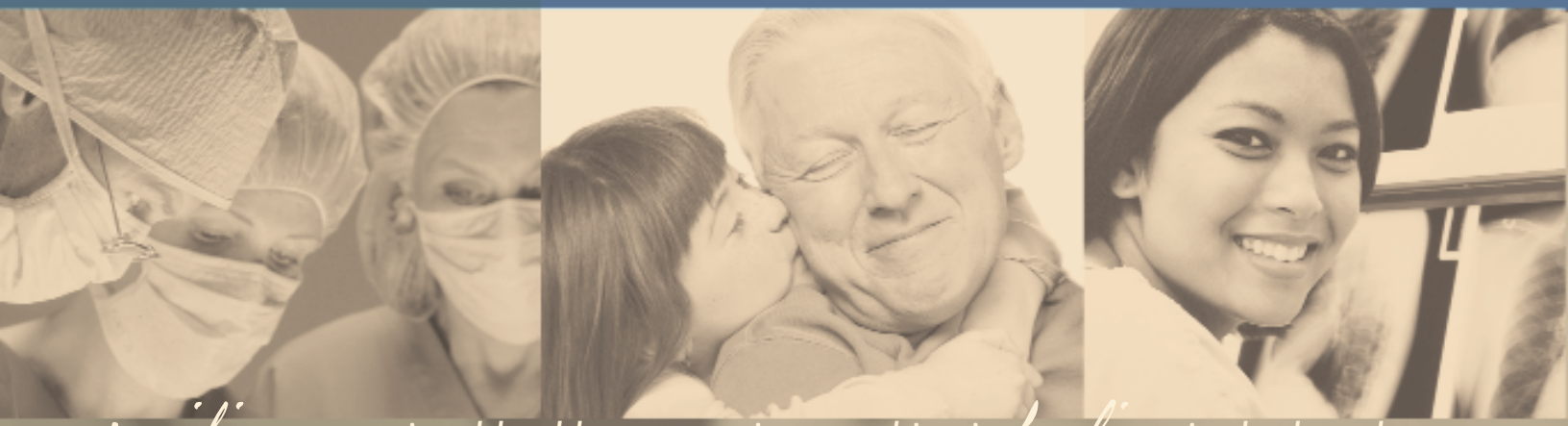
Mercy Health System



providing exceptional health care services resulting in *healing* in the broadest sense

Malcolm Baldrige *2007*

NATIONAL QUALITY PROGRAM APPLICATION

Table of Contents

P.1 Organizational Description

Mercy Health System (MHS) is an integrated healthcare system organized to provide comprehensive services to residents in southern Wisconsin and northeastern Illinois. While Mercy Alliance, Inc. (MAI) is the parent company and legal name of the organization, Mercy Health System is the recognized name and refers to all operating units included in this application. MAI consists of three legal entities.

a. Organizational Environment

a(1) MHS established its roots in 1895 when Dr. Henry Palmer created Janesville's first hospital by organizing a team of 12 physicians in what had been a private home. In 1907, the Sisters of Mercy, a Catholic religious order, purchased the 30-bed hospital. In 1972, the Sisters transferred control of the charitable corporation to a self-perpetuating volunteer board of directors. In 1989, the board of directors recruited a new president and CEO, Javon R. Bea. Together with the hospital staff and BOD, he developed a vision to create a vertically integrated healthcare system that would partner with physicians to deliver patient-focused, high quality care; provide excellence in patient care services through conveniently located medical centers; provide complementary care through post-acute care and retail health services; and offer this range of care through an integrated insurance plan.

Today, MHS maintains an unwavering commitment to quality and cost-effective healthcare. In 2003, MHS received the Governor's Forward Award of Excellence, the state of Wisconsin's equivalent to the Malcolm Baldrige Award. MHS is a national leader in the integration of healthcare services, and has ranked in the top quartile of Verispan's top 100 integrated healthcare networks for the past six years. MHS's network of care includes four core services (Figure P-1) providing a complete spectrum of healthcare services, from the most basic—preventive medicine and health education—to the most complex—open heart surgery and neurosurgery. The integration of physicians as partners creates a collaborative atmosphere that enables MHS to provide a wide array of healthcare services convenient to patients. MHS also strategically positions itself for financial stability through standardization of support processes and growth of diverse, comprehensive services and programs.

a(2) MHS's success has been guided by its mission and vision, which are reviewed annually and modified to reflect new strategies as appropriate. The mission, vision, and values mirror key patient requirements and provide consistent organizational guidance in a changing healthcare industry. The vision is aligned with the Four Pillars of Excellence as shown in Figure P-2. Central to the vision statement objective to assure excellence in patient care is the Culture of Excellence (COE). The COE provides the foundation for fostering a supportive, entrepreneurial spirit, empowering staff to suggest changes, continually improve performance, and better serve customers. This culture is reinforced by MHS's Servant Leadership Philosophy (Figure 1.1-2). Because all employees embody MHS's mission, they are referred to as "partners." The COE is built upon the Four Pillars of Excellence. These pillars are cascaded through the vision statement and all levels of performance accountability, aligning partners with organizational strategies.

Figure P-1, MHS Core Services

Hospital-Based Services

- Mercy Hospital Janesville (MHJ) is a 325,000 sq. ft. facility with 240 beds, 24/7 emergency services, inpatient/outpatient surgery, and diagnostic services.
- Mercy Harvard Hospital (MHH), is a 79,500 sq. ft. critical access hospital with 32 beds, 24/7 emergency services, and outpatient surgery.
- Mercy Walworth Hospital and Medical Center (MWH), expanded from a multi-specialty clinic into a critical access hospital in December 2005, is a 60,000 sq. ft. facility with 6 beds, 24/7 emergency services, outpatient surgery, physician clinics, and diagnostics.

Clinic-Based Services

- 38 community clinics located in six counties in WI and IL, ranging from single-physician practices to large, multi-specialty centers with outpatient surgery, urgent care services, and diagnostics (1,500 to 60,000 sq. ft.).

Post-Acute Care/Retail Services

- Mercy Manor Transition Center (MMTC), a 28-bed, subacute unit located on the Janesville hospital campus.
- Mercy Harvard Care Center (MHCC), a 45-bed, long-term care unit located at MHH.
- Home health services and durable medical equipment.
- Residential hospice facility in Janesville, WI.
- Community-based residential facility in Janesville, WI.
- Mercy Health Mall
- Six retail pharmacies in Wisconsin and Illinois.

Insurance Products

- MercyCare Insurance Company (MCIC) offers Health Maintenance Organization (HMO) products, Point-of-Service (POS) products, Medicaid HMO products, and Medicare supplement plans to employers.

a(3) MHS employs a diverse workforce of over 3,700 staff partners as summarized in Figure P-3. The average age of MHS partners is 42 years and the average length of employment is 7.5 years. The employee composition is 7% minority, which reflects community demographics. MHS has a bargaining unit located at one clinic, which was in place at acquisition, and its members comprise 4% of the workforce. As needed, MHS contracts for temporary staff with staffing agencies. A number of contract labor service agreements are ongoing, such as those for select housekeeping and security services. MHS also has an association of volunteers serving MHJ and MHH with 905 active members. The key requirements and expectations of the MHS workforce include: a safe and healthy work place; competitive compensation and benefits; development and career mobility; effective communication; and involvement and recognition.

Physicians are essential MHS collaborators in improving clinical outcomes. A key MHS strategy is partnering with physicians through its employment model. MHS employs 275 physicians, 78% of its medical staff. MHS collaborates with non-employed, privileged physicians through its medical staff committee structure and credentialing process. All medical

Figure P-2, MHS Mission, Vision, Values, and Pillars

MHS Mission Statement

The Mission of Mercy Health System is to provide exceptional healthcare services resulting in healing in the broadest sense.

MHS Vision and Four Pillars of Excellence

Quality – Excellence in Patient Care

- Demonstrate excellence in patient care using best practice benchmarks to ensure continuous improvement
- Promote a culture of patient safety
- Foster an effective Corporate Compliance program
- Provide information systems and technology to support excellence in healthcare

Service – Exceptional Patient and Customer Service

- Provide exceptional patient service through measured customer satisfaction
- Continually improve integrated programs and services based on patient need
- Provide educational programs and health initiatives to improve community health
- Improve community good with special concern for those most in need

Partnering – Best Place to Work

- Cultivate high partner satisfaction by being a best place to work
- Recruit and retain board-certified physicians and other qualified partners
- Promote a safe and healthy work environment
- Foster a learning organization

Cost – Long-Term Financial Success

- Continue growth initiatives and integration strategies
- Emphasize cost containment through efficient operations
- Enhance access to capital
- Achieve long-term financial success

MHS Values

- Healing in its broadest sense
- Treat each other like family
- Patients come first
- Strive for excellence

staff physicians are privileged at sites where they practice and all hold M.D.s or D.O.s and other medical staff credentials.

Many MHS partners are part of special Occupational Safety and Health Administration (OSHA) risk categories, requiring personal protective equipment (respirators, gloves, gowns) and special engineering controls (exhaust hoods, filters). The MHS Safety Committee oversees organizational safety and security processes. Each department maintains Material Safety Data Sheets and addresses safety needs based on specific potential exposure. System-wide safety and wellness initiatives include safe lifting programs, immunizations, ergonomics, emergency preparedness and wellness programs.

a(4) One of the main tenets of the MHS vision statement is to "continually improve integrated programs and services based on patient need." MHS has expanded its network to include 59 facilities, totaling 1.2 million square feet, located primarily in Rock, Walworth, and McHenry Counties. In addition to the healthcare services and facilities described in Figure P-1, MHS includes several operational support facilities.

MHS acquires and maintains highly advanced, cost-effective technology necessary to provide excellent care. Major medical equipment at MHS supports diagnostic, treatment, and surgical services. State-of-the-art procedures and technology include: off-pump coronary bypass surgery; coronary screening; stereotactic breast biopsies; a StealthStation image-guided surgery system; a linear accelerator for IMRT; the latest radiology equipment (MRI, CT, PET scanning); medication management technology using fingerprint access; and a Picture Archiving Communication System (PACS). Information systems technology is the cornerstone to providing applications that support healthcare delivery and treatment and maintain communication and timely flow of information between facilities. MHS is currently phasing in a comprehensive electronic medical record (EMR) to further integrate patient health information. An infrastructure of local and wide area networks connects all facilities. System-wide applications support the sharing of electronic health information, including: patient demographics; visit history; diagnostic and medication orders; test results and images; and physician transcribed reports, which are electronically available to authorized caregivers at all sites. Each patient is assigned a unique Master Person Index number to promote flow of clinical information between hospital and clinic systems. Implementation of a clinic-based electronic record began at the end of 2005 with rollout anticipated over the next three years. This allows physicians and nurses to immediately document at the point of care and access pertinent patient information. The clinic electronic record is interfaced with other software systems already in place (lab, radiology, and transcription) to provide a comprehensive medical record to clinicians. It also enables access to data and information to support performance improvement initiatives.

Figure P-3, Staff Breakdown by Groups/Segments

Groups/Segments	Number (Percent)			
Staff Partners/LG	3,605 (97%)		111 (3%)	
Male/Female	595 (16%)		3,121 (84%)	
Union/Non Union	165 (4%)		3,551 (96%)	
Education	High School 1,349 (36%)	College 1,770 (48%)	Graduate 597 (16%)	
Positions	RNs 711 (19%)	MDs/DOs 275 (7%)	Tech/Prof 1,153 (31%)	Other 1,577 (43%)
Ethnicity	Caucasian 3,447 (93%)	Black 57 (2%)	Hispanic 84 (2%)	Other 128 (3%)

a(5) MHS operates in a highly regulated industry, governed by numerous federal, state, and local agencies. Some agencies are specific to healthcare, such as The Joint Commission, the National Committee for Quality Assurance (NCQA), and the Centers for Medicare & Medicaid Services (CMS). Others include the same regulatory agencies that oversee general business, such as the IRS, OSHA, FDA, Nuclear Regulatory Commission (NRC), and the American Institute for Certified Public Accountants (AICPA). Many regulations are unique to specific entities and departments. For example, skilled nursing facilities and home health agencies have specific federal- and state-specific regulations, while the NRC regulates the radiology department.

Numerous agencies grant accreditations, certifications, and licenses to MHS. Regulation compliance responsibility is

centralized for the system and requirements are addressed by function, not location. This standardized approach allows MHS to ensure regulatory requirements are met or exceeded consistently throughout the system. The Corporate Compliance Plan (CCP) helps MHS fulfill its mission to patients and the community by ensuring consistent compliance with laws relating to business activities, such as the Health Insurance Portability and Accountability Act (HIPAA).

b. Organizational Relationships

b(1) There are three separate entities within MAI: Mercy Health System Corporation (MHSC), Mercy Assisted Care, Inc. (MAC), and Mercy Harvard Hospital, Inc. (MHH). Subsidiaries of MHSC include MercyCare Insurance Company (MCIC), which provides insurance products in Wisconsin and Illinois, and Janesville Medical Center, Inc. (JMC). MHSC represents 80% of MAI's net revenue.

Due to the integrated nature of the entities, the overlapping Boards of Directors (BOD) all report to the MAI BOD, which consists of eight members. The MHSC BOD has nine members, seven who serve on the MAI BOD. The MAC BOD has eight members, two who serve on the MAI and MHSC BODs. JMC has two members, one of whom serves on the MAI and MHSC BODs. The MHH BOD has seven members, one of whom serves on the MAI BOD. The MHSC BOD has four standing committees to support the organization in achievement of its mission. MHSC's senior leaders comprise the Executive Council (EC), which includes the CEO, vice presidents (VPs), and the director of medical affairs.

b(2) MHS's market segments are divided into customers within the four core service areas. Acute care patients are further segmented by service type, including inpatient, emergent care, outpatient surgery, and outpatient services. Post-acute care/retail services complement inpatient and outpatient care delivery, and are segmented by nursing home, home health, retail pharmacy, and durable medical equipment (DME). MHS segments the communities and employer groups it serves by location of its healthcare services, resulting in collaborations with other organizations and contracts with employers in those areas. MHS defines its primary service area as Rock, Walworth, and McHenry Counties; however, not all customer segments are served in all geographic areas. While MHS serves diverse customers, its key customers are its patients. MHS's customer groups and differences in key requirements are shown in Figure P-4.

b(3) As a fully integrated delivery system, MHS engages in many relationships to obtain essential supplies, equipment, and services in order to offer a wide spectrum of quality healthcare services close to home. To promote innovation, MHS solicits vendor input to identify leading-edge, evidence-based processes and technology. MHS's key suppliers/ partners include those for medical/surgical supplies, pharmaceuticals, medical equipment and related services, facility services, and information systems. These include: Cardinal Health, McKesson Pharmaceuticals, Siemens Medical System, Alliant Energy, and McKesson Information Solutions. MHS participates in a purchasing cooperative,

Figure P-4, Customer/Stakeholder Requirements

Patients—*Inpatient, Outpatient, ED, Physician Clinic*
• High-quality services • Access to care • Friendly, courteous service • Cost-effective care • Comprehensive services
Communities—*Rock/Walw (WI) and McHen (IL) Counties*
• Community health improvement and promotion • Providing care to poor
Employers/Enrollees—*Rock/Walw (WI) McHen (IL) Counties*
• Cost-effective care • Convenient access to needed care • Quality provider network

Healthtrust Purchasing Group (HPG), to optimize cost savings. MHS is part owner of Madison United Healthcare Linen (MUHL), which provides linen supplies to southern Wisconsin hospitals. MHS senior leader representation on the MUHL BOD enables MHS to create economies of scale and partner with other hospitals to make improvements. MHS also partners with organizations such as United Way and area schools to improve community health and develop healthcare delivery strategies.

