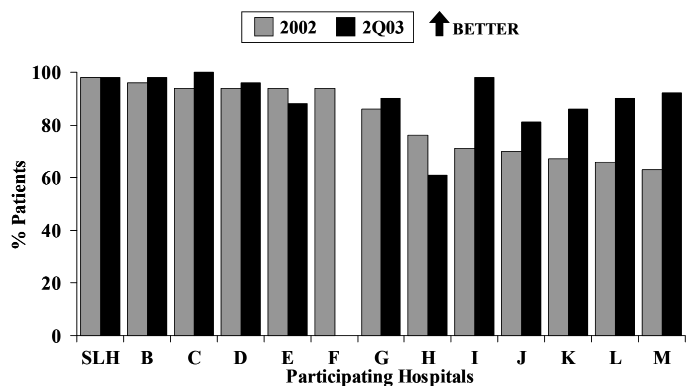



Figure 7.1-5 VHA Surgical Infection Project – Hip/Knee Arthroplasty 2002 and 2Q03 Data: Antibiotics Received Within 1 Hour of Incision

SLH also participates in JCAHO's ORYX Project. As one of the core measures, SLH compares its performance in four CHF measures against its ORYX vendor project mean, with the results for 2002 noted in Figure 7.1-6, demonstrating SLH's superior performance in all four measures. Figure 7.1-7 notes

SLH's performance in five measures of CAP compared to the ORYX project mean. SLH performance has improved in four of the five measures and lags the comparison in only one.

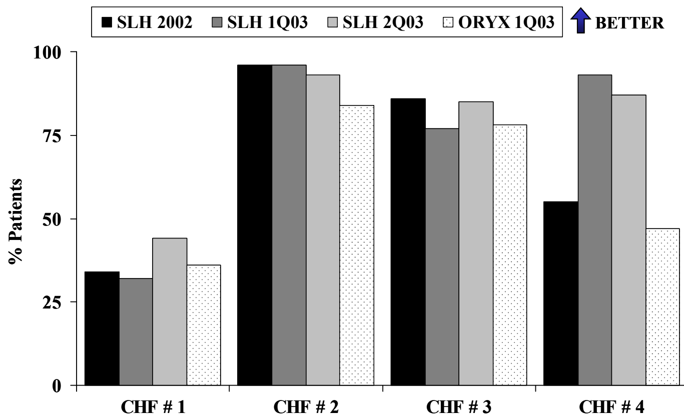



Figure 7.1-6 SLH JCAHO Core Measures – CHF

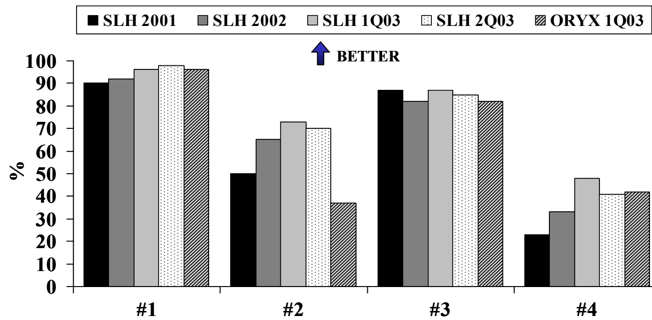



Figure 7.1-7 SLH JCAHO Core Measures 1-4 Community Acquired Pneumonia

In treating a leading cause of death and permanent neurologic disability, ischemic stroke, SLH is leading the nation, establishing benchmark performance in the use of tPA over the last 3 years (Figure 7.1-8).

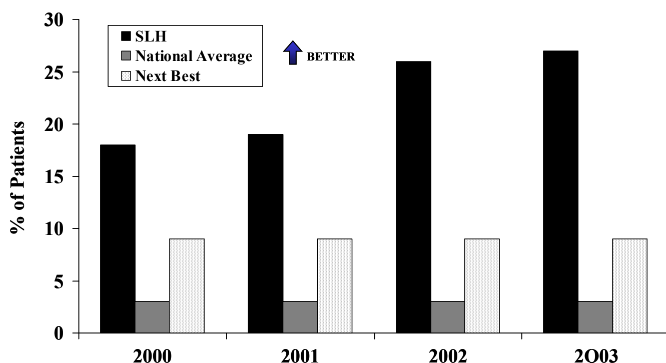



Figure 7.1-8 Percent of Patients Diagnosed with Ischemic Stroke Receiving tPA

## *7.2 Patient- and Other Customer-Focused Results*

7.2a(1) Figures 7.2-1 and 2 provide the results of the independent study conducted by the National Research Corporation (NRC) each year. These data indicate that SLH delivers the best quality health care, has the best doctors, and has the best nurses in its market area. SLH has sustained the top position since 1997. In addition, SLH is viewed as providing the best heart care, the best neurology services, and the best orthopedic care, and ranks among the leaders for OB care.

| | Overall Quality | | | Best Doctors | | | Best Nurses | | |
|---|---|---|---|---|---|---|---|---|---|
| Hospital | 2003 | 2002 | 2001 | 2003 | 2002 | 2001 | 2003 | 2002 | 2001 |
| SLH | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| HOSP B | 2 | 2 | 2 | 3 | 4 | 3 | 3 | 2 | 2 |
| HOSP C | 3 | 4 | 3 | 4 | 3 | 5 | 2 | 3 | 3 |
| HOSP D | 6 | 7 | 5 | 7 | 5 | 6 | 8 | 6 | 5 |
| HOSP E | 5 | 5 | 4 | 2 | 2 | 2 | 6 | 5 | 6 |
| HOSP F | 15 | 8 | 13 | 10 | 6 | 12 | 10 | 8 | 13 |
| HOSP G | 14 | 16 | 12 | 17 | 15 | 15 | 15 | 16 | 15 |

Figure 7.2-1 NRC Perception Rankings vs. Top Competitors

| | Best Heart Care | | | Best Neurology Services | | | Best OB Care | | | Best Orthopedic Care | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital | 2003 | 2002 | 2001 | 2003 | 2002 | 2001 | 2003 | 2002 | 2001 | 2003 | 2002 | 2001 |
| SLH | 1 | 1 | 1 | 2 | 1 | 2 | 3 | 3 | 4 | 1 | 1 | 1 |
| HOSP B | 6 | 5 | 6 | 6 | 6 | 6 | 1 | 1 | 1 | 4 | 4 | 2 |
| HOSP C | 3 | 3 | 2 | 3 | 3 | 5 | 2 | 2 | 2 | 3 | 2 | 3 |
| HOSP D | 5 | 6 | 4 | 4 | 5 | 3 | 11 | 10 | 8 | 6 | 6 | 5 |
| HOSP E | 2 | 2 | 3 | 1 | 2 | 1 | 9 | 12 | 9 | 2 | 5 | 5 |
| HOSP F | 8 | 9 | 10 | 13 | 10 | 11 | 10 | 6 | 10 | 8 | 8 | 11 |
| HOSP G | 13 | 15 | 14 | 15 | 15 | 15 | 17 | 16 | 12 | 15 | 15 | 14 |

Figure 7.2-2 NRC Perception Rankings Product Line vs. Top Competitors

Figure 7.2-3 displays the results of the Press Ganey patient satisfaction survey, and shows the percent of respondents providing "4" or "5" ratings for the "overall satisfaction" question. Inpatient satisfaction, the most important customer segment for SLH, exceeds 90% and has continued to increase. Outpatient satisfaction has also been traditionally high, and rebounded from a dip in 2001 when difficulties were encountered with a new service offering. Emergency Department satisfaction, traditionally a more challenging area to produce high satisfaction, has increased slightly and remains high by industry standards.