MHS's most important supply chain requirements include: product and service quality; timely delivery and response to service requests; competitive pricing and cost savings; and system reliability. MHS ensures that each supplier is committed to providing quality products and improving services in support of MHS's mission.

b(4) MHS establishes effective communication channels and relationships with suppliers and partners to ensure supply continuity and to deliver high quality care. Inventory, downtime, and preventive service reports are reviewed at scheduled meetings with key suppliers to evaluate service delivery performance and improve processes. Communication mechanisms include the use of telephone, email, in-person meetings, and internet. Relationships with employed physicians, non-employed medical staff, and other care providers are cultivated through formal medical staff departments and committees, which promotes clinical integration and effective decision making. Shared decision making is also promoted through physician representation on the BOD, standing committees, and process improvement committees.

P.2 Organizational Challenges

a(1) Competitive Environment

MHS competes with various providers by product line and geographic location as shown in Figure P-5.

Hospital-Based Services: MHJ is the only general acute care hospital located in Janesville, WI, is the largest of six hospitals within a 30-mile radius, and is the market leader in the two-county Wisconsin service area. Inpatient discharges have increased at about the same pace as those for the overall service area, while outpatient surgery cases have increased at a faster pace, resulting in increased market share. Regional providers from Madison and Milwaukee continue to exert pressure in MHS's key Wisconsin markets. Despite these pressures, MHS has continued to realize growth. In response

Figure P-5, Key Competitors

Core Services	Rock and Walworth Counties, WI	McHenry County, IL
Hospital-Based Services	Competing hospitals and surgical centers in Rock and Walworth Counties or serving the needs of community members located in Rock or Walworth Counties	Competing hospitals in McHenry County
Clinic-Based Services	Competing clinics in Rock and Walworth Counties	Competing clinics in McHenry County
Post-Acute Care/ Retail Services	Competing long-term care, assisted living, hospice, home health, and retail pharmacy providers in Rock and Walworth Counties	Competing long-term care, home health, and retail pharmacy providers in McHenry County
Insurance Products	Competing health plans offered to community members of Rock and Walworth Counties	Competing health plans offered to community members of McHenry County

to market research and community feedback, MHS expanded Mercy Walworth in 2005 to include six critical access beds.

MHH has the second largest inpatient market position in Harvard, IL. Since affiliating with Harvard Memorial Hospital in 2003, MHS has made significant investments in facilities and technological upgrades to attract physicians and patients to the hospital.

Clinic-Based Services: MHS operates an expansive network of outpatient clinics and holds 60% of the physician office visit market in its Wisconsin service area and about 20% in its Illinois service area. MHS visit volumes have increased faster than those of the competition, especially in Illinois. In the early 1990s, MHS began creating its primary care clinic network in Wisconsin, which soon evolved into a major medical center model with integrated specialty, ancillary, urgent care, and outpatient surgery services. MHS expanded into Illinois with its first primary care clinic in 1996 and a major medical center in 1999.

Post-Acute Care/Retail Services: As part of its integrated delivery strategy, MHS entered the post-acute care business in 1994 and the retail business in 1997. MHS's goal for these businesses is to maximize profits while providing convenient services along the full care continuum. MHS has designed these services to complement hospital- and clinic-based services and to provide seamless transitional care for current patients. MAC operates a community-based residential facility with 40 beds, which provides a higher level of care than other similar facilities. Only two other area facilities are similar in size; the rest are 20 beds or fewer. MAC also operates the largest skilled home care agency in Rock County, competing with two other providers. The hospice program includes a homecare program and the only residential unit in Janesville, the second largest in the area. MMTC is a 28-bed, subacute facility designed to provide transitional services to patients treated at MHS's hospital in Janesville who no longer require acute care treatment but are not yet ready to return home. Other long-term care providers in the area are not considered direct competitors since they serve a different patient type. MHCC is a 45-bed, skilled nursing facility competing with eight other facilities in McHenry County. However, it is the only skilled nursing facility in Harvard offering short-term rehabilitation stays, long-term placement, or 24-hour respite care. MHS has designed its retail pharmacy business to serve its hospital and clinic patients conveniently at treatment sites, and not to compete with major retail pharmacies in its service areas. In 1998, MHS opened Mercy Health Mall, a one-stop superstore offering durable medical equipment, outpatient clinic and urgent care, cardiac rehabilitation, outpatient diabetic treatment, complementary medicine, optometry, community education, and retail services.

Insurance Products: In 1994, MHS established a provider-owned managed care company as an additional component of its integrated delivery system. MCIC covers over 36,000 lives and operates the second largest HMO in the two-county Wisconsin market area.

MHS's key collaborators include Blackhawk Technical College, Janesville School District, Healthnet, and Community Health Centers Inc. and over 20 chambers of commerce. MHS's involvement with the American Hospital Association (AHA), Wisconsin Hospital Association (WHA), and Illinois Hospital Association (IHA) provides collaborative opportunities to work together on multiple healthcare issues.

a(2) The goal behind MHS's strategies is optimal coordination of healthcare services, thereby achieving a key element of the mission, "healing in the broadest sense." The principal factors influencing MHS's success are: 1) an integrated delivery system strategy, providing comprehensive services along the continuum of care and delivered through use of a physician employment partnership model; 2) an accountability system that promotes execution of strategic initiatives through use of dashboards, report cards, and action plans; and 3) the Culture of Excellence, which provides the foundation for engaging all partners and empowering them to work as a team to provide quality, patient-focused care.

Key changes in the marketplace that affect MHS's competitive situation, including opportunities for innovation and collaboration, include:

- Conversion of Mercy Walworth Medical Center to a hospital;
- Growth in Illinois markets, resulting in service expansions and a long-term plan for continued expansion of services;
- Significant increases in ED visits, resulting in relocation of the MHJ Urgent Care and Pain Clinic and innovative remodeling to improve patient flow;
- Increased consumer expectations for convenient, on-demand physician care, resulting in implementation of an innovative 30-minute commitment at urgent care sites;

- Increases in the uninsured population, resulting in collaboration with the Community Healthcare Center;
- Voluntary public reporting initiatives, resulting in collaboration with national/state governmental agencies;
- Increased focus on electronic communication and workflow management, resulting in partnerships with key vendors; and
- Continued healthcare worker demand, resulting in collaborations with local high schools and colleges.

a(3) MHS uses Press, Ganey (PG), the American Medical Group Association (AMGA), and NewMeasures for patient and employee satisfaction comparisons. Inpatient clinical indicators are benchmarked with the national Maryland Indicator Project (MIP) and CMS's Hospital Quality Alliance (HQA). Healthcare Baldrige winners and national and state quality indicator reporting, including Wisconsin Hospital Association's (WHA) Checkpoint project, provide MHS with additional sources for clinical benchmarking. MHS also uses state inpatient and outpatient surgery data to benchmark hospital and physician performance.

MHS benchmarks its physician clinic indicators with the Medical Group Management Association (MGMA), including revenue, staffing, costs, and other performance metrics. Managed care quality, satisfaction, and financial comparisons are obtained from NCQA and the Wisconsin Office of the Commissioner of Insurance. MHS uses state clinical and financial survey results for competitor, peer group, and aggregate analyses. The Verispan Top 100 Integrated Health Networks (IHN) and Ingenix benchmark studies provide industry comparisons for key integrated system and financial indicators. Since 2002, MHS has identified key sources for best practice and competitor comparisons: Malcolm Baldrige healthcare winners and NCQA top performers, including a competitor health system and a competitor health plan. MHS has selected other competitors for comparison purposes based on size and services provided and their impact in markets served. MHS also uses best practice comparisons from outside the industry, such as the Great Place to Work Institute (100 BEST) and the Bureau of National Affairs (BNA). Challenges with acquiring and utilizing benchmark data include: time lags from state and national data sources; limited comparative data for physician office practices and post-acute services; and potential inconsistencies in comparative data due to complex definitions for coding and clinical outcomes measures.

b. Strategic Context

The key challenges affecting MHS are: 1) increased economic pressures/shrinking reimbursement; 2) increased focus on quality, safety, and privacy initiatives; 3) continued expansion of information technology; 4) system growth strategies; 5) consumer demand for service excellence; 6) governmental/ payor focus on public reporting and transparency; and 7) increased demand for qualified healthcare workers.

MHS's key strategic advantages identified below have helped address key challenges, both in the shorter range and longer term, to assure organizational sustainability:

- Integrated healthcare delivery system strategy provides growth and diversification of business lines as well as the ability to effectively coordinate quality healthcare delivery along the continuum of care;
- Partnership model with employed physicians provides for a collaborative focus on quality healthcare services between hospitals, clinics, and the insurance company;
- Retention of staff at best practice levels is critical in meeting patients' needs and maintaining cost-efficient care; and
- Leadership accountability within the Four Pillars provides a balanced approach to all priorities, enabling MHS to sustain operations and meet the organizational Mission.

c. Performance Improvement System

The Plan-Do-Check-Act (PDCA) model is used as the standard approach for process design, evaluation, and improvement. When planning new services or improving services, leaders use the model to identify key processes and requirements and define measures to assure requirements are met (Figure 6.1-1). MHS also uses Failure Modes and Effects Analysis (FMEA) to proactively identify and prioritize risks. The PDCA process is then engaged to address identified risks. MHS promotes a culture of performance improvement and organizational learning through the Leadership Excellence Model (Figure 1.1-3). The model encourages continued focus on strategic goals and breakthrough performance by using customer feedback and benchmarks to determine if performance meets expected levels.

MHS's performance measurement system is used to systematically evaluate and measure key processes and to prioritize improvement opportunities (Figure 4.1-1). Leadership reviews dashboard results and additional indicators on a scheduled basis and uses color-coded dashboards to communicate performance to all partners [Item 4.1b(1)]. In 2000, MHS began using the Malcolm Baldrige Award (MBA) Criteria for Performance Excellence and feedback to further increase focus on performance improvement and organizational learning. In addition, leaders systematically identify, educate, and disseminate information related to performance improvement initiatives through: the Strategic Planning Process (SPP); committees and task forces; the system-wide Quality Council and quality review processes; and leadership meetings at the system and section levels.

Category 1.0: Leadership

MHS's senior leadership team is committed to achieving organizational excellence through adoption of the Culture of Excellence (COE). The COE is supported by the Four Pillars of Excellence—Quality, Service, Partnering, and Cost—and is defined by the visionary strategic goals (Figure 1.1-1). In support of the COE, senior leadership adopted a Servant-Leadership Philosophy (Figure 1.1-2). This philosophy is based on the belief that when leaders provide excellent service to partners, partners provide excellent service to customers. This approach inverts the traditional, top-down management style; thus, organizational leaders become facilitators whose role is to serve those who provide value to patients and other stakeholders.

1.1 Senior Leadership

MHS senior leaders provide guidance to the organization by deploying the mission, vision, and values throughout the organization, empowering partners to initiate action. This approach is promoted by the Servant-Leadership Philosophy, enhanced by a system-wide partnering concept, and supported and communicated through the COE. Senior leaders use the Leadership Excellence Model to sustain the organization through a commitment to continuous improvement using best practice benchmarking to drive innovation and agility (Figure 1.1-3). This model inspires breakthrough change to systems and processes, assuring continued focus on the organization's visionary strategy. It also fosters partner ownership and commitment in achieving the strategic goals.

a. Vision and Values

a(1) The MAI BOD reviews the mission, vision, and values, sets long-term strategy and objectives, and refines long-term action plans. Senior leaders prepare information for BOD strategic discussions, including system updates, market intelligence, healthcare trend reports, and Baldrige feedback. Once the BOD has identified the long-term strategy and objectives, the Executive Council (EC) discusses potential shorter-term action plans to achieve the strategies, which are further focused and prioritized during the budget allocation process. EC reviews system-level performance data and best practice measures recommended by the Benchmarking Committee, and determines which goals, indicators, and targets to include on the system and department dashboards. EC also prepares the specific annual system goals for which they will be held accountable and obtains BOD approval. Senior leaders oversee system operations and translate the vision into quantitative goals through discussions at EC meetings. System-level action plans are formulated at VP Operations (VPO) meetings and include identification of customer and stakeholder needs and impact, needed resources, key supplier requirements, and steps and timelines for deployment. Systems used to engage partners and share ownership for achieving strategic objectives and operational improvements include: departmental dashboards; Leadership Group (LG) report cards; Partner Performance Appraisals (PPAs); Personal Development Plans (PDPs); and Physician Incentive Program (PIP) goals. Senior leaders deploy the vision and values to patients through patient handbooks. Key suppliers and partners are provided COE booklets that explain their role in the MHS COE.

Figure 1.1-1, Visionary Strategic Goals

Visionary Strategy	Goal
Excellence in Patient Care	Top Decile, AHRQ and CMS Core Measures
Exceptional Patient and Customer Service	Top Quartiles of PG, AMGA, and NCQA CAHPS
Best Place to Work	Top Decile, NewMeasures
Long-Term Financial Success	Top Quartile, Ingenix Top "A2" Performers, Moody's

Senior leaders' personal demonstration of commitment to the organization's values is a critical element in the servant-leadership approach. With this underlying philosophy, EC has adopted the following best practices:

- Frequent, open, and honest communication—EC members bring issues to weekly EC meetings for full discussion, supporting integrated system strategies;
- "Cruising and connecting"—EC members perform weekly administrative rounds, connecting with partners to seek out new ways to better serve their needs;
- Personal renewal and connections with patients and customers—EC members perform line work alongside staff annually and review patient complaints weekly; and
- Monthly VP Luncheons—EC members conduct small group sessions to promote two-way communication.

a(2) EC commissioned the creation of, and actively participates in the deployment of, the Corporate Compliance Plan (CCP). The Plan fosters legal and ethical behavior and compliance throughout the organization [Item 1.2b(2)]. Each partner is provided training in the plan's elements during orientation and is required to review the plan during their annual performance appraisal. EC members participate in quarterly Corporate Compliance Committee meetings to review ethical performance and strategies. EC provides an annual business ethics inservice to the LG, and LG members must sign a confirmation statement stating they have read and understand the CCP policies. In 2006, MHS began requiring key suppliers to sign an acceptance of MHS's CCP principles. To further ensure ethical practices, the Committee creates action plans including educational plans, develops policies and procedures, and oversees annual internal and external audits such as those for coding and business expenses. The CCP and HR policies of the organization communicate a "zero tolerance" for illegal or unethical behavior. A hotline is available for partners to report concerns or ask questions. The corporate compliance director follows up on hotline issues within 48 hours. The

Figure 1.1 -2, Servant Leadership Philosophy

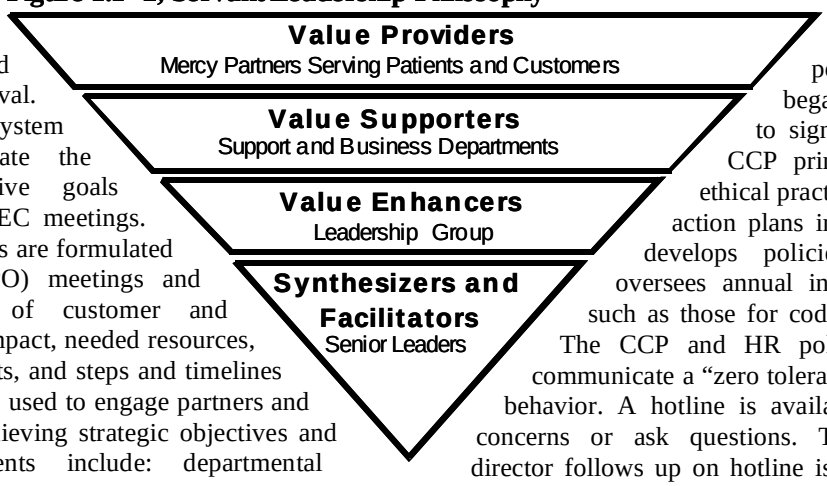
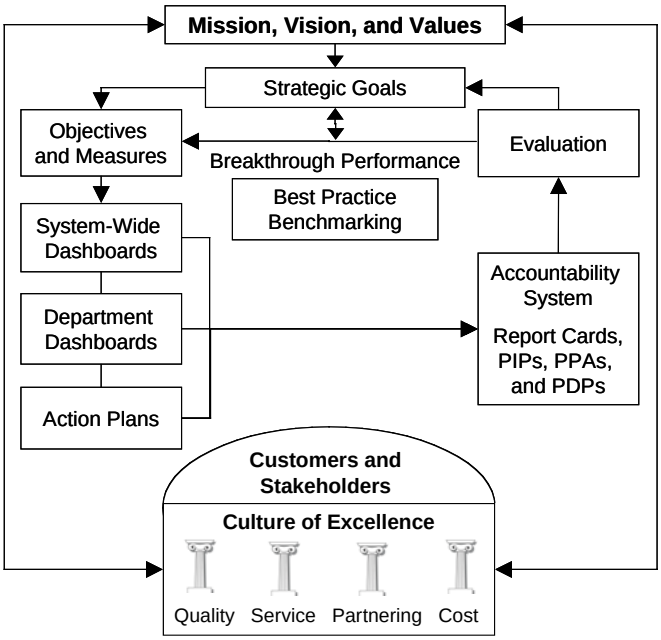


Figure 1.1-3, Leadership Excellence Model



Committee reviews hotline reports and discusses issues during meetings to address trends or system-wide processes.

a(3) To sustain a progressive, service-oriented culture conducive to accomplishing the mission and vision, MHS senior leaders developed the COE initiative to communicate and create a common understanding of MHS's values and goals. COE is introduced to partners in a two-day formal training session identifying COE processes and tools. COE in-services are provided annually. Activities derived from COE initiatives help set the tone for organizational improvement and regeneration. The key principles of the COE Four Pillars are described below:

Quality—Excellence in patient care. MHS uses national and state benchmarks to measure clinical quality, and targets performance at the top decile or top quartile (depending on available data). MHS uses published, evidence-based information for improvement initiatives. Improvements are centered on dashboard focus areas and are accomplished through teams empowered to effect change. These teams use the PDCA approach to improvement. Patient and customer expectations and perceptions of quality care are monitored through the Customer Relationship Management (CRM) process. These inputs are a critical component of the total quality focus to achieve MHS's mission.

Service—Exceptional patient and customer service. MHS's service standards focus on: patient and customer satisfaction; timely problem resolution; expansion of services; improved service delivery and response; and recognition of the internal customer concept. A sophisticated satisfaction surveying process and benchmarking against national data sources maintain partner and physician focus on this pillar's importance. MHS targets performance at the top quartile for PG, AMGA, and NCQA CAHPS. MHS has implemented a systematic internal customer survey process to motivate partners to provide exceptional service.

Partnering—Best place to work. MHS leadership uses the servant-leadership approach to empower employees by cultivating an attitude and philosophy of employees as partners. This encourages partners to keep communication flowing, support each other, stay self-motivated, become involved in issue resolution and decision making, and to treat each other with respect. The partnering model builds relationships of trust through two-way, open communication among partners and LG, and recognizes and rewards excellent performance. Partners are asked to personally commit to achievement of the MHS mission at the time of hire, participate in performance improvement efforts, and create Personal Development Plans (PDPs) to address improvement opportunities. Annually, partner satisfaction is assessed and compared to top decile national benchmarks. EC reviews results and initiates improvement plans for areas below target.

A key factor that differentiates MHS from its competitors is its physician partnership model within an organization governed by a community board. This model involves forming partnerships with employed physicians to address the delivery of exceptional quality care. As a community-based organization, MHS also welcomes non-employed physicians who serve on the medical staffs of MHS's hospitals. MHS works with its employed physicians and its medical staff members (some who are not employed by MHS) to achieve alignment with the mission, vision, and values. This strategy is a key success factor linked to the COE. The employed physician partnership model uses production-based compensation formulas and PIP guidelines to accomplish integration of care while allowing physicians to emulate private practice. The model also achieves economies of scale, fosters an entrepreneurial spirit, and assists in physician recruitment and retention (Figure 7.4-11).

Cost—Long-term financial success. As recognized by Moody's, MHS is one of a few systems nationally that has "successfully implemented an employed physician integration model with minimal subsidization of physician practices." Since 1998, many healthcare systems have seen declining bond ratings. MHS's rating has remained stable at A2 since 1996 [Item 7.6a(3)]. MHS's hospital facilities maintain an average charge per discharge competitive with other regional hospitals (Figure 7.6-6). MHS has achieved this success by engaging partners to identify innovative ideas for growing system revenue, decreasing expenses and waste, increasing productivity, maximizing economies of scale, and managing resource utilization. Financial targets are compared nationally and regionally to the top quartile for similar organizations.

Senior leaders foster partner innovation, engagement, and agility through COE initiatives, forums, VP luncheons, weekly rounds, and section meetings with LG. MHS uses a formal Partner Idea Program to encourage, recognize, and reward partners for their innovation, ideas, and suggestions. The Cruise and Connect Committee assesses these ideas, and MHS recognizes partners whose ideas are adopted. If the idea

results in generation of revenue or reduction of cost, partners receive a monetary reward. These processes and the servant-leadership approach encourage partners to offer new ideas and identify performance barriers.

To promote an organizational culture of learning, EC includes staff education targets on the system dashboard. EC commissioned a system-wide education committee to address staff development processes and systems. EC also provides significant financial funding of partner and physician continuing education (Figure 7.4-8). MHS partners learn from each other by sharing information and best practices at staff meetings, participating in partner forums, and through the Best Practices Sharing Program. Career ladders reward partners for learning and using new skills (Figure 7.4-8). Partners develop a PDP with their supervisor during the annual performance appraisal process. Organizational learning is also fostered by a commitment to seeking national best practices and incorporating them into MHS systems, processes, and policies. The use of evidence-based clinical protocols, Baldrige criteria, best practice benchmarking, and other planning inputs further supports organizational learning.

Senior leaders personally participate in succession planning by discussing PDPs with LG during the annual leadership performance review process. This process allows for one-on-one discussion regarding ways that leaders can develop individual skills. Each fall, the VPO team collectively reviews LG performance during the annual incentive plan review process to identify LG members with potential for development. Annually, the CEO prepares a succession plan for EC members, and senior leaders support MHS succession planning on a system level.

a(4) Senior Leaders create and promote a culture of patient safety through the Patient Safety Committee, an interdisciplinary team that develops the Patient Safety and Medical Error Reduction Plan and coordinates organizational patient safety activities. Senior leaders also promote this culture by including patient safety goals on the system dashboard and incorporating them into the Leadership Excellence Model and partner performance standards. Patient safety activities and goals are discussed during partner forums, VP luncheons, and via other communication methods identified in Figure 1.1-4 to keep a focus on their importance in overall quality of care, in keeping with the MHS value of "patients come first."

b. Communication and Organizational Performance

b(1) Senior leaders communicate with partners using the methods shown in Figure 1.1-4. The CEO communicates the system mission at partner and volunteer orientation through a video that provides for consistency and emphasizes each partner's role. The MHS mission and vision statements are posted prominently throughout the system. Department-specific mission statements, linked with the system mission, are also created with partner input and posted in visible locations to align and engage partners to achieve goals.

Senior leaders engage partners by keeping them informed. EC meeting highlights are shared with LG in weekly section meetings. LG shares this information with partners in regular departmental meetings. This provides for two-way flow of information, encourages input, and actively involves partners in the direction of the organization. To provide opportunities for staff partners to share ideas, the CEO holds annual forums and VPs hold monthly VP luncheons. These meetings engage partners in strategies of the organization, and encourage open, frank communication between front-line staff and senior leaders. Monthly meetings between senior leaders and physician partners are held at clinic sites to share information and ideas for innovation. Monthly medical staff department meetings, which include EC, LG, and clinicians, provide a forum for communication of system values and exchange of information. In 2006, EC implemented physician roundtable discussions with both employed physicians and medical staff members to expand methods for sharing system goals, obtaining input, and meeting system objectives. Senior

Figure 1.1-4, Methods for Communicating with MHS Partners

Communication Method	Frequency	Purpose
EC meetings	Weekly	EC members discuss strategies and create deployment plans
VPO meetings	Weekly	VPs review performance, brainstorm performance improvement action plans, provide integration of tactics across system sections
LG/section/partner update meetings	Weekly/Monthly	EC, LG, and partners communicate strategies/information, gather feedback, and share best practices
Leadership rounds	Daily	Promotes hands-on communication with partners and physicians
Physician Roundtables	At least quarterly	EC members and physicians discuss quality care intitatives and provide two-way communication on current plans and COE
CEO/Partner Forums	Annual	Communicates strategies to engage partners and gather feedback
Monthly VP Luncheons	Monthly	Small group meetings to involve staff, promote two-way discussion
Department communication boards	Ongoing	LG posts important information/flyers for all partners on all shifts
Partner/physician newsletters	Wkly, Mnthly, Qtrly	EC and LG communicate system information to all stakeholders
CEO weekly email	Weekly	CEO shares current information and supports COE strategy
MHS intranet and shared folders	Ongoing	Shares information on physicians, services, HR, and wellness
COE initiatives	Ongoing	Align patient-focused care with business strategy

leaders also exchange information through leadership retreats, the budget process, Quality Council, and participation on performance improvement teams. To reward partners for behaviors which focus on customers and improvement activities, EC sponsors a special recognition program, Above and Beyond the Call of Duty (ABCD). EC and LG members present ABCD awards at departmental meetings to provide public recognition. EC members also send personal letters to partners who have accomplished various ABCD achievement levels. The partner merit increase program, and incentive compensation programs for employed physician partners and LG members, provide recognition for high performance. The Matched Savings Program rewards partners for organizational goal attainment.

b(2) MHS's Leadership Excellence Model illustrates how EC creates and deploys a focus on action to accomplish the organization's vision and objectives and to improve performance through system and department dashboards, LG report cards, PPAs, PDPs, and PIP guidelines (Figure 1.1-3). System dashboards, representing measurable goals, are updated annually based on strategic objectives and are geared toward reaching the strategic visionary goals (Figure 1.1-1). Organizational improvement is accomplished by evolution of the system-wide dashboard goals to drive performance at benchmark levels. EC reviews system-wide indicators on a scheduled basis and dashboard results quarterly. These results form the basis for action plans and improvements (Figures 4.1-2 and 7.6-1). LG members design departmental dashboards in alignment with the system dashboard and the Four Pillars, reflecting priorities unique to their areas and creating and balancing value for patients, customers, and other stakeholders. Accountability for achieving system and department dashboard targets is accomplished through complementary LG report cards and action plans that personalize tasks and outcome measures for LG members. Report cards are aligned with the Four Pillars and scoring is weighted annually based on system-level strategic priorities.

A color-coded Dashboard Alert System is used to identify improvement priorities [Item 4.1b(1)]. Action plans are developed or revised for changing priorities, serve as the platform to drive performance accountability through interactive, two-way communication between EC and LG, and create agility through continuous focus on improvement. To further promote physician and staff alignment with system goals, MHS evaluates employed physicians through PIP goals and staff partners through performance appraisals, each aligned with the pillars. These processes are designed to balance the Four Pillar elements, creating value for all stakeholders.