Nursing student satisfaction, as determined by EBI, a third party surveyor, shows that SLH students are more satisfied in every measured area as compared to direct competitors and nursing schools across the country as shown in Figure 7.2-4.

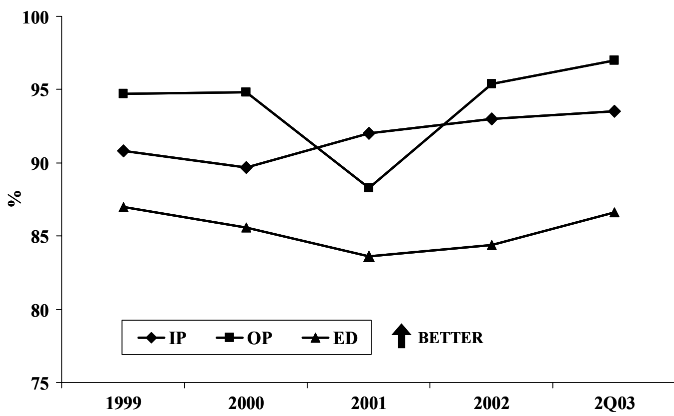



Figure 7.2-3 Patient Satisfaction

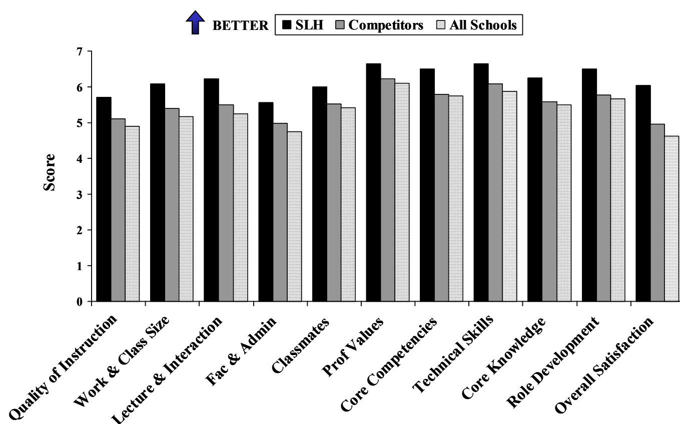



Figure 7.2-4 Nursing Student Satisfaction – 2002

7.2a(2) Figures 7.2-5 through 7 show the Press Ganey results for the "would recommend" question on the survey. Inpatients continue to recommend SLH at a very high rate, exceeding 94%, and suggesting a strong likelihood for positive referral and surpassing local competitors by a considerable margin. Outpatient recommendations increased considerably during 2002, and emergency department patients continue to recommend SLH at a higher rate than competitors.

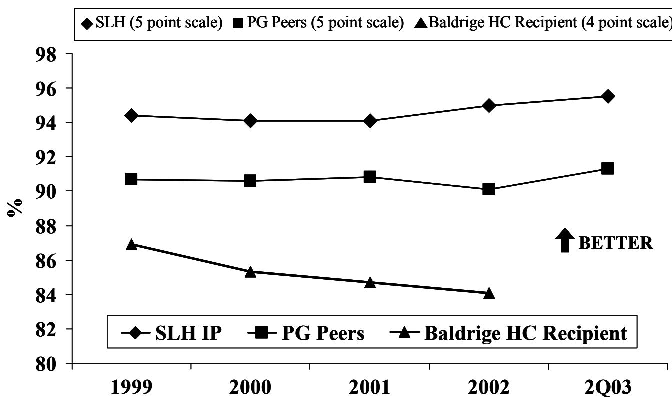



Figure 7.2-5 Inpatient Would Recommend

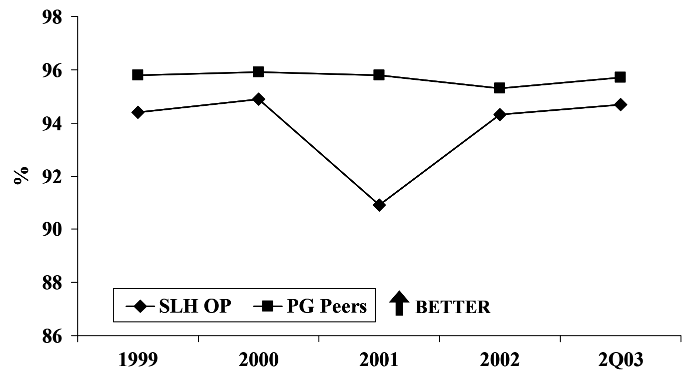



Figure 7.2-6 Outpatient Would Recommend

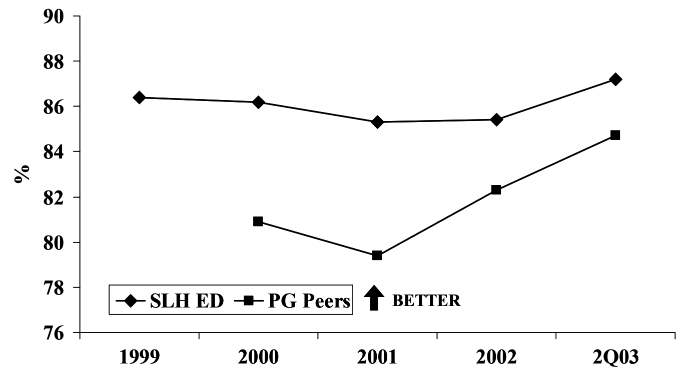
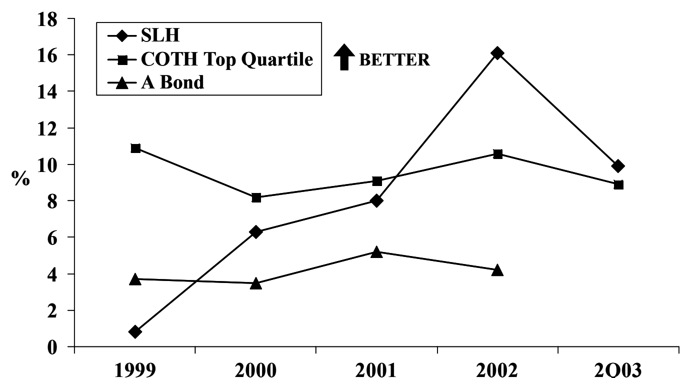



Figure 7.2-7 Emergency Department Patient Would Recommend

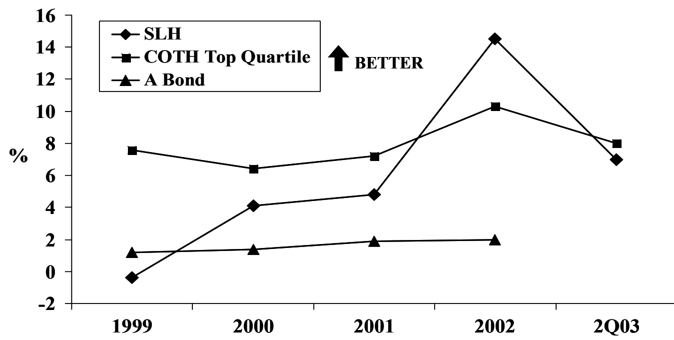
### *7.3 Financial and Market Results*

7.3a(1) SLH financial performance from 1999 to 2Q03 is shown in Figures 7.3-1 through 7 and indicates that SLH has made dramatic improvements and ranks among the very best performers in the country in most measures. Total Margin (Figure 7.3-1) and Operating Margin (Figure 7.3-2), both BSC measures, show significantly improved performance from 1999 through 2002. In both of these measures, SLH ranked among the top 5% of comparison hospitals in the nation in 2002. Total Revenues (Figure 7.3-3) and, more importantly, Net Revenues (Figure 7.3-4) both show strong gains.




*SLH data represents best 5% of comparative group

Figure 7.3-1 Total Margin




*SLH data represents best 5% of comparative group

Figure 7.3-2 Operating Margin

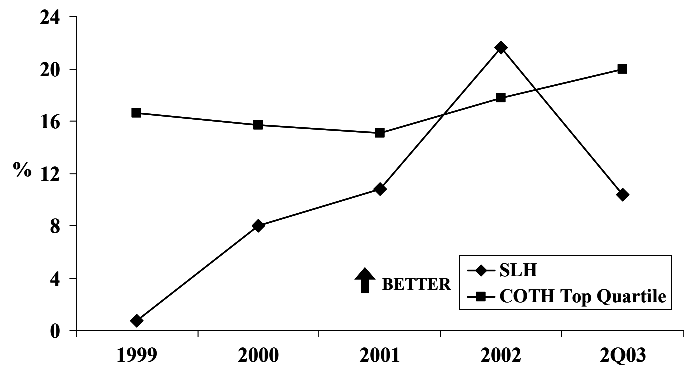



Figure 7.3-5 Return on Equity

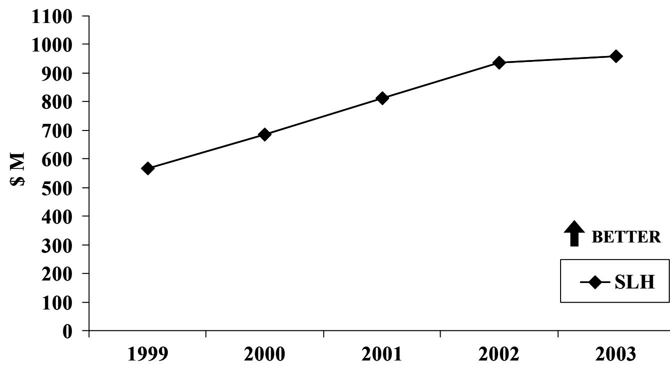



Figure 7.3-3 Total Revenues*
*Comparative data not available
†Annualized

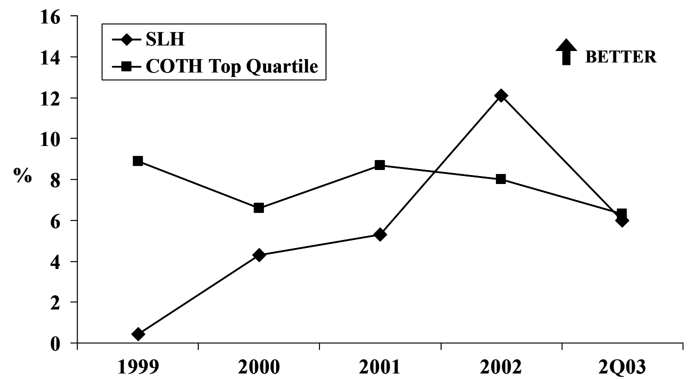



Figure 7.3-6 Return on Total Assets

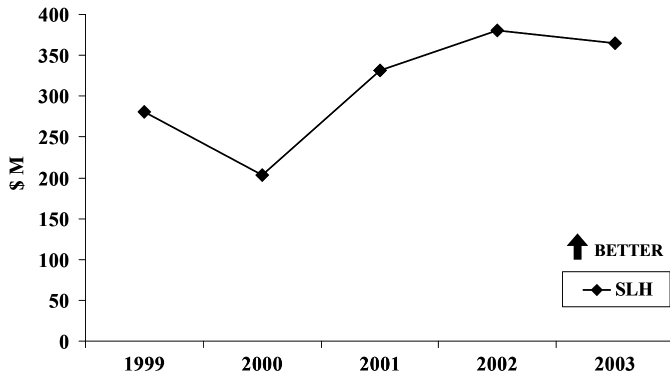



Figure 7.3-4 Net Revenues*
*Comparative data not available
†Annualized

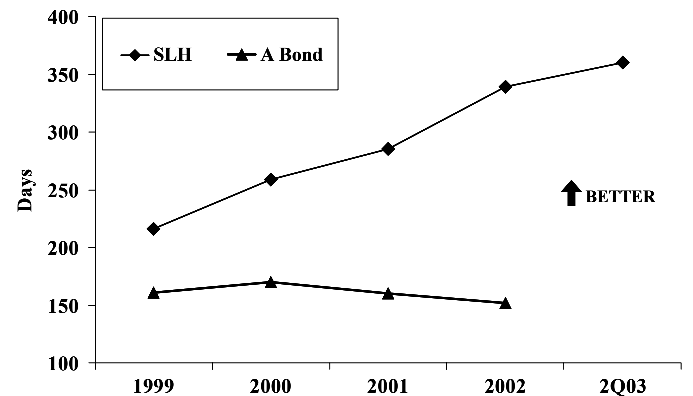



Figure 7.3-7 Days Cash on Hand

Figures 7.3-5 and 6 show that Return on Equity and Return on Total Assets both reached performance levels that are among the best in the nation in 2002. Days Cash on Hand (Figure 7.3-7), a BSC measure, has also improved substantially and significantly above the A bond requirement.

7.3a(2) SLH supports the SLHS strategy, which dictates that market share increase System-wide through increases at the suburban area hospitals. At the same time, the strategy drives SLH to hold market share steady and focus on profitable product line segments. In this manner, SLH contributes to System growth, while maintaining its ability to generate revenue through

emphasis on services that produce excess income over expenses. As a result, SLH does not seek to gain market share from its sister hospitals within the System. To track market progress, SLH calculates a Market Value Index, as shown in Figure 7.3-8. SLH far exceeds all competitors in MVI.