1.2 Governance and Social Responsibilities

MHS BODs and senior leaders are committed to the mission of providing "exceptional healthcare services." To achieve this, responsibilities to all stakeholders are considered, including a focus on accountability to uphold legal and ethical principles, responsible utilization of both financial and environmental resources, and practicing good citizenship.

a. Organizational Governance

a(1) The BODs hold senior leaders accountable for the organization's actions and outcomes through systematic reviews and bimonthly reports to BOD committees. These committees review reports measuring performance against national and internal benchmarks, data and information from the quality committees of the medical staffs and Quality Council, credentialing activities, and reports on staffing effectiveness, market share, Joint Commission, and risk management. The BOD reviews capital expenditures exceeding $100,000, approves annual budgets, and reviews monthly financial reports and annual audit results. Internal and external auditors have direct access to the BOD Chair, the BOD Finance/Audit Committee, and the CEO. Stakeholder issues and legislative/regulatory/community reports are presented to the Strategic Planning Committee of the BOD. Annually, BOD members disclose conflicts of interest. In 2003, the BOD adopted the 21st Century Governance Principles to guide its actions and promote operational transparency (Figure 7.6-9).

a(2) The BOD conducts a full evaluation and assessment of the CEO's performance and determines effectiveness through evaluation of year-end accomplishment of short- and long-range organizational goals. Annually, the CEO evaluates EC members based on achievement of shared and assigned organizational goals. EC evaluates all LG members by comparing objectives achieved with identified targets on annual report cards. These evaluations include those for both administrative and healthcare leaders. EC members discuss personal leadership effectiveness during annual evaluations. Performance review findings are discussed in individual meetings between EC and LG members and at EC, and are incorporated into future PDPs or refined report cards. During its annual retreat, the BOD completes a self-evaluation to assess its effectiveness and identifies improvement opportunities; for example, the addition of regular legislative/ regulatory updates at BOD strategic planning meetings. Enhancement of leadership systems, based on partner feedback or best practice ideas, are discussed at LG retreats and EC meetings and are assigned to EC members to create action plans for improvement. An example of this is the inception of VP luncheons in 2005.

b. Legal and Ethical Behavior

b(1) EC and LG have the primary responsibility for evaluating the societal impact of delivering healthcare services and use several methods to assist in this process: 1) the PDCA improvement cycle, which includes research and evaluation of regulatory requirements associated with services and programs as they are planned or redesigned (Figure 6.1-1); 2) FMEA, which proactively assesses healthcare services to prevent errors before they occur; and 3) an Environment of Care Plan (EOC) that addresses systems and processes, which provide oversight for ensuring safe physical settings in which care is given. Reviewed annually by the BOD, the EOC includes several sub-processes such as safety rounds, inspections, environmental compliance activities, and waste management programs. The Quality Council oversees systems that review patient care processes, and MHS uses a medical

staff peer review process to assess medical care provided by healthcare practitioners.

MHS senior leaders anticipate public concerns with services through the use of various survey tools (e.g., market research studies, focus groups) and through systematic interaction with key leaders in government and businesses, not-for-profit, community-based organizations, and the general public. In 2002, MHS added the vice president of community advocacy. To solicit feedback on services, community needs, and emerging issues, this VP meets with members of local government boards, key business leaders, economic development agencies, and chambers of commerce in communities served. Information regarding emerging issues is obtained from: the internet; newspapers; local, state, and federal government agencies and governing boards; and key community contacts. Monthly, the marketing department prepares a healthcare industry report for EC on emerging national and regional trends. The VP of community advocacy and VP of risk management and general counsel update EC on emerging community or legislative issues and, bi-monthly, provide reports at BOD Strategic Planning Committee meetings.

A key process for assuring compliance is the implementation of CCP initiatives, which are monitored by the compliance director with the assistance of the Corporate Compliance Committee. The educational component of the plan includes training during partner and physician orientation, an annual leadership inservice, periodic presentations, and continuing medical education programs for medical staff members, and presentations for other identified areas within the system. Partners are required to sign off on CCP policies each year at the time of their evaluation (Figure 7.6-10).

The scope of regulatory focus determines who and how activities are monitored for compliance and proactive programming. EC and LG members receive weekly legislative updates from the WHA and the IHA. EC appoints LG members and teams to review and implement new regulations, create applicable policies and procedures to guide compliance, and manage quality assurance functions. Education updates are provided to leadership at conferences and workshops, with research materials, or through department-specific training for areas affected by changing laws or regulations. Legal counsel and other experts supplement education. For example, programs are provided to physicians on the Emergency Medical Treatment and Active Labor Act and HIPAA training is provided to partners. MHS addresses regulation changes through evaluation of affected departments with internal and external survey audits. Senior leaders are personally involved in community and public policy-making boards and report activities at EC meetings.

In 2003, MHS added the VP of risk management and general counsel to EC to increase support of efforts in the areas of corporate compliance and risk management. To proactively assess risks, this VP works closely with the safety and risk manager to refine processes. In 2006, MHS created a Risk Management Committee designed to enhance efforts to increase patient safety, reduce risks, and minimize liability exposure. MHS also added an information security manager to enhance protection of electronic patient information. Figure 1.2-1 identifies processes, measures, and goals that ensure compliance with regulatory, legal, and accreditation requirements and with risks associated with healthcare services and other organizational operations.

b(2) The BOD appoints a corporate compliance officer and committee to serve as a resource for addressing business ethics and to ensure awareness and understanding across the system. BOD and EC members sign Conflict of Interest Statements and partners sign Commitment to Corporate Compliance forms. Independent and internal audits are reviewed directly with the BOD to obtain unqualified opinions on all external audits. External auditors meet with the Finance and Audit Committee without management present to assure the Committee has the opportunity to discuss concerns or ask questions. The Committee conducts administrative reviews of lobbying and fundraising activities annually and evaluates priorities. These activities are reported to appropriate state/ federal agencies as required. MHS addresses clinical ethical concerns through the BOD-appointed Ethics Committee, which serves as a resource for caregivers and patients facing medical ethical issues and is comprised of physicians, community representatives, and healthcare members.

Commitment to ethical practices is part of every partner's orientation and is a condition of employment. Annual inservices, including MHS's Code of Ethics, are provided to reinforce principles, and an anonymous 24/7 hotline is provided for communication of infringements. Adherence to these standards and re-education is documented during annual performance evaluations. The Corporate Compliance Committee meets quarterly to review ethical issues, prioritize action plans, establish targets, and review performance (Figure 7.6-10). MHS has a "zero tolerance" statement in its CCP and in its HR policies. Both internal and external audit functions serve as additional processes to monitor ethical behavior. Ethical breaches are addressed in accordance with disciplinary policy. The BOD Executive Committee addresses BOD issues. MHS gives key suppliers packets describing MHS's business ethics and, in 2006, adopted vendor standard commitment language describing business ethics expectations and requiring acceptance of MHS's Code of Ethics.

c. Support of Key Communities and Community Health
Good citizenship and responsibility to the public are crucial to MHS's core mission, "healing in the broadest sense," and its vision statement, "promote educational programs and healthcare initiatives to improve community quality of life." MHS actively supports and strengthens key communities by collaborating with community agencies, providing health education programs, and delivering integrated healthcare services. MHS considers all communities in which it has facilities and services to be "key communities," with an emphasis on those in Rock, Walworth, and McHenry Counties. New communities are identified during the SPP through market analysis and community needs assessments. Annually, the VP of community advocacy and the director of community development conduct formal needs assessment

Figure 1.2-1, Regulatory, Legal, Accreditation, and Risk Management Processes/Measures and Targets

Regulatory Processes	Measures	Standards/Targets (Results Reference)
Internal audit process and CMS audits	Specific audit criteria	100% compliance/no sanctions (7.6-9,12)
Internal and independent audits	Specific audit criteria	No material findings [Item 7.6a(3)]
Reportable events filed with FDA	Specific audit criteria	100% compliance (7.6-12)
HIPAA privacy compliance process	Privacy Breeches	Zero violations (7.6-12)
CCP orientation and training of all staff	CCP sign off on PPAs	100% trained (7.6-10)
Licensure Processes	**Measures**	**Standards/Targets (Results Reference)**
Staff credentialing and licensing	Current licensure	100% licensure (7.6-12)
Facility licensure assessments	Current licensure	100% licensure (7.6-12)
Accreditation Processes	**Measures**	**Standards/Targets (Results Reference)**
Joint Commission Accreditation	Survey standards	Full accreditations (7.6-11)
NCQA survey participation	Survey standards	Excellent rating; 3-year accreditation (7.6-11)
Risk Management/ Public Reporting Processes	**Measures**	**Standards/Targets (Results Reference)**
Environmental Protection Agency standards	Infectious waste reduction	H2E Best Practice (7.6-13)
Patient safety initiatives	NPSG criteria	100% compliance (7.1-15)
CMS national voluntary reporting	Specific measures	100% measures w/in target (7.1-3, 5-6, 8-9, 18-19)
WHA Checkpoint initiative	Specific measures	100% measures within target (7.1-15)

surveys with agencies and individuals in key communities. These assessments include an evaluation of current community support systems. EC and the BOD review these assessments and prioritize identified needs for incorporation into organizational strategy. Decisions to provide services and collaborate with other organizations are based on identified needs of key communities, the number and services MHS provides in each community, affordability, and impact on financial performance. When evaluating collaborative opportunities, MHS seeks partners with common goals. Examples of initiatives and collaborations promoting healthier communities are listed in Figure 1.2-2. In 2006, MHS received the Spirit of Excellence Award from *Modern Healthcare* and Sodexho for the House of Mercy.

As a positive change agent in the communities served, MHS initiates and implements programs designed to meet community needs and enhance public health. MHS collaborates with service agencies and chambers of commerce, including those in Rock, Walworth, and McHenry Counties. Each year, MHS provides community support through charity care (Figure 7.6-14) and sponsors over 3,800 screenings, community education classes, and special events designed to meet the specific needs of key communities (Figure 7.6-16).

Senior leaders champion efforts to improve key community health by supporting community foundation funding, designing services and educational programs, and implementing programs that encourage and support staff involvement in community activities. One process supporting this effort is the Mercy Foundation, which establishes funding priorities based on benefit to key communities as well as to MHS. Throughout the year, a panel of leaders prioritizes requests for financial assistance. To reinforce commitment to community support, senior leaders communicate the formal expectation to LG that community service is an extension of each leader's responsibility. Through the MHS Ambassador Program, physicians, LG, and other partners are encouraged to make presentations to community groups and organizations regarding MHS services and activities. EC members are actively involved in many community boards; local, state, and national organizations; and service clubs. This helps senior leaders understand and support community needs and priorities. MHS partners are encouraged to participate in their communities' quality of life improvement efforts by volunteering time or expertise to organizations and at health promotion events. As active volunteers in community agencies, MHS partners help identify areas of need. To support volunteerism, MHS uses programs to recognize partner contributions such as paid release time for community service and ABCD awards.

Figure 1.2-2, Community Initiatives and Collaborations

Initiatives
• House of Mercy, a 25-bed homeless shelter • Meals on Wheels and 24-hour emergency Lifeline • Mercy in Motion transportation services • Health Line—24-hour health information and referral line • Free/low-cost health screenings, clinics, education fairs • MHS Speakers' Bureau for community organizations • MHS's health and wellness web site • Emergency Medical Service training and MD sponsorship • Scholarship Programs • Parish nurse training and scholarships • Health Career Awareness Projects for youths
Collaborations
• MDs volunteer in free clinics—Rock, McHenry Counties • Family Health Partnership—provide free mammograms • Rock County Health Department—bioterrorism readiness • Red Cross—blood donations at MHS facilities • United Way—annual campaign and fund raising efforts • Community Action, Inc.—community health awareness • Area Police/Fire Departments—portable defibrillators • Area Employers—worksite occupational medicine nurses • Community Health Ctr, Inc.—low income clinic services

Category 2.0: Strategic Planning

MHS is a successful integrated healthcare system, a strategy that underlies all planning efforts and is supported by the COE. Strategy deployment through the Leadership Excellence Model results in comprehensive accountability and empowerment from senior leaders to front-line partners.

2.1 Strategy Development

Promoting the mission and vision is the overall objective of the Strategic Planning Process (SPP). The visionary strategic goals shown in Figure 1.1-1 balance all stakeholder needs throughout strategy development and deployment.

a. Strategy Development Process

a(1) MHS uses a six-step SPP to establish strategic objectives and deploy action plans. Balancing strategic initiatives through the Four Pillars promotes alignment of strategic, financial, and operational objectives. Key participants in the planning process represent the entire organization and include the BOD, EC, LG, departmental process owners, and other stakeholders. Leadership deploys strategies and measures of performance to all levels of the organization through the accountability system. Figure 2.1-1 outlines MHS's SPP, which follows an annual timeline that incorporates the budgeting process. Strategy development occurs from December through April and is outlined in Steps 1–4. Strategy deployment begins in May preceding the fiscal year, and is outlined in Step 5. Monitoring of progress and action plans occurs throughout the year as described in Step 6.

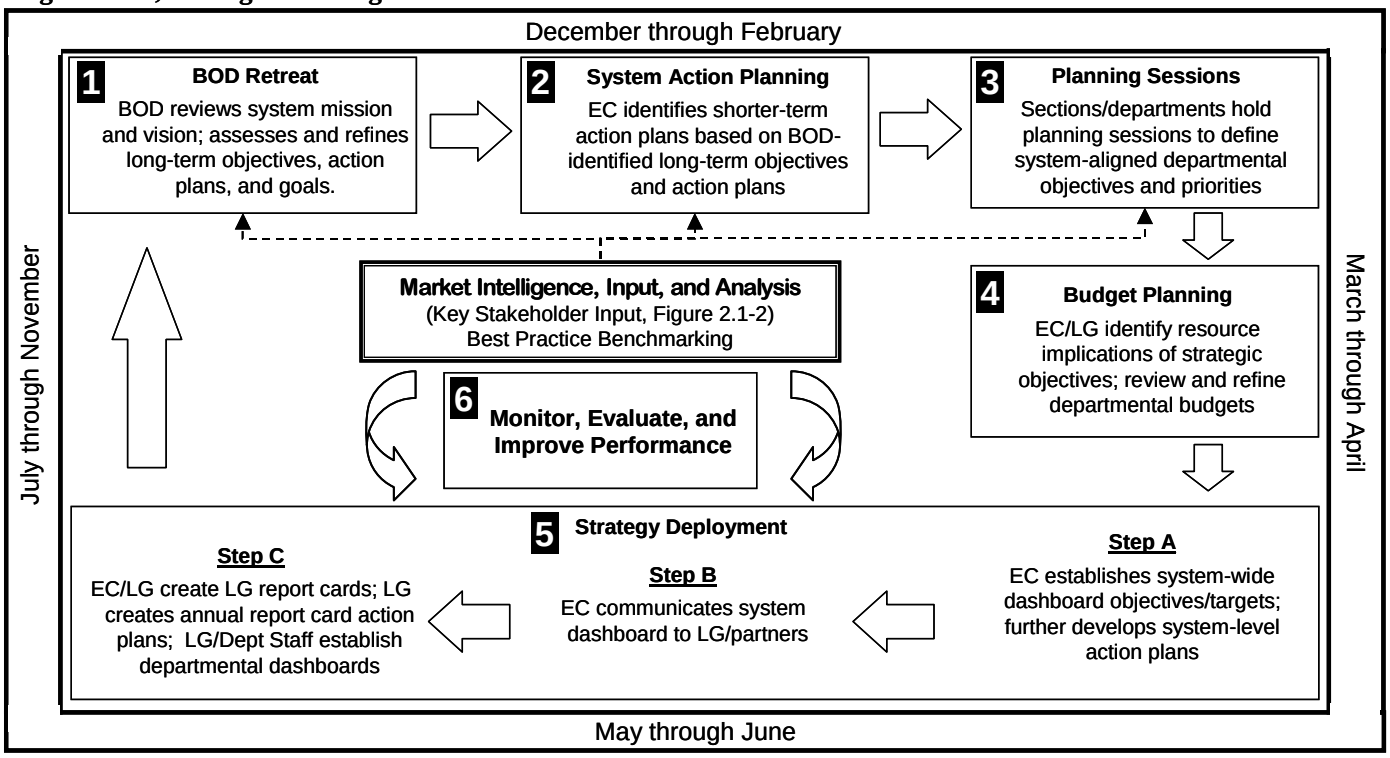
Development: ❶ At its annual retreat, the BOD reviews the system mission and vision statements; assesses existing long-term (3-5 year) strategies and strategic objectives; identifies additional objectives needed to attain the long-term strategy; and refines long-term action plans and goals. The overlapping nature of the BODs enables alignment and consistent deployment of system strategies. Senior leaders present strategic updates at the annual BOD retreat and bimonthly to the BOD Strategic Planning Committee. These updates include challenges, industry trends, input from section and department planning sessions, and new opportunities for consideration.