| Hospital | A KCBJ IP Volume | B NRC Overall Rating | | C PG Would Recommend | | D Adjusted Market Share | | E Market Index | |
|---|---|---|---|---|---|---|---|---|---|
| | 2002 | 2002 | 2003 | 2002 | 2003 | 2002 | 2003 | 2002 | 2003 |
| SLH | 9.07% | 16.6% | 18.4% | 95.0% | 95.5% | 21.90% | 25.97% | 327.0 | 387.8 |
| HOSP B | 8.81% | 9.4% | 10.0% | 93.1% | 91.3% | 12.69% | 13.11% | 189.5 | 195.7 |
| HOSP C | 9.47% | 9.9% | 8.7% | 93.1% | 91.3% | 12.43% | 12.26% | 185.6 | 183.0 |
| HOSP D | 6.98% | 9.6% | 5.1% | 93.1% | 91.3% | 8.50% | 5.30% | 126.9 | 79.1 |
| HOSP E | 7.44% | 7.7% | 7.4% | 93.1% | 91.3% | 8.17% | 8.19% | 121.9 | 122.3 |
| HOSP F | 5.14% | 3.6% | 1.9% | 93.1% | 91.3% | 2.61% | 1.45% | 38.9 | 21.7 |
| HOSP G | 4.16% | 1.6% | 2.0% | 93.1% | 91.3% | 0.95% | 1.24% | 14.2 | 18.5 |
| Average | 6.70% | 7.00% | 6.69% | 93.29% | 91.72% | 6.70% | 6.70% | 100.0 | 100.0 |

*Sources: (C) Press Ganey, 2Q03, Would Rec; (B) NRC Healthcare Mkt. Guide, 2003; (A) KCBJ Top 25 Hospitals, 3/03; (D) Mkt. Shr (A) has been adjusted to reflect perception and loyalty multipliers in the market. RAD 9/30/03.

Key to Calculations:
D Adjusted Market Share = (A* (B/avg B)) * (C/avg C) or [IP Mkt Shr * Perception * Pt Experience]
E Market Index = (D/avg D) * 100 or [Adj Mkt Shr/Mkt Average]

Figure 7.3-8 Kansas City Market Value Index–Top Competitors 2002/2003

## *7.4 Staff and Work System Results*

**7.4a(1)** Figures 7.4-1 through 3 show indicators of SLH work system performance and effectiveness. SLH has been widely recognized for the high level of its employee performance and effectiveness of its work system design. Examples include the receipt of three Paragon Awards presented by the local Human Resources Management Association, identification as one of the top 100 employers in the nation by Working Mothers Magazine, and the receipt of the Missouri Team Quality Award in both 2001 and 2003.

Human Capital Value Added, a BSC measure, is considered a cutting edge measure of employee productivity and is calculated by subtracting the total cost of salary and benefits, including temporary/agency expenses, from net operating revenue and dividing by the total FTEs. HCVA is an indicator of employee leverage on productivity, and represents the adjusted profit dollars added per FTE. Figure 7.4-1 shows that SLH performance is improving and now exceeds the Saratoga Institute benchmark. Diversity, another BSC measure, reflects the percent of managerial and professional staff reported as minorities per EEO-1 definition. SLH is making progress in recruiting minority managers and professional staff as shown in Figure 7.4-2 and currently exceeds the local labor market.
Finally, SLH correlates employee turnover with inpatient satisfaction to determine if high turnover has an impact on customer satisfaction. Figure 7.4-3 indicates that there is an inverse correlation between employee turnover and inpatient satisfaction. When turnover is higher, satisfaction tends to be lower, suggesting that important gains can be made if turnover is reduced. This has prompted a strong emphasis on retention in SLH planning and improvement prioritization.

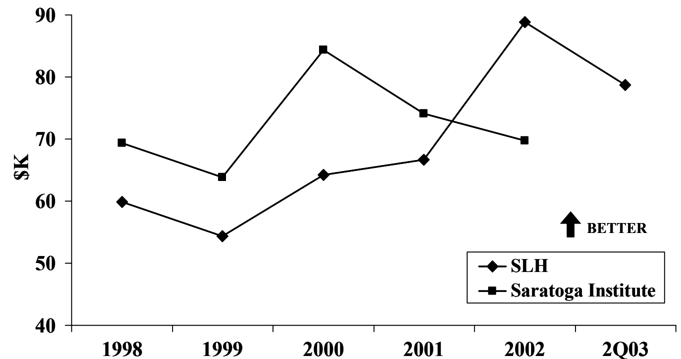



Figure 7.4-1 Human Capital Value Added
†2003 comparative data not available

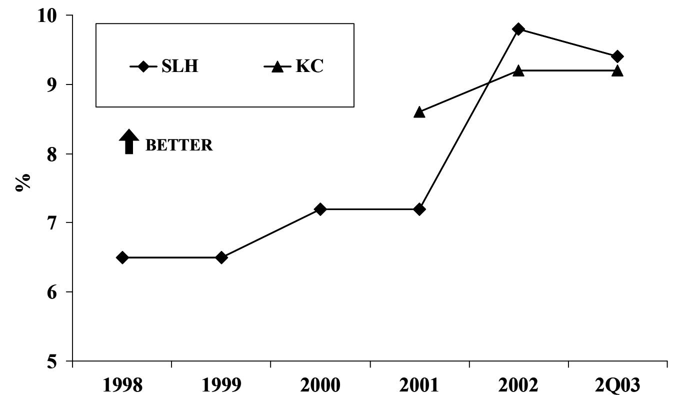



Figure 7.4-2 SLH Diversity vs KC Community Diversity as a % of Workforce

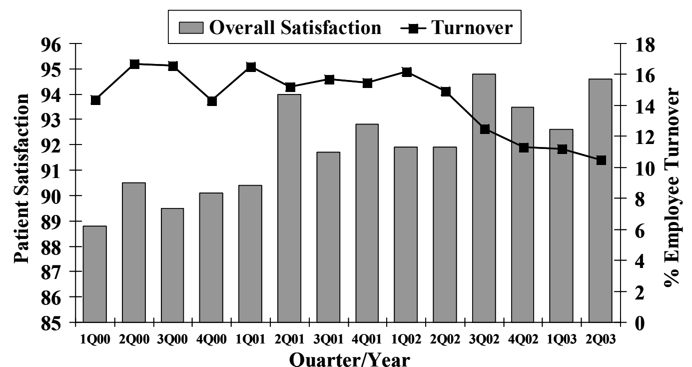



Figure 7.4-3 Employee Turnover Correlated with IP Satisfaction

**7.4a(2)** Figures 7.4-4 and 5 indicate employee development. Overall PMP ratings, indicating the percent of employees meeting expectations on their PMP evaluation regarding their job performance, attainment of goals and objectives relative to

the SLH strategic plan and core values, and achievement of development objectives, are shown in Figure 7.4-4. The percent of "Outstanding" and "Exceeds Expectations" ratings have increased, while the percent needing improvement has declined. Figure 7.4-5 shows the number of hours and participants in SLH continuing medical education training programs, which have been sustained at a high level.

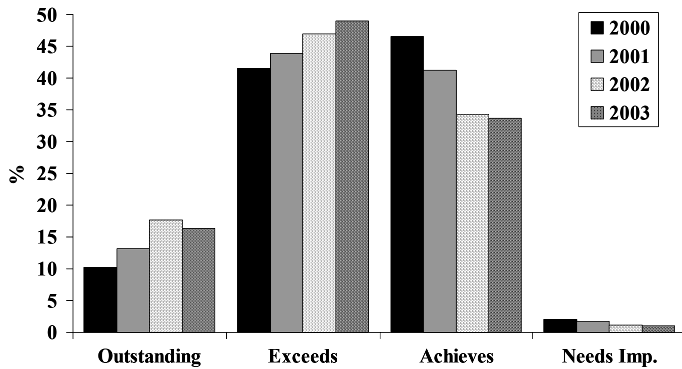


Figure 7.4-4 PMP Ratings

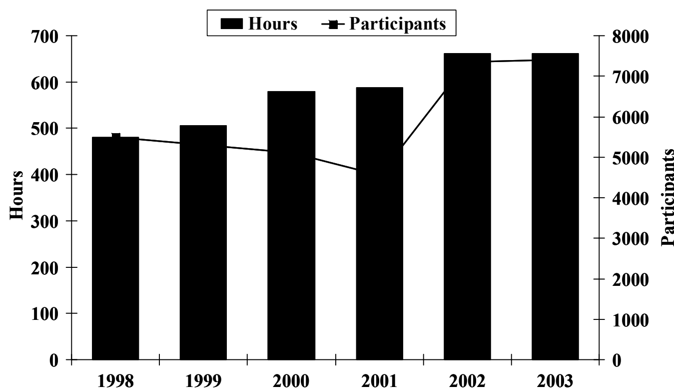


Figure 7.4-5 CME Volume and Participation
†Projected for 2003 based on 1st 9 months of 2003

7.4a(3) Figure 7.4-6 shows the results of SLH indicators of employee well-being. Needlesticks have remained steady with performance considerably better than the EpiNet national benchmark.

Employee satisfaction, a BSC measure, is demonstrated in Figures 7.4-7 and 8. The results of the last four employee opinion surveys are shown in Figure 7.4-7 for five key questions. The results indicate the percent of employees responding to the question with a "4" or "5" response. The questions pertain to employee views regarding diversity of the organization, the willingness to recommend SLH, the pride they feel about SLH, their sense of accomplishment, and their overall satisfaction. Satisfaction levels are quite high and have generally increased over the period of the four surveys. SLH retention, a BSC measure, continues to be very high and remains well above the Saratoga Institute benchmark as noted in Figure 7.4-8.

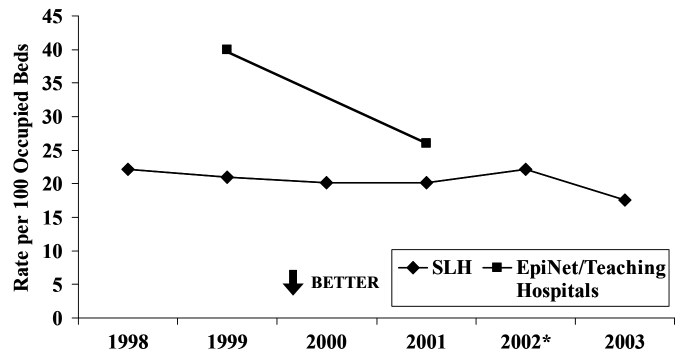


Figure 7.4-6 Needlesticks

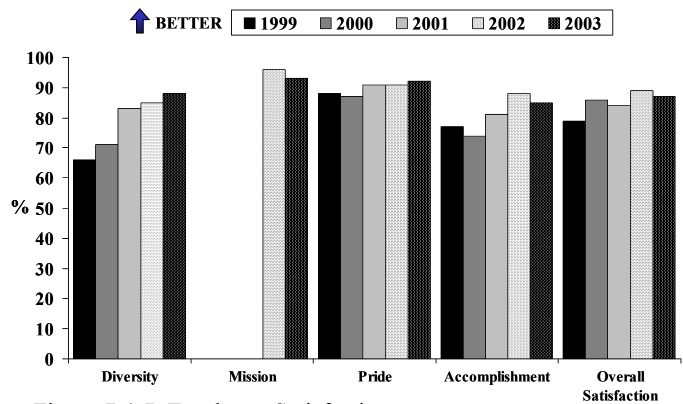


Figure 7.4-7 Employee Satisfaction

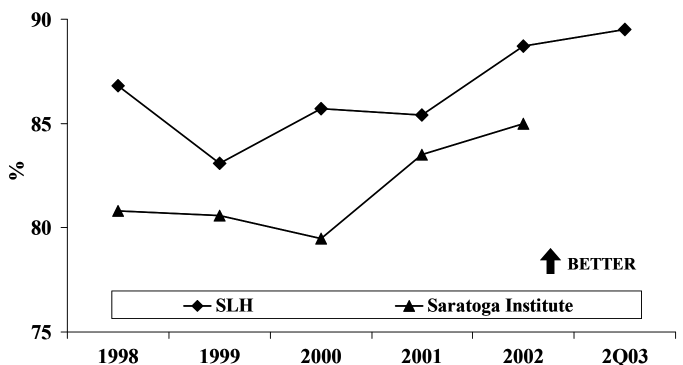


Figure 7.4-8 SLH Retention

Figure 7.4-9 shows employee dissatisfaction by the percent of employees providing a "1" or "2" response to the five key questions on the survey. It is low and declining.

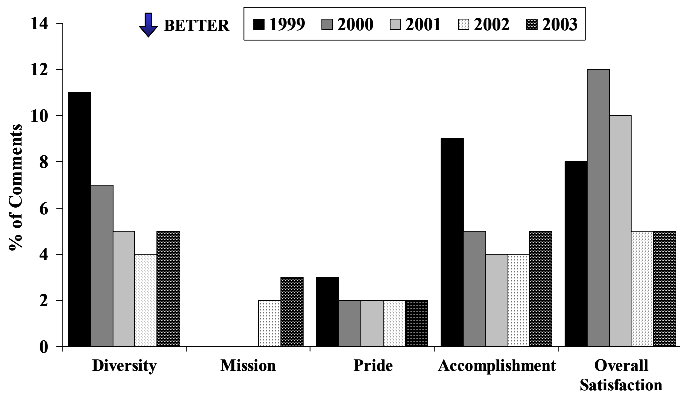


Figure 7.4-9 Employee Dissatisfaction Scores

| Laboratory Precision | | | | | | |
|---|---|---|---|---|---|---|
| Test | SLH | | | | | Goal |
| | 1999 | 2000 | 2001 | 2002 | 2003† | |
| Cholesterol (%) | 1.5 | 1.6 | 2.1 | 1.6 | 1.9 | < 3 |
| HbA1C (%) | 1.4 | 1.9 | 3.4 | 2.1 | 2.1 | < 3* |
| PSA (%) | 6.2 | 9.9 | 6.9 | 5.4 | 5.2 | < 10 |
| Troponin (%) | 19.6 | 16.0 | 19.6 | 6.3 | 7.3 | < 10 |
| TSH (%) | 8.6 | 16.5 | 10.1 | 5.4 | 5.3 | < 10 |

Figure 7.5-2 Laboratory Precision
†2003 data updated from application (2Q03)
*Goal for HbA1C updated since application

## 7.5 Organizational Effectiveness Results

7.5a(1) Figures 7.5-1 through 4 demonstrate performance in selected health care delivery processes listed in Item 6.1. Figure 7.5-1 shows wait times for the admitting process for both inpatients and outpatients, both of which are at very low levels in relation to patient expectations. Figure 7.5-2 shows laboratory precision, which is a key measure for laboratory effectiveness. Precision is determined by testing against known standards and calculation of a coefficient of variation (cv). The cv is compared to goals based upon stretch performance targets documented nationally in relevant literature and shows that SLH generally outperforms these high performance standards. Figure 7.5-3 indicates that Radiology Turnaround Time is continually improving, as is the case for Pharmacy Stockout Rates (Figure 7.5-4). Nurses use a Pyxis (automated dispensing machine) for as much as 90% of the medications administered and it is crucial to patient care to have these machines stocked and medications available.