❷ EC identifies MHS's shorter-term (1-2 year) action plans based on the BOD-identified long-term objectives and action plans. The Benchmarking Committee recommends best practice measures to EC for use with dashboards, action plans, and report cards, all aligned with the Four Pillars.

❸&❹ Synchronizing the strategic planning and budgeting cycles ensures funds are available to meet strategic objectives and objectives will achieve financial and operational targets. Planning and budget assumptions are developed based on environmental assessments, industry trends, and financial analyses. During the budgeting process, LG, sections, and departments hold formal and informal planning sessions to define departmental objectives and priorities that align with system objectives and action plans. This process captures input from physicians, team leads, program coordinators, caregivers, and other front-line staff. During the budget review and refinement process, EC and LG identify economic trends and budget implications of strategic objectives, including recruitment needs, equipment requirements, and facility costs. This process helps EC focus and prioritize system-level action plans necessary to achieve objectives and further provides direction to LG about corresponding departmental objectives and action plans.

Deployment: ❺ After the budget is finalized, EC identifies system dashboard and other system-level indicators, sets targets based on recommended benchmarks, and assigns

Figure 2.1-1, Strategic Planning Process



system-level action plans to senior leaders for deployment. EC defines required measures for LG report cards and department dashboards in alignment with the system dashboard. LG members create annual action plans for all report card indicators and define department dashboard indicators with staff input. EC and LG communicate the final system and department dashboards to all partners.

❻ EC reviews system dashboard performance quarterly and other key system-level indicators on a scheduled basis. LG members monitor department dashboards and develop 90-day action plans when quarterly performance falls in the red. Modifications can be made more frequently if environmental or operational changes necessitate adjustments. Review of departmental action plan progress occurs during departmental meetings, team lead meetings, and weekly section meetings.

MHS leaders conduct comprehensive analyses during the planning process to anticipate potential blind spots, including an annual SWOT analysis at the LG retreat. MHS leaders maintain awareness of changing healthcare trends and customer needs by synthesizing information from multiple sources, including stakeholders, competitors, governmental agencies, and regulators. EC accomplishes this through scheduled review of aggregated data, with timing of reviews based upon data availability. These analyses help detect and reduce competitive and regulatory threats, shorten reaction time, and identify opportunities. During the annual budget process, finance prepares a long-range financial forecast with "what-if" scenarios to help anticipate adverse changes which could impact financial viability. MHS uses these processes to determine its key strategic challenges and advantages.

MHS leadership defines 3–5 years as its longer-term planning horizon. This provides adequate time for anticipating significant capital commitments, market changes, and technological advancements, while 1–2 years affords adequate time for achievement of corresponding shorter-term goals and action plans. Timelines for strategic objectives are established during the SPP and are incorporated into operational, financial, human resource, capital, and other system-level action plans; however, adjustments are made if external or internal influences necessitate changes. Continuous evaluation and improvement of the SPP contribute to organizational agility. Recent improvements include: enhancement of PIP guidelines to better align physician goals with system strategies; online automation of the accountability system; refinement of the action plan process to support strategic objectives; and medical staff roundtables to enhance physician input processes and support of key organizational objectives.

a(2) Analyses conducted throughout the SPP help leaders evaluate strengths and weaknesses, identify current and potential gaps, and determine opportunities. Prior to annual planning and budgeting sessions, key departments and process owners prepare analyses, many of which are identified in Figure 2.1-2. These include: market research and assessments encompassing review of current and potential customer needs within the four core service areas; customer survey and complaint feedback; competitor intelligence; regulatory and legislative changes; physician need analyses used to develop an annual recruitment plan; a technology advancement assessment incorporating physician and LG input; and CRM Committee reports that compile results from these and other demographic, utilization, and market share analyses.

During Steps 4 and 5 of the SPP, EC and LG develop capital and operational budget requirements and review and revise system-level action plans that support strategic objectives. These action plans include the HR, PI, Information Management (IM), and EOC Plans, which are revised annually. Finance prepares a long-range financial forecast which

Figure 2.1-2, Strategic Planning Analyses and Inputs

Key Factors	Analysis and Input Examples	Responsibility (Frequency)
Strengths, Weaknesses, Opportunities, and Threats	SWOT Analyses (LG/section/depart planning sessions) HR Strategic Plan; Capital Plan Baldrige Assessment and Feedback Analysis Benchmarking and Best Practices	EC/LG/Sections/Departments (annual) HR, Finance (annual) EC/LG (annual) Benchmarking Committee (quarterly)
Shifts in Technology; Healthcare Markets; Competitive and Collaborative Environments; and Regulatory Environment	Customer Relationship Management (CRM) Reports Health Care Industry Reports; Trends Research Technology Advancement Assessment; IM Plan Vendor Consultations, Conference Attendance Demographic, Utilization, and Physician Need Analyses Market Research/Focus Group/Community Needs Studies Patient/Customer Satisfaction Surveys and Complaint data Market Share Analyses; Competitor Research/Database Regulatory/Legislative Analysis Joint Commission, NCQA, Other Regulatory Assessments	CRM Committee (quarterly) Marketing (monthly); Planning (ongoing) Planning (annual); IS (annual) Departments, LG (annual, ongoing) Planning (annual, ad-hoc) Planning, Mktg, Comm Advoc (annual) CRD (annual, qtrly, monthly, weekly) Planning (annual, quarterly) VP Comm Advocacy (annual, bimthly) Readiness Teams (ongoing)
Organizational Sustainability; Continuity in Emergencies	Long-Range Financial Forecast (including "what-ifs") Emergency Operations Plan; Capital Plan Contingency and Backup Plans	Finance (annual) Disaster Committee; Finance (annual) Department, Plan Owners
Ability to Execute Strategic Plan	Resource Allocation Process System-Level Action Plans; HR, EOC, PI, IM Plans Variance Reporting by Cost Center Dashboard, Report Card, and Action Plan Review	VPs (annual) EC, HR, Facil. Mgmt, IMAC (annual) VPs, LG (monthly) VPs, LG (quarterly)

projects operating results, capital requirements, and available cash. Incremental updates are prepared and reviewed throughout the year to support action plans.

The Cost Pillar goal to achieve long-term financial success promotes sustained focus on fiscal responsibility. One key way MHS ensures solid operating performance is through diversification, by maintaining complementary business lines and expanding services into multiple markets. Expansion into Illinois markets has proven to be a successful strategy over the past five years, and has enhanced MHS's ability to grow while meeting the needs of medically underserved communities (Figure 7.6-3). Ongoing communication of mission and values, supported by COE initiatives, maintains a culture of integrity, mutual respect, and understanding of organizational direction. Input obtained from LG, physicians, and partners during the SPP and other feedback processes ensures ongoing learning and improvement. These intangible aspects of sustainability are crucial to maintaining high quality services and sustaining financial success over time.

The Emergency Management Committee uses hazard vulnerability analyses to assess probability, risk, and preparedness related to natural, technological, and human events with the potential to affect organizational continuity in emergencies. The Committee uses information from the analyses to develop and improve the system-wide Emergency Operations Plan, activated when a situation arises that is beyond MHS's capability to respond with normal staffing levels or has the potential to burden or disrupt normal operations.

The accountability system, facilitated through the Leadership Excellence Model (Figure 1.1-3), spreads responsibility for effective operations throughout the organization, ensuring the ability to execute the strategic plan. In addition, a rigorous Resource Allocation/Budget Review Process gathers feedback from LG and physicians and results in a realistic budget that provides sufficient resources to achieve strategic objectives [Item 2.2a(1)]. This process includes prioritization of capital requests to support system objectives and use of a top-down, bottom-up operating budget development process. Monthly variance reporting by cost center and quarterly review of dashboards and action plans identify opportunities to redirect resources at both the system and department level. VPs and LG use additional analyses to support ongoing review of performance and action plan refinement. Use of benchmarks on dashboards and report cards, and ongoing review of system action plan progress, further promote systematic improvement throughout the organization.

b. Strategic Objectives

b(1) MHS's vision statement includes all key strategic objectives (Figure P-2). Figure 2.2-1 shows a sampling of these objectives for each visionary strategy and related goals and timetables. The system dashboard includes performance measures for the most important goals.

b(2) During the SPP, MHS conducts varied analyses to identify key strategic challenges and advantages. Senior leaders and the BOD determine strategic objectives based on these analyses to ensure challenges/advantages are addressed. MHS also uses this process to identify opportunities for innovation in services, care delivery, and business practices. The visionary strategies and their objectives and related goals set the tone that drives sustained focus on best practice achievement and continual performance improvement efforts. By incorporating the strategies of each corporate entity and its BOD into the SPP, MHS creates a synergistic, non-competing environment that promotes its integrated delivery system. In addition, the stability of senior leadership and periodic reassignments contribute to knowledge sharing and balancing of stakeholder needs. Aligning objectives and action plans with the Four Pillars, and incorporating input from all customer groups into the SPP, help balance the needs of internal and external stakeholders across MHS entities. Strategy deployment through the accountability system ensures goals are attained.

2.2 Strategy Deployment

a. Action Plan Development and Deployment

a(1) Based on the BOD approved strategic objectives and long-term action plans, senior leaders further develop long-term action plans. Senior leaders identify those key service initiatives to be completed within the next fiscal year and incorporate them into the system dashboard. VP owners develop appropriate system-level action plans. MHS uses the Leadership Excellence Model to ensure objectives can be reached and outcomes of action plans can be sustained. LG members develop report card/department dashboard indicators and action plans that align with system objectives. System goals are deployed to physician partners through PIP guidelines, motivating them to help reach organizational objectives.

The Leadership Excellence Model creates a flexible environment for handling changing and conflicting priorities. PI teams associated with new action plans develop relevant measures and monitor results closely to ensure key outcomes can be sustained. If monthly review of budget performance reveals deviations from targets, action plans are refined. Ongoing review of dashboard performance, accountability for report card goal achievement, and adjustments made through the 90-day review cycle further ensure action plans are accomplished. Continued monitoring of measures ensures that improvements and associated gains are maintained.

a(2) MHS takes a comprehensive approach to strategic planning, which integrates all appropriate facets of the organization. Completion of the strategic plan results in a collection of integrated plans and budgets that support achievement of the organization's strategic objectives. This integrated approach to planning enables the development of robust action plans supported by appropriate financial and other resources. This includes the necessary human resource, information technology, facility, and other resources required to successfully implement an approved action plan.

Senior leaders review internal and external environmental challenges, and other strategic and financial information, to compile budget assumptions and priorities. Senior leaders also assess available and needed financial resources for short- and long-term operations, weighing financial stability with the

primary goal of providing quality services. Annually, EC uses the Resource Allocation/Budget Review Process to prioritize system and departmental needs, and allocates resources based on contribution to achievement of strategic goals and financial benefit to the entire system. If a service or product supports the MHS mission, but is not profitable, adjustments are made in other areas to make up the financial deficit. This ensures resources are allocated to align with system strategies. Capital requests are prioritized during the annual budget allocation process based on the organizational objectives and balanced by the Four Pillars. Capital funding is tied to operating income targets, is subject to available funds, and is adjusted during the year to maintain corporate financial goals.

The impact of known and unknown risks is assessed using the "what-if" capabilities of the forecasting model. The BOD and EC use the modeling information to make strategic decisions regarding current operations and major new investments. Finance also maintains a five-year financial forecast and updates it annually. This financial forecast is used to balance strategic desires with available financial resources while maintaining access to capital.

a(3) During its review of organizational and departmental performance (Fig. 4.1-3), EC and LG identify red indicators and develop action plans at the appropriate levels to bring results back into alignment with targets. These plans receive resources from within the department or from reallocation of other system resources if necessary. The VPO team reviews and approves system-level action plans, and takes them to EC for final approval. This approach supports a systems perspective in the development and deployment of modified action plans. It also enables the modification of any associated action plans affected by these changes. Modified action plans are rapidly deployed to LG during weekly section and department meetings, and to partners as appropriate, to ensure accomplishment of the plans.

a(4) MHS's key system-wide action plans are shown in Figure 2.2-1, and have associated short- and longer-term goals. Action plans are aligned with strategic objectives and prioritized within the balanced Four Pillar framework. Plan progress is monitored quarterly through system and department dashboard indicators and through additional PI Plan measures, the HR Plan, customer and partner satisfaction reports, and financial reports, all regularly reviewed by EC. Key service changes planned by MHS to respond to significant population growth and unmet hospital and physician need include: 1) expansion of Mercy Walworth Medical Center; 2) a new multi-specialty medical center in Crystal Lake; and 3) enhancement of services and partnering with additional physicians in Illinois.

a(5) Based on the key strategic objectives developed during the SPP, MHS updates the annual HR Plan, which includes both long- and short-term action plans. Benchmarks and targets are identified for key HR measures and incorporated into the accountability system under the Partnering Pillar. HR action plans also support strategic objectives in other pillars. Key system-wide HR action plans for FY 2007 include: Quality—maintain low vacancy rates and turnover; Service—provide expanded employee training for customer service; Partnering—expand work/life benefit programs; and Cost—decrease on-the-job injuries through healthy moves and low lift programs. The HR Planning Committee meets weekly to review input from mechanisms such as the SPP, partner survey, forums, and VPO and EC discussions. The Committee assesses potential impacts on people and creates and monitors action plans to assure implementation. During the SPP, LG identifies workforce capability and capacity issues, which are incorporated into the HR Plan and referred to the appropriate committees or teams for roll-out plan development.

a(6) Figure 2.2-1 shows the key indicators used to track action plan progress. Each year, senior leaders adjust report card Pillar weightings to address changes in organizational priorities and ensure balance of stakeholder needs. MHS ensures that the overall action plan measurement system aligns with organizational strategy, objectives, and action plans through the Leadership Excellence Model. As system-level action plans are developed, LG develops corresponding action plans and measures. Corresponding indicators are also included on physician PIPs. This ensures measurements are established for all deployment areas and promotes consistency when prioritizing action plans and resource allocations.

b. Performance Projection

Performance projections for both short- and long-term planning time horizons are reflected in Figure 2.2-1. MHS establishes projections through a process which includes analysis of past performance, comparative data, market intelligence, and expected results of planning initiatives. Based on this analysis, EC makes decisions regarding new services, determines improvements needed to support initiatives, and ensures actions will achieve desired performance.

Based on its projections, MHS performance for its key indicators is expected to compare favorably to those of competitors and other similar regional and national organizations. Key clinical and patient safety measures are benchmarked against MIP, HQA, and CheckPoint. MHS has set incremental targets and implemented processes to reach the national 90th percentile. Customer satisfaction indicators compare favorably with best practice levels, and human resource indicators surpass best practices from NewMeasures, ASHHRA, and the 100 BEST. Financial indicators also exceed national benchmarks and competitor performance in Ingenix's financial study and Verispans's Top 100 IHNs analysis.

During the SPP, EC selects indicators most important to organizational success for the system dashboard, incorporates benchmark comparisons, and establishes appropriate indicator balance. Stretch targets are set aggressively to promote progress toward benchmark performance. EC reviews progress for system-level action plans quarterly and other key organizational measures on a scheduled basis. MHS addresses current or projected gaps in performance through the ongoing action plan and performance review process. If necessary, action plans are adjusted to make incremental improvements and close the gap.

Figure 2.2-1, MHS Strategic Objectives, Action Plans, and Indicators [*Dashboard Indicator*; + = Favorable comp to competitor; NCC = No competitor comp]

Chall	Pillar/Visionary Strategy	Strategic Objectives (SO) and Action Plan Examples LTAP = Long-Term Action Plan; STAP = Short-Term Action Plan	Key Measures, Results Reference	Current Benchmk	1–2 Year Projection	3–5 Year Projection	Comp Proj
Challenge #2, #3, #6	***Quality*** Excellence in Patient Care	SO: Assure excellence in patient care LTAP: Utilize caregiver teams to support evidence-based medicine STAP: Implement concurrent review for core measures patients	***Core Measures, 7.1-3, 5, 6, 8, 9, 18, 19***	90th %ile	90th %ile	90th %ile	+
		SO: Promote a culture of patient safety LTAP: Enhance processes to address National Patient Safety Goals STAP: Initiate/improve communication of critical test results process	***Safety Measures, 7.1-15*** Test Results TAT, 7.5-8	90th %ile --	90th %ile 100%	90th %ile 100%	+ NCC
		SO: Advance information systems and technology LTAP: Implement integrated EMR STAP: Implement Design, Build, Validate (DBV) phase of clinic EMR	Rollout Complete DBV Phase Complete	-- --	-- Completed	Completed --	
Chall #4, #5	***Service*** Exceptional Patient and Customer Service	SO: Provide exceptional patient service LTAP: Maintain CRM Committee to identify opportunities STAP: Establish MHJ Inpatient PI team; implement action plan	***Patient/Customer Sat, 7.2-1–10***	75th %ile	75th %ile	90th %ile	+
		SO: Develop integrated programs and services LTAP: Expand Walworth Hospital and Medical Center	Expansion Complete	--	--	Completed	
		SO: Promote community health initiatives LTAP: Implement initiatives based on community needs assessments STAP: Implement Community Health Center, Inc. (CHC) initiative	Community Health Center Initiative Implemented	--	CHC Implemented	--	
Challenge #7	***Partnering*** Best Place to Work	SO: Improve partner satisfaction LTAP: Develop/execute HR Plan based on best practices STAP: Implement enhanced work-life benefits	***Partner Sat, 7.4-5*** ***Turnover Rate, 7.4-1*** 100 BEST Benefits, 7.4-7	90th %ile 75 th %ile 80%	95th %ile 90th %ile 85%	95th %ile 90th %ile 87%	+ + NCC
		SO: Promote a safe and healthy work environment LTAP: Attain Wellness Councils of America recognition STAP: Implement Employee Health and Wellness action plan	Recognition Attained Lost-Time Injuries, 7.4-17	-- 1.2	-- 0.7	Rec Attain 0.6	 NCC
		SO: Foster a learning organization LTAP: Implement a Mercy Learning Center STAP: Complete LMS installation and launch	***Educ Hrs/FTE, 7.4-8*** Rollout Complete	60 --	60 Completed	65 --	NCC
Chall #1, #4, #6	***Cost*** Long-Term Financial Success	SO: Continue growth initiatives/integration strategies LTAP: Obtain Level II Trauma designation STAP: Complete Level II Trauma assessment	***Growth in Net Rev, 7.3-1*** ***Growth in Equity, 7.3-3*** Assessment Complete	6% 11% --	6% 11% Completed	6% 11% --	+ +
		SO: Emphasize cost containment through efficient operations LTAP: Maintain solid budgeting and financial forecasting systems STAP: Improve operations through use of new budgeting system tools	Systems Maintained System Implemented	-- --	-- Implemented	Maintained --	
		SO: Achieve long-term financial success LTAP: Maintain solid operating margin STAP: Restructure long-term financing	***Operating Margin, 7.3-2***	3.0%	3.6%	3.9%	+

Category 3.0: Focus on Patients/Customers/Markets

To support its commitment to service excellence and delivery of quality care, MHS incorporates customer requirements into the SPP and the PDCA improvement cycle through use of the Customer Relationship Management (CRM) Model (Figure 3.1-1). The CRM Committee uses this model to systematically review current and potential customer feedback and determine changing customer requirements.

3.1 Patient/Customer and Market Knowledge

a. Patient/Customer and Market Knowledge

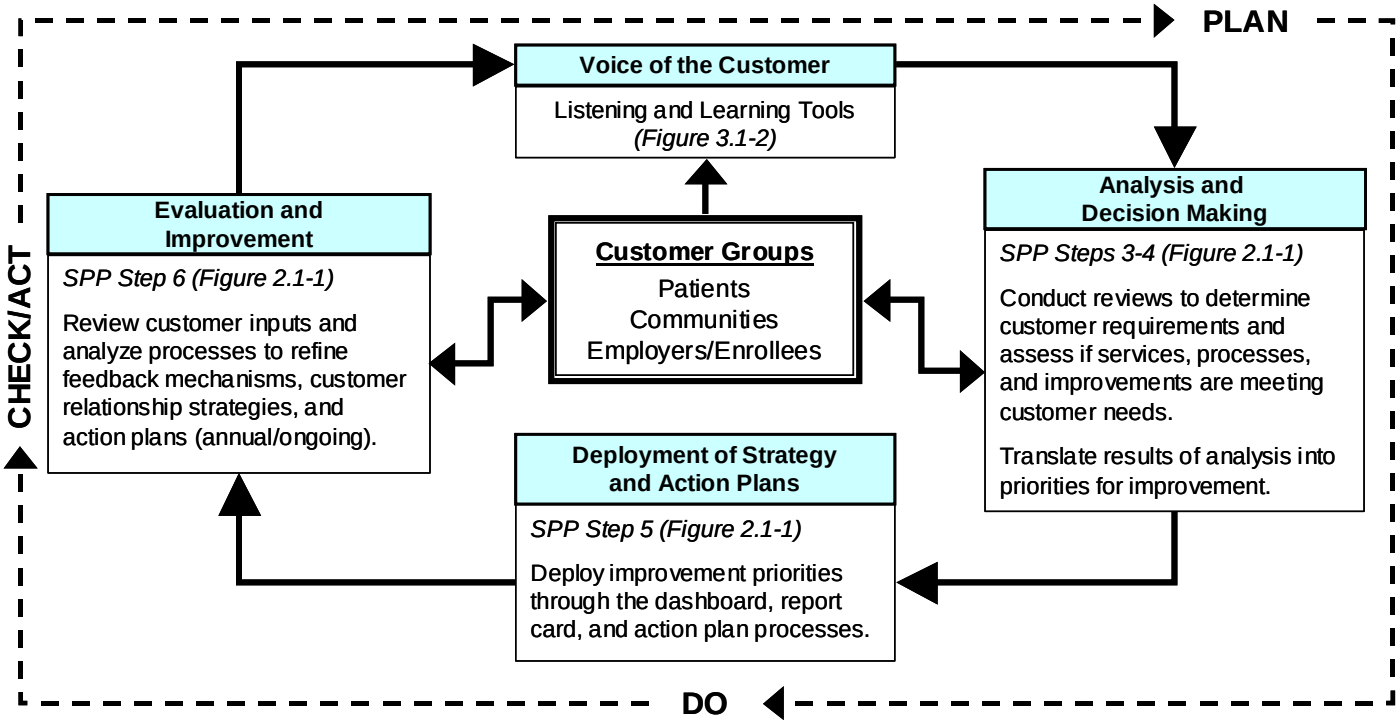
a(1) MHS's key customers include patients, communities, and employers/enrollees. MHS segments patients based on type and site of care—*Hospital:* acute care, emergent care, outpatient services; *Clinic:* physician location and specialty; and *Post-Acute/Retail:* long-term care, home health, DME, and pharmacy. Patients, communities, and employers are also segmented by the counties in MHS's service area and by the key communities where MHS provides services. These customer groups are further segmented by other pertinent factors, such as demographics, payor status, and disease type.

During Steps 3 and 4 of the SPP, EC and LG review customer groups and markets to determine if existing segments and strategies continue to align with the system vision and make financial sense. At the same time, new markets and customer groups are considered for potential service development and expansion opportunities. Key inputs used during this process include SWOT analyses generated during the LG retreat and section/department planning sessions, CRM reports, service utilization and financial analyses, population and patient demographic data, competitor assessments, win/loss analyses, and information about new product lines or services offered in the industry. As part of this determination, MHS identifies potential customers and customers of competitors through independent market research studies and focus groups, secret shoppers, win/loss analysis, and community needs assessments. The Mercy HealthLine call center surveys former and competitor customers to identify potential customers for current and future healthcare services. During the customer/market determination and segmentation process, key questions consider if: 1) the service or customer group aligns with MHS's mission and vision; 2) addition of a new customer group or market would add value to the organization, improve financial viability, or better meet the needs of a particular customer/market segment; and 3) the needs of a subgroup or market are different enough to require a change in data collection and analysis. Changes in service offerings, customer groups, or markets are proposed by LG during the budgeting process, and prioritized and finalized by EC during the Resource Allocation/Budget Review Process.

a(2) While MHS uses results of forward-thinking analyses in its longer-term planning efforts, MHS also recognizes the value of learning from past customers and historical performance. Through the CRM Model, MHS incorporates a comprehensive system of listening and learning mechanisms to use the voice of the customer to determine key customer requirements and changes in expectations. The CRD conducts correlation analysis using survey data to identify variables with the most impact upon overall patient satisfaction and likelihood to recommend. Market research surveys and focus groups include select questions regarding needs and expectations of the community. Focus groups and other industry research are used to determine employer/enrollee requirements and priorities.

Figure 3.1-2 shows the key methods used to gather the voice of the customer from different customer groups and markets. The type and frequency of the method used varies based on

Figure 3.1-1, Customer Relationship Management Model



customer group and market characteristics (e.g., phone vs. written surveys; market research surveying vs. focus groups; nature of questions asked). The varied methods and their timing enable MHS to capture relevant data and information from each customer group to ensure planning and improvements respond to differing requirements. Key inputs used to determine customer requirements, maintain dynamic customer interaction, and facilitate rapid response to needs include:

- **Patient/Customer Satisfaction Surveys**—Surveys are customized for each core service area, including inpatient and emergent care, outpatient clinic, post-acute care and retail, and insurance products. The CRD also provides segmented rapid-cycle feedback reports to LG.
- **Service Recovery Program (SRP)**—CRD tracks complaint resolution and provides weekly reports to VPs, including detailed complaint reports and run charts on total concerns and the top six categories. This information, combined with monthly dissatisfaction reports, is used to identify needs for further investigation.
- **Market Research—**To analyze use of services by MHS and competitor customers, the planning and marketing departments conduct market research studies, focus groups, secret shopper audits, and win/loss analyses. EC also reviews market share analyses, admission trends, and physician need analyses to create plans for new services and physician recruitment.
- **Retention/Referral Analyses**—Analyses of patient transfers, medical record transfer requests, HealthLine survey calls, MCIC referrals out of system, and likelihood to recommend survey responses are used to assess customer loyalty, retention, and referral patterns.

Quarterly, the CRM Committee reviews feedback from these inputs, as well as those shown in Figure 3.1-2, to identify changing customer requirements and submits its findings to the VPO team for incorporation into the annual SPP and ongoing action planning cycle. Key improvement initiatives are deployed through the Leadership Excellence Model and the CRM Model, which keep the customer at the center of the planning and improvement processes.