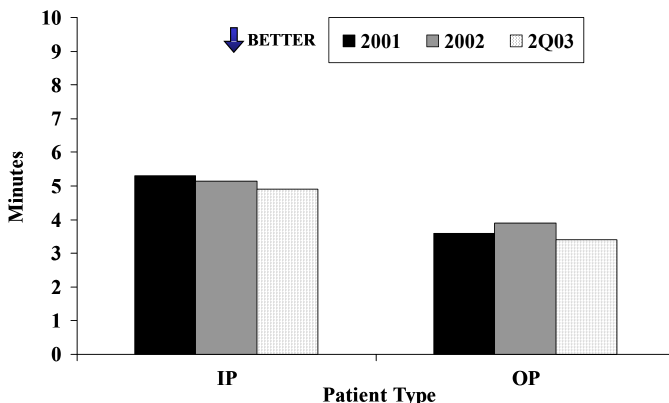


Figure 7.5-1 Admitting Wait Time

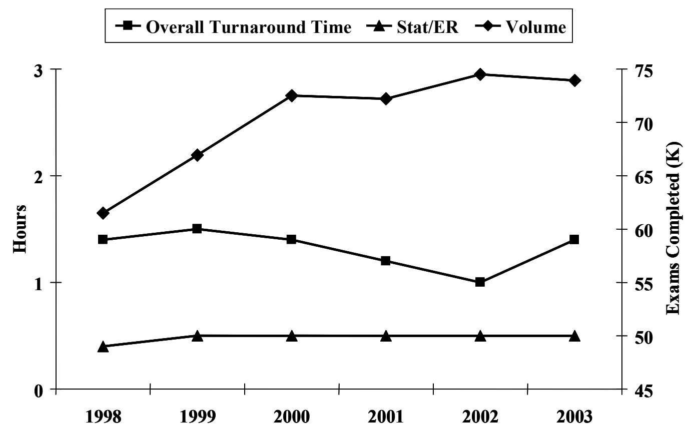


Figure 7.5-3 Radiology Turnaround Time (Note: Order entry to completion of Examination)
†Annualized (2Q03)

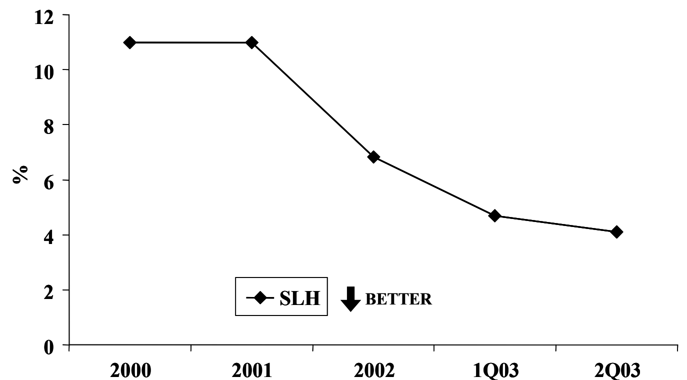


Figure 7.5-4 Pharmacy Stockout Rate
Comparative data not available

7.5a(2) Figures 7.5-5 through 13 show the performance of selected SLH key support processes listed in Item 6.2. Figure 7.5-5 indicates the effectiveness of the SLH Education Process. Nursing Student First Time Pass Rates exceed both the Missouri

and national comparisons by a considerable margin. Figures 7.5-6 shows the effectiveness of the SLH Research Process. Active research protocols remain high and grant dollars have grown.

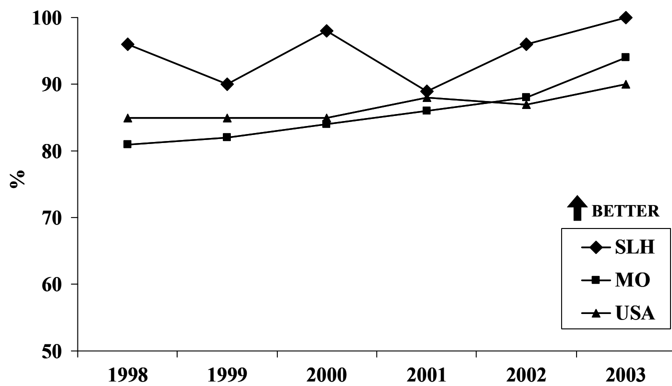


Figure 7.5-5 Nursing Student First Time Pass Rate

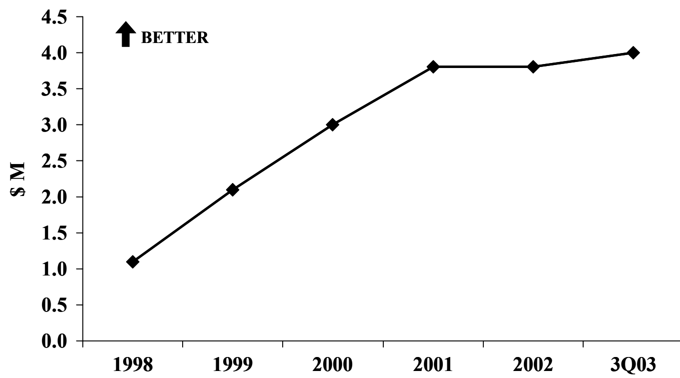


Figure 7.5-6 Research Grant Dollars Received
Comparative data not available
†Projected based on 1st 9 months of 2003

Figure 7.5-7 shows key supplier performance for on time delivery (OTD), order accuracy (OA), and invoice accuracy (IA), and Figure 7.5-8 shows that SLH has sustained a high level of IS System Availability from 1998 to the present, exceeding the Meta Group comparison.

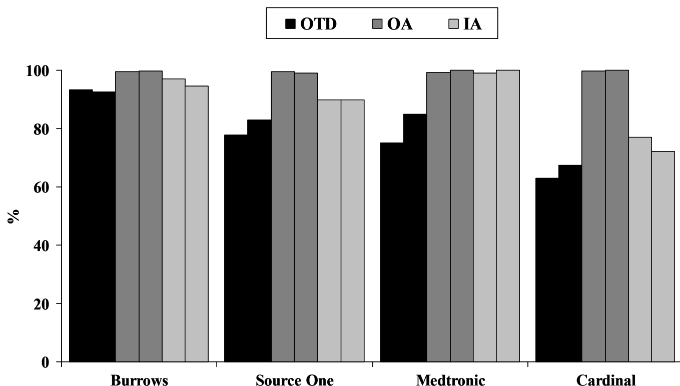


Figure 7.5-7 Key Supplier Performance

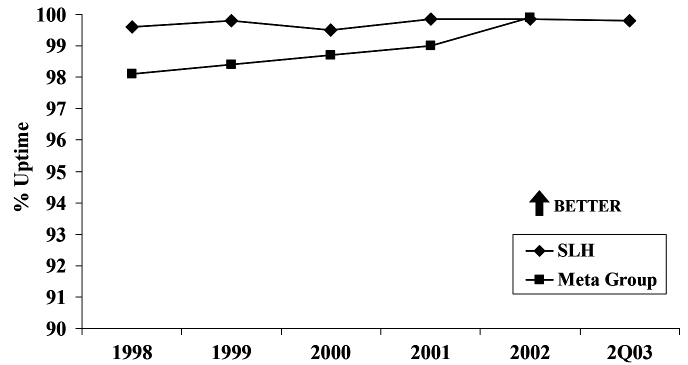


Figure 7.5-8 Information System Availability

Figures 7.5-9 and 10 display the effectiveness of the SLH Physician Partnering Process. Inpatient Tests/Discharge remain among the lowest in the nation, while the Doctors' One Call process has produced greater patient volumes over time.

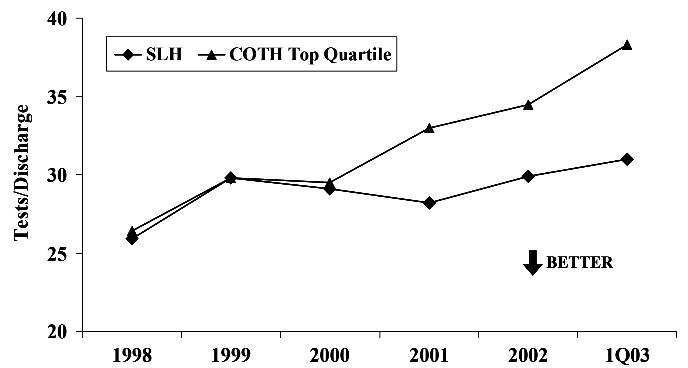


Figure 7.5-9 Inpatient Tests/Discharge – High CMI Hospitals

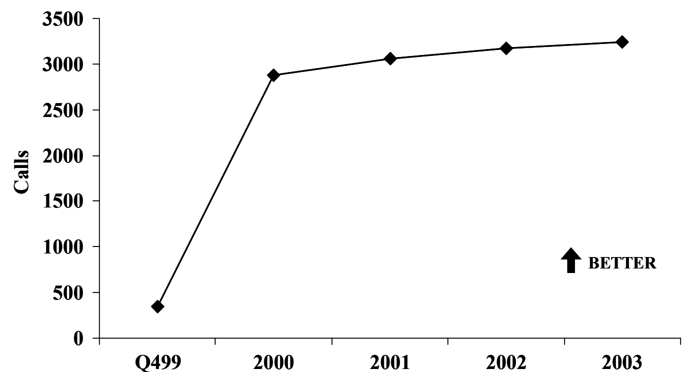
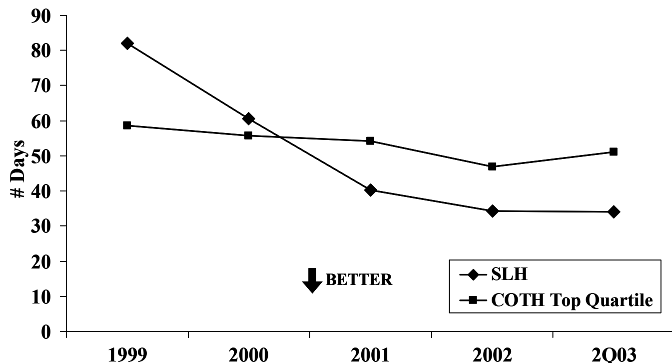


Figure 7.5-10 Doctor's One Call Volume
†Projected based on 1st 6 months of 2003

Figures 7.5-11 and 12 show the effectiveness of the Revenue Cycle Management process, which has played a significant role

in SLH's financial performance. Net Days in Accounts Receivable, another BSC measure, has declined substantially and is now among the very best in the nation. Cash Collections to Target also shows significant improvement that exceeds the target since this process has been in place.




*SLH data represents best 5% of comparative group

Figure 7.5-11 Net Days in Accounts Receivable

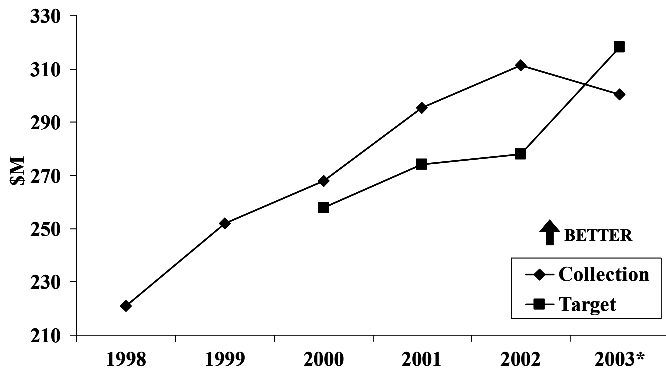



Figure 7.5-12 Cash Collections to Target

*Projected based on 1st 6 months of 2003

Figure 7.5-13 shows the effectiveness of the HR Process, indicating that the cost to hire new employees has been declining and is lower than the Saratoga benchmark.

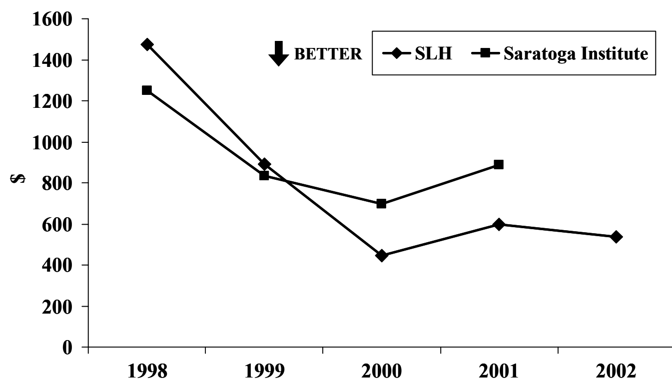



Figure 7.5-13 Cost Per Hire

7.5a(3) Figure 7.5-14 shows some of the many awards that SLH has received, indicating superior performance and success in achieving its strategic objectives.

| 2002 Awards/Recognitions | Sponsor |
|---|---|
| Women's Heart/Best 11 in Nation | Women's Heart |
| 100 Most Wired in Nation | Hospitals and Health Networks |
| Best Place to Work for Information Services | CIO Magazine |
| Best Hospital in Kansas City – Gold Award | Ingram's Magazine |
| Best Quality Hospital in Missouri | Missouri PRO |
| 2002 Consumer Preference Award | NRC |
| Missouri Quality Award – Health Care Sector | Governor of Missouri |
| 35th Best Hospital in Nation | AARP |
| 45th Best U.S. Employer | IDG's Computerworld |
| MBNQA Site Visit Recipient | MBNQA |
| **2003 Awards/Recognitions** | **Sponsor** |
| 2003 Consumer Preference Award | NRC |
| 100 Most Wired in Nation | Hospitals and Health Networks |
| Paragon Award for Best HR Practices in Kansas City Metropolitan Area | HRMA |
| ASHP Best Practices Award in Health System Pharmacy | American Society of Health System Pharmacists |
| Best Hospital in Kansas City – Gold Award | Ingram's Magazine |
| A-1 Bond Rating | Standard and Poor's |
| A+ Bond Rating | Moody's |
| Best Place to Work for Diversity | Kansas City Business Journal |
| Band 6 –Baldrige Assessment | Missouri Quality Award |
| Missouri Team Quality Award – Extreme Neuro Team | Governor of Missouri |
| MBNQA Recipient | MBNQA |