Figure 3.1-2, Voice of the Customer Inputs/Methods

Input/Method	Patients	Community	Emps/ Enrollees
Customer Surveys	M	A	A
Service Recovery Program	D	D	D
Mercy HealthLines	D	D	D
Customer Service Centers	D	D	D
Market Research	A, AN	A, AN	AN
Competitor Intelligence	M, A	M, A	M, A
Retention/Referral Analyses	Q	A	M, Q
VP Lunches/Rounds/Forums	O	O	O
Physician Feedback	O	O	O
Commun Educ/Screenings	M	M	AN
Health Fairs	Q	Q	AN
Web Site/Intranet	D	D	D
Community Networking	O	O	O

D=Daily M=Monthly Q=Quarterly
A=Annually AN=As Needed O=Ongoing

a(3) MHS's dynamic use of customer information and feedback promotes continuous enhancements to customer-focused approaches. The CRM Committee provides quarterly reports to senior leaders, who incorporate improvement plans requiring significant resources into the SPP. Inclusion of key satisfaction results on quarterly dashboards keeps LG focused on satisfaction results, which lead to action plan development when results fall in the red. Leaders also use more frequent customer feedback to engage the PDCA cycle to identify performance gaps, determine causes and solutions, and make necessary process adjustments to improve results. Specific feedback used to identify leading-edge approaches and improvement opportunities include review of competitor activity, industry trends, and other research conducted during the planning and continuous improvement cycles. Examples of recent innovations include:

- Hospital—Follow-up calls; mailing of thank you cards to discharged patients; addition of MHJ patient representative;
- Clinic—Urgent care 30-minute service commitment;
- Post-Acute—Mail order pharmacy; and
- Insurance—Outbound calls to patients of primary care physicians within five days of visit to assure satisfaction with care received.

a(4) Process owners evaluate their specific listening and learning tools and processes annually during the SPP and on an ongoing basis during the evaluation and improvement phase of the CRM Model. The CRM Committee conducts quarterly reviews to determine tool effectiveness and ensure process changes achieve desired results. CRM Committee recommendations and other tool assessments are provided to VP owners and the VPO team for follow up. Methods used to assess effectiveness of feedback tools include:

- Benchmarking with PG, AMGA, NCQA, and market research vendors, who conduct their own survey assessments annually to ensure survey quality;
- Participation in user groups, conferences, and professional societies; review of literature and web-based research; and review of processes used by MBA recipients;
- Review of survey questions for relevancy and validity, including input from LG and other staff responsible for functional areas; and
- Competitive intelligence and leadership networking.

3.2 Customer Relationships and Satisfaction

Providing exceptional healthcare services is central to MHS's mission, and is based on the ability to understand and strengthen customer relationships. MHS's Critical Moments of Service (CMOS) and Service Recovery Program are the key mechanisms for engaging all staff partners in customer relationship management to ensure sustained customer satisfaction and loyalty.

a. Patient/Customer Relationship Building

a(1) Each MHS partner is a designated customer service specialist and is trained to use the strategies in Figure 3.2-1 to further develop patient relationships and create strong personal bonds with patients/customers. The role of the customer service specialist spans all core services, and each customer service specialist uses COE principles and CMOS

standards as the basis for service delivery. These principles and standards are introduced to new partners at the COE Institute (COE-I) as part of the orientation process. All new physicians are oriented to the mission, vision, values, and COE expectations upon application for medical staff privileges and again at orientation. To clearly convey elements identified as key to relationship building and loyalty, COE booklets have been developed and customized for LG, physicians, and partners. Additionally, COE principles are reviewed during department meetings with medical staff and partners, partner forums, newsletters, and annual partner performance reviews. Tailored goals are also included in employed physician PIP guidelines to maintain physician focus on customer service.

Figure 3.2-1, CRM Strategies

Patient Loyalty	
Centers of Excellence	Mercy In Motion
Greeters	Valet Parking Service
Patient Representative	Senior Connection
Room Service	Mercy HealthLine
Service Recovery	Interpreters
Toll Free number for families	Kiosks
Baby Photos Online	
Community Loyalty	
Mercy HealthLine	House of Mercy
Community Advocacy Program	Scholarships
Community Education Events	Foundation Activities
Newsletters	Community Events
Website	Support Groups
Employer/Enrollee Loyalty	
MCIC customer service center	Online Quotes
Wellness program	Health Fairs/Education
MercyCare HealthLine	Newsletters
Case Management	Educational Mailings

a(2) Figure 3.2-2 lists the many access mechanisms that enable customers to seek information, obtain services, and make complaints. These contacts can be made in person, via web and phone, and through written communication. These varied options support ease of contact across a diverse customer base and markets. Each partner is trained as a customer service specialist to manage customer needs and expectations at each critical moment of service and through other available contact mechanisms, whether in the clinical setting, business setting, or community.

To determine contact requirements and identify improvement opportunities, MHS analyzes access mechanisms on an ongoing basis as part of the CRM Model and incorporates changes into the SPP and ongoing improvement cycles (Figure 3.1-1). Customer survey responses regarding speed of treatment, perception of service, staff courtesy, and overall visit satisfaction are included in this review. The CRD further determines contact and service requirements for patient and customer access through correlation analysis for each satisfaction survey by core service [Item 3.1a(2)]. Evaluation of website feedback helps identify how customers use the site and to identify potential improvement opportunities.

Figure 3.2-2, Key Customer Access Mechanisms

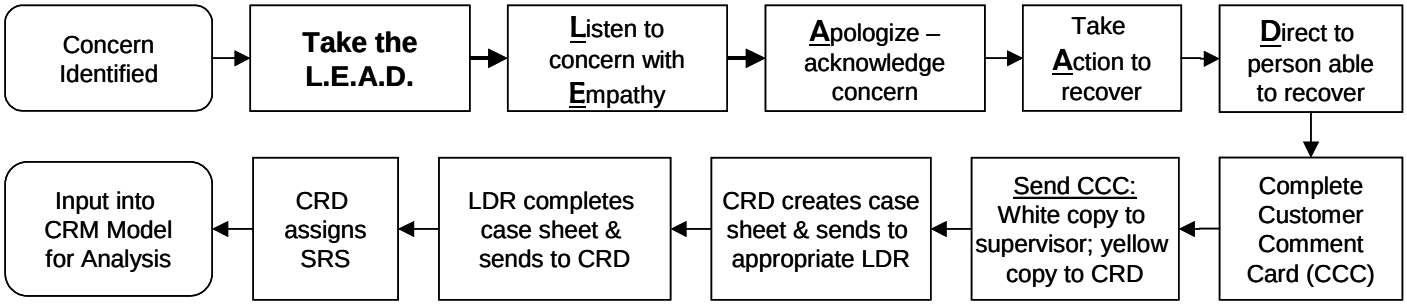
Mechanism	Seek Info	Obtain Svcs	Make Complaints
Customer Service Specialists	X	X	X
MHS/MCIC HealthLines	X	X	X
MHS Web Site/PC Kiosks	X	X	X
Interpreter Line	X	X	
Publications/Newsletters	X		
Reference Guides	X		
VP-Community Advocacy	X	X	X
Urgent Care/Same-Day Appts		X	
Emergency/On-Call Contacts		X	
Clinic Network/Rotating MDs		X	
MCIC Contracting Department		X	
Customer Comment Cards			X
Patient Satisfaction Surveys			X
Customer Relations Department			X
MCIC Grievance Procedure			X

To ensure effective customer relations throughout its widely dispersed locations, MHS deploys contact management requirements and skills during partner orientation and through COE programs. For example, partners use scripts to provide consistent, friendly responses during customer interactions. Requirements are further deployed through the use of department dashboards and LG report cards. Inclusion of COE standards in partner performance appraisals reinforces MHS's expectation of positive customer relationship building. These processes are further reinforced through the COE-I and ongoing COE initiatives.

a(3) The Service Recovery Program (SRP), MHS's complaint management process, facilitates prompt and effective handling of complaints (Figure 3.2-3). This program encourages customer service specialists to "Take the L.E.A.D" with customers to turn negative experiences into positive ones. Partners initiate the complaint management process at the point of service, and the SRP empowers partners to take swift, appropriate action and remedy customer issues. The SRP uses customer comment cards to promote tracking of service recovery issues to identify improvement opportunities. A continual focus on service excellence and service recovery minimizes customer dissatisfaction at the point of service, increasing the likelihood of returning for service and positive referrals. MHS provides service recovery training at partner orientations, annual refresher training, and updates at annual COE fairs. New LG members receive training in complaint management at leadership orientation, offered quarterly. All new medical staff are oriented to the service recovery process during medical staff orientation.

The CRD assists LG in bringing issues to closure and assembles complaint reports that enable analysis at the EC and LG levels. At closure, a service recovery score (SRS) is calculated for each encounter using established criteria. These criteria, based on customer expectation research, include response time and problem resolution components. The SRS target is set by EC at 85 out of 100 points, weighting response time at 25% and problem resolution at 75%. An aggregate

Figure 3.2-3, Service Recovery Process, Complaint Management



SRS is calculated and reported quarterly to identify trends system wide by department/unit and by type of concern. Inclusion of service recovery scores on report cards holds LG accountable for timely and effective complaint resolution. VPO team members review weekly complaints, monthly customer dissatisfaction reports, and trend charts provided by the CRD. Each LG member receives a cumulative monthly report of complaints by location, comment category and subcategory, and physician involved. This rapid-cycle feedback supports identification of potential systemic issues to promote rapid, effective responses. LG uses this data in conjunction with other performance indicators to identify process improvement opportunities that will proactively minimize dissatisfaction. Performance improvement projects, with LG and partner participation, may be initiated at the departmental, unit, or system level. Key objectives are incorporated into report cards and action plans. EC evaluates cross-system issues before initiating system-wide performance improvement projects.

MCIC uses the same complaint management process but must also comply with insurance regulatory requirements. MCIC's customer service department monitors, tracks, and evaluates complaints regarding member benefits, access issues, and provider availability. If complaints remain unresolved, customers may access an official grievance procedure. The claims/customer service department meets daily to review complaints and backlog, and initiates PI teams when necessary. The claims/customer service manager shares issues requiring more significant action at the weekly directors meeting.

a(4) MHS uses ongoing feedback on customer needs and requirements to keep relationship building approaches current. Methods used to keep approaches current include: 1) EC review of industry, competitor, and e-technology trends; 2) monthly Healthcare Industry Reports prepared by marketing for EC and LG review; and 3) literature review by LG members pertaining to their areas of specialty. Annually, process owners and the CRM Committee evaluate feedback tools/mechanisms and present recommended changes to the VPO team. EC subsequently directs improvements, including modification of feedback tools and processes, frequency of analysis and review, and contact mechanism enhancements.

Because online communication to and from customers has been identified as a key change in customer contact requirements, MHS continues to enhance its online services. The online health library offers 24/7 access to health and wellness information and MCIC provides instant online insurance quotes for small businesses and agents. MHS is also piloting online tools to provide alternative customer access options, including community education registration, prescription refill ordering, and retail purchasing. MHS has further improved customer access by offering open access scheduling and a 30-minute service commitment at all urgent care locations.

b. Patient/Customer Satisfaction Determination

b(1) The CRM Model depicts how MHS determines customer satisfaction/dissatisfaction on an ongoing basis and incorporates this information into its analysis, strategic planning, and improvement cycles. Data collection and analysis of satisfaction surveys, comment cards, and complaint management feedback facilitate better understanding of customer perceptions and help improve service delivery and customer satisfaction. Customer satisfaction surveys are used in all of MHS's core service areas, and are tailored based on the type of service and customer. The CRD modifies its survey tools to provide answers to new questions as needs arise. In all core areas, MHS partners also use CMOS standards, service recovery, customer comment cards, and customer service specialist business cards to follow up with patients and customers at the point of service.

For MHS's key communities, the primary methods used to monitor satisfaction/dissatisfaction include market research studies and focus groups, community needs assessments, community education/event surveys, and feedback obtained by the VP of community advocacy. Feedback on employer and enrollee satisfaction/dissatisfaction is acquired through the annual enrollee satisfaction survey, ongoing sales and agency contacts, agency focus groups, MCIC customer service center, and MercyCare HealthLine.

Exceeding customer expectations in areas highly correlated to overall satisfaction helps secure future interactions with the organization. All patient customer surveys report top response percentage (Excellent or Very Good dependent on scale) which is a high predictor of future customer use and referral. The CRD also tracks customer "Likelihood to Recommend" across the system. Using this key indicator of patient loyalty and positive referrals enables MHS to validate key service and access requirements for patient loyalty (Figures 7.2-12–13).

LG uses rapid-cycle reporting of satisfaction surveys and complaints to drive improvements and action plans. The CRD

segments data by core service area and further by department/unit, physician, and specialty to support in-depth analysis and process improvements. LG reviews results with care teams and physician specialty groups, and creates dashboard items to reflect identified needs and promote accountability. Employed physicians are further motivated to improve results through the inclusion of Service Pillar goals in PIP criteria. Major improvement efforts requiring resources are prioritized and presented during the budget allocation process or to the VPO team if more immediate response is necessary. The team reviews satisfaction trends and dashboard progress on a quarterly basis, appoints PI teams, or initiates system-wide implementation of best-practice methods. For example, MHJ inpatient units created a PI team in FY 06 to improve communication and customer service. CMOS service standards were reviewed and enhanced and all partners were asked to recommit to the standards. MHJ attained the top quartile in the initial quarter of CY 2007.

b(2) AMGA, PG, and MCIC CAHPS surveying is used to benchmark perceived service quality by service type. MHS also uses a continuous internal surveying process for each patient type to respond efficiently and effectively to customer feedback. This rapid-cycle feedback surveying process, which tracks both the percent satisfied and top-box scores, provides prompt and actionable feedback from customers of all patient care service areas, including inpatient and emergent care, outpatient clinics and ancillary services, post-acute care, and retail services. CRD receives surveys weekly for scanning and screening of individual comments.

Nursing leadership members make rounds during inpatient stays to ensure quality and obtain actionable feedback. A patient representative for MHJ was hired in early 2007 to assist LG in visiting patients to assure excellence in service delivery at MHS' highest volume hospital. Follow-up phone calls are made to patients, discharged from the inpatient units, emergency departments, and outpatient surgery departments, to assess compliance with discharge instructions and obtain feedback regarding services provided. LG members with clinic, outpatient services, and post-acute care responsibilities also interact with customers daily to receive feedback on service quality. The service recovery and "Take the L.E.A.D." processes evaluate transaction quality and capture feedback for unsatisfactory transactions for immediate intervention, minimizing dissatisfaction and enhancing future referral opportunities (Figure 3.2-3).

The VP of community advocacy plays a vital role in tracking community opinion by attending meetings with chambers of commerce and city councils where services are located. Information is shared with LG and EC for discussion and follow up. MHS initiates quarterly meetings with area employer health cooperatives to assess member satisfaction. MCIC marketing representatives gather information from employer HR representatives or agents on an ongoing basis to evaluate product performance, new products and services, and any service or quality improvements requested by employees and employers. MCIC's customer service department also initiates inquiry-based outbound phone calls to obtain additional feedback from enrollees.

b(3) MHS benchmarks acute care patient satisfaction with PG national, regional, and peer comparisons and with regional competitors. Clinic satisfaction is compared with AMGA national and state benchmarks and best practices. MCIC benchmarks enrollee satisfaction with NCQA CAHPS national and state benchmarks and best-practice regional and competitor health plans. Additional information on satisfaction relative to competitors is obtained through independently conducted community surveys and focus groups and HealthLine surveys. This market research provides valuable feedback on the perception of healthcare providers in MHS markets, including reputation, quality, and customer preference. The Benchmarking Committee uses comparative data to recommend targets for incorporation into the accountability system. Performance against targets is used during the strategic planning and ongoing improvement cycles to identify opportunities and deploy service improvements.

b(4) The CRD and MCIC's customer service department review patient survey processes using healthcare periodicals, the internet, survey research data, conferences, and best practice round tables. Response rates and data integrity are monitored through the patient survey reporting process. Using input from LG, the CRD annually reviews the patient survey process and feedback mechanisms prior to budget preparation. The CRM Committee reviews survey tool effectiveness quarterly and submits incremental improvement suggestions to the VPO team. Because customer satisfaction surveying is a key organizational focus, the VPO team evaluates potential surveying tools and methodology annually to assess if methods are efficient and up to date. To prepare for CMS-required participation in the HCAHPS patient satisfaction process, and to obtain additional benchmarks, MHJ participated in the pilot collection project. This allows benchmarking with the PG database (1,400 hospitals) and with regional and peer comparisons. Initial public reporting of HCAHPS data is scheduled for March 2008. Additional examples of systematic improvements made to satisfaction determination approaches are outlined in Figure 3.2-4.