Figure 7.5-14 SLH 2002-2003 Awards and Recognitions

## *Governance and Social Responsibility Results*

7.6a(1-4) Figure 7.6-1 shows the results for SLH measures of governance and social responsibility. SLH has: received full accreditation from every appropriate accrediting body; experienced no compliance or ethics violations; fully trained all employees on compliance and ethics requirements; and maintained a level of independence on the Board of Directors exceeding goal.

| Measures | Result |
|---|---|
| • # Compliance Investigations (intentional/improper behavior) | • 5 investigations |
| • % Employees trained on Corporate Compliance | • 100% trained |
| • JCAHO Survey | • Full accreditation |
| • CAP Survey | • Full accreditation |
| • AABB Survey | • Full accreditation |
| • RRC Surveys | • Full accreditation |
| • Nursing College Certification | • Full accreditation |
| • Staff Licensure | • 100% compliance |
| • % Employees trained on Ethical Behavior | • 100% trained |
| • # Ethics violations | • 0 violations |
| • % Independent Board Members | • 82.7% |
| • Independent Auditor Results (consolidated financial statements) | • 0 irregularities (1997-2002) |

Figure 7.6-1 SLH Governance and Social Responsibility

†No investigations in 1st 6 months of 2003 revealed intentional or suspected improper behavior

Figure 7.6-2 shows that SLH has responded quickly to issues that have been raised by anyone who has a compliance or ethical concern, and Figure 7.6-3 indicates that SLH has made continuous progress in its Baldrige assessment scores. In both

1998-1999 and 2000-2001, SLH moved from the low to the high end of the respective bands.

Figures 7.6-4 through 7.6-6 show SLH performance relative to community support. The dollar amounts SLH has contributed to charity care and other community support initiatives is reflected in Figure 7.6-4, and the level of charitable giving by SLH employees is shown in Figure 7.6-5. The extremely high level of satisfaction with SLH community education programs is shown in Figure 7.6-6.

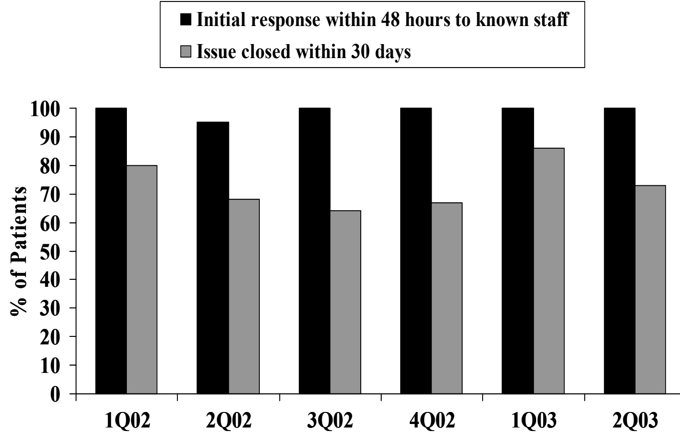



Figure 7.6-2 Corporate Compliance Response to Issues

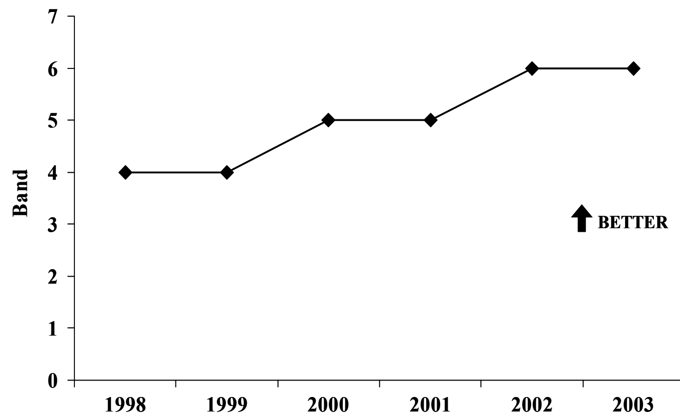



Figure 7.6-3 Baldrige Assessment Scores

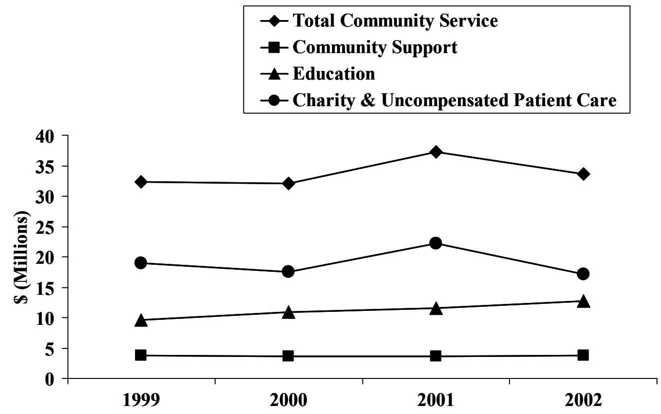
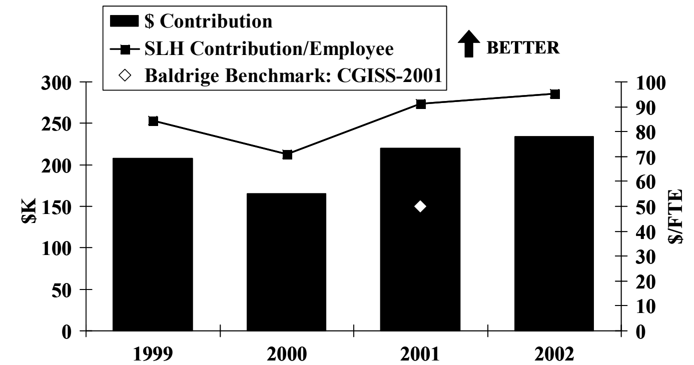



Figure 7.6-4 SLH Community Service




*Includes: United Way, SLH Foundation and Chaplain's Discretionary Fund

Figure 7.6-5 Charitable Giving – SLH Employees (FTE)

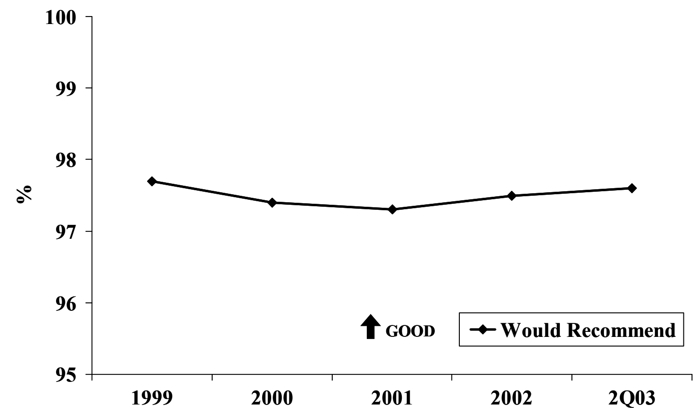



Figure 7.6-6 Community Education Satisfaction