Figure 3.2-4, Customer Feedback Tool Enhancements

2004
▪ Incorporated PG benchmark for MHJ acute care ▪ Enhanced MCIC CAHPS survey ▪ Added customer feedback options to internet and intranet
2005
▪ Enhanced AMGA survey distribution/collection process ▪ Incorporated PG benchmarks for MHH and ED ▪ Added specialty areas to rapid-cycle survey process
2006
▪ Enhanced alignment of rapid-cycle survey processes with available benchmarks ▪ Transitioned to continuous PG benchmarking for inpatient and emergency services
2007
▪ Revised complaint database to include additional subcategories and comment/outcome summaries

Category 4.0: Measurement, Analysis, and Knowledge Management

Accomplishment of MHS's mission and vision is achieved through its ability to make timely and informed decisions based on the analysis of reliable data.

4.1 Measurement, Analysis, and Improvement of Organizational Performance

a. Performance Measurement

a(1) MHS's vision statement and the Four Pillars guide the development of strategic objectives and action plans during strategic planning at the system and department levels. The Information Management (IM) Plan is MHS's guide to systematically select, collect, and align data and information to support successful implementation of action plans and achievement of objectives. Figure 4.1-1 shows how system and department measures align. The Information Management Advisory Committee (IMAC), guided by the IM Plan, ensures proper infrastructure and technology are in place for gathering, reporting, analyzing, and integrating data and information. The PI process further ensures data integration through the committee reporting structure.

Scopes of service and departmental PI plans drive the selection of measures for tracking daily operations. Department leaders establish data collection methods, thresholds, and accountability for results. These in-process measures support decision making about work process quality, efficiency, and effectiveness on a continuous basis. Monitoring these measures enables changes to be made if desired results are not achieved. In-process measures roll into department dashboards, which roll into system dashboards.

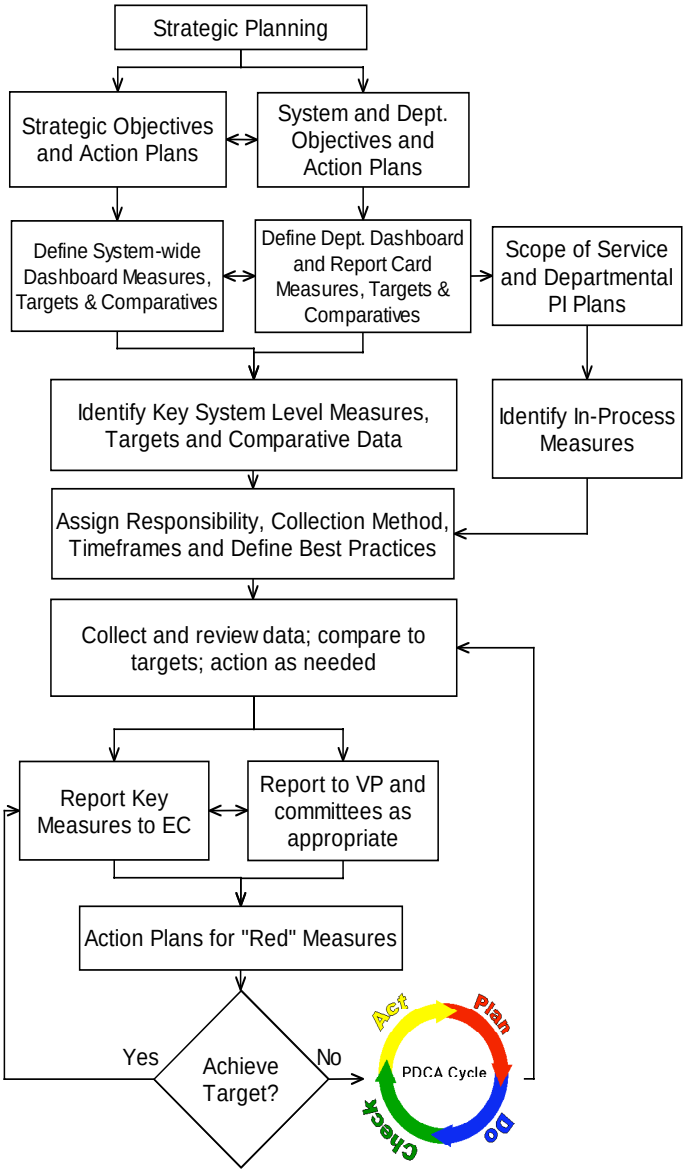
MHS's key organizational performance measures are defined and presented in the system dashboard and key system-level indicators reports, and are balanced across the Four Pillars (Figure 4.1-2). The measures track progress toward meeting strategic objectives. Measures to address operational objectives and action plans are presented on department dashboards, and LG members are held accountable through corresponding measures on their report cards. These measures align with system dashboards and the Four Pillars. EC reviews the system dashboard and key system-level indicators quarterly to prioritize and prompt action plans if needed. LG members continue the PDCA cycle until targets are achieved.

EC and LG make decisions regarding selection of new indicators based on the following:

- New organizational strategies requiring new data;
- New programs and services;
- Problems identified in programs and services; and
- High-volume or high-risk services.

Using the "Check" step of the PDCA model, EC and LG re-evaluate targets and performance of chosen indicators based on changing priorities, new benchmark information, or improved methodologies. Indicators are systematically reviewed by EC, LG, committees, and physicians on a scheduled basis appropriate to the measure. The timing of reviews is based on data availability. The reviews facilitate drill-down analysis, rapid identification of opportunities for innovation, and deployment of action plans, supporting efficient decision making.

Figure 4.1-1, Performance Measurement System



a(2) To assess organizational performance on a relative basis, MHS identifies its comparative data needs during the SPP and uses benchmark data to establish stretch goals. The Benchmarking Committee identifies and evaluates comparative data sources for indicators based on data availability, reliability, and relevancy to MHS strategy. Based on recommendations from the committee, EC selects comparative data sources for dashboard indicators and other key system-level measures to identify performance gaps relative to competitors and industry best practices. Based on identified organizational measures, LG includes measures on departmental dashboards and report cards to ensure alignment of objectives and that targets are set based on top quartile or decile performance. Data sources are selected to validate relative performance and include Malcolm Baldrige Award recipients; similar-sized

Figure 4.1-2, System Dashboard for Third Quarter FY 2007

Pillar/Indicator	Benchmark Source	Current Period (Actual)	Current Target	Benchmark/ Stretch Goals	Figure Reference
Quality		DATA REMOVED			
AMI Composite Score	CMS				7.1-3
CHF Composite Score	CMS				7.1-18–19
CAP Composite Score	CMS				7.1-5–6
Diabetes Composite Score	HEDIS				7.1-22–23
Infection Control Composite Score	Multiple				7.1-8–12
Patient Safety Composite Score	Multiple				7.1-15
Service					
Percentile Rankings:					
Inpatient Satisfaction	Press, Ganey				7.2-2
Emergency Care Satisfaction	Press, Ganey				7.2-4
Clinic Satisfaction	AMGA				7.2-6
MercyCare Enrollee Satisfaction	NCQA CAHPS				7.2-9
Percent Satisfied Scores:					
Inpatient Satisfaction	Press, Ganey				7.1-1
Emergency Care Satisfaction	Press, Ganey				7.1-1
Clinic Satisfaction	AMGA				7.1-1
Post-Acute Care Satisfaction Roll Up	Internal				7.1-1
MercyCare Enrollee Satisfaction	NCQA CAHPS				7.1-1
Partnering					
Partner Satisfaction-Feeling Valued (%ile Rank)	NewMeasures				7.4-4
Partner Satisfaction-Feeling Valued (Pct Sat)	NewMeasures				7.4-4
Staff Development Hours/FTE	Internal/MBA				7.4-8
Performance Appraisal Timely Completion	Joint Commission				7.4-12
Turnover Rate	BNA				7.4-1
Cost					
Operating Margin	Moody's				7.3-2
Growth in Equity	Ingenix				7.3-3
Growth in Net Revenue	Moody's				7.3-1
Key Budgeted Initiatives Completed	Internal				--

and structured healthcare systems; regulatory and accreditation agency data; local, state, regional, national healthcare organization data, including quality data and competitor analyses; and comparative data from outside the industry where applicable.

Committees and PI teams also evaluate and select comparative data for project analysis, to set stretch goals, and to establish projections. Comparative data are used as part of the PDCA cycle to set targets and validate relative performance. Sources of comparative information include best practice leader site visits and vendor visits to MHS; hospital organization and association literature review; best practices and healthcare information analysis; and state- and federal-sponsored clinical quality performance measurement projects.

a(3) To ensure the performance measurement system remains current with healthcare service needs and strategic direction, EC and LG conduct an annual analysis of the performance measurement process and dashboard indicators. Using the PI Plan as a guide, EC reviews system-level measures, and LG reviews department indicators, to determine if measures should be retained, discontinued, or added. Continued monitoring is recommended when outcomes do not match the goal, sustained improvement is required, or when a service is so high risk that continued monitoring is necessary to assure a safe and effective process. EC analyzes LG input, industry trends, and strategic goals to further determine necessary changes to the performance measurement system.

Process owners at the level closest to the service also evaluate performance measurement systems. Partners are empowered to engage the PDCA model and quickly respond to changes in the industry, strategic direction, or customer requirements. Knowledge of external changes is obtained through interaction with the planning and marketing departments and review of the monthly Healthcare Industry Report. Sharing at weekly VPO team meetings enables senior leaders to respond quickly to organizational and external changes. Through formal weekly meetings and informal daily communication, EC members remain aware of activities and changes throughout the organization, and meetings occur weekly to

Figure 4.1-3: Organizational Performance Reviews

	System Dashboard and Key System-Level Indicators	BOD	EC	VP	LG	QC	Dept/ Owner
Quality	CMS Quality	Q	Q	Q	Q	Q	O
	Patient Safety	Q	Q	Q	Q	Q	O
	OASIS	Q	Q	Q	Q	Q	O
	HEDIS	A	A	A	A	A	O
Service	Hospital Sat	A	B	M	M	--	M
	Clinic Sat	A	B	B	B	--	B
	Post-Acute Sat	A	B	B	B	--	O
	MCIC Sat	A	A	A	A	--	O
Partnering	Turnover	B	B	B	M	--	O
	100 BEST	A	A	A	A	--	--
	PPAs/Compet	B	M	M	M	--	O
	Partner Sat	A	A	A	A	--	O
Cost	Grwth Eq/Rev	M	M	M	M	--	--
	Op. Margin	M	M	M	M	--	M
	Market Share	A	B	B	B	--	--

A-Annual, B-Biannual, Q-Quarterly, M-Monthly, O-Ongoing

promote discussion and action planning as needed. Frequent review of performance measures, and LG's participation in professional organizations and the community, create agility in recognizing and responding to changing needs and directions.

b. Performance Analysis, Review, and Improvement

b(1) MHS systematically reviews organizational performance to evaluate organizational success, progress towards goals, and competitive performance. Key organizational performance reviews are presented in Figure 4.1-3. MHS's prioritization process, the Dashboard Alert System, color codes each dashboard indicator relative to progress made toward targets: green (99% of target or higher); yellow (94–98% of target); and red (93% or less of target). Red dashboard measures prompt 90-day Dashboard Alert action plans. EC mobilizes PI teams or LG to redirect resources toward underperforming areas. Green indicators showing sustained success assist in identifying areas for potential best practice. Senior leaders also participate in indicator review as members of interdisciplinary committees. Standing system-wide committees, such as the Quality Council, Safety Committee, IMAC, and Pharmacy and Therapeutics Committee, review in-process, trended performance and create action plans to achieve goals. System and departmental dashboard indicators are translated into LG report card and partner performance goals, ensuring accountability and consistent system deployment. Report cards also facilitate quarterly and annual evaluation of organizational performance.

MHS uses analyses in statistical and graphical form to support the Dashboard Alert System and other key performance reviews. Analyses include correlation, root cause, FMEA, variance analysis, competitive assessments, and market analysis. MHS uses consistency in measurement, knowledge-based information, data validation, and tested solutions to problems to ensure conclusions from analyses are valid.

Key performance indicators are compared to best practice measures during analysis to assess organizational success and competitive performance. Data summaries are integrated and reported to appropriate committees, EC, LG, and physicians. EC uses these analyses throughout the year to assess performance and progress towards operational goals. Comparative data and market analysis are used to evaluate competitive performance, assess changing industry and market trends, and prompt action plans. Results from the reviews are analyzed and presented to BOD committees. Measures that support the system dashboard are reviewed in-process and at the department level, allowing MHS to rapidly respond to changing organizational needs and environmental factors.

b(2) The VPO team uses performance review findings to identify improvement opportunities. The Dashboard Alert System and key system-level indicator reports facilitate identification of issues; however, early signs of performance issues are identified in reports that are received more frequently, such as daily staffing reports, weekly financials, and monthly budget reports. EC and LG members monitor these in-process indicators. Key performance indicators are monitored by measures on both system and departmental dashboards. EC prioritizes improvement efforts based on potential impact on system dashboard indicator performance. The VPO team addresses gaps by assigning accountability to LG members to form subgroups or PI teams with representation from across the system, including physicians and suppliers as appropriate. The VPO team reviews action plans and results at least quarterly to determine effectiveness of actions. Action plans from the subgroups and PI teams are deployed to work groups and partners through education, formation of policies and procedures, and at unit meetings. Priorities and opportunities are deployed to suppliers through their involvement on PI teams and through formal lines of communication, such as regular quarterly meetings held with key suppliers and partners or special meetings called to address specific issues.

b(3) MHS uses the results of organizational performance reviews to evaluate achievement of system-wide goals, on both an annual and ongoing basis. During the SPP and budgeting processes, EC identifies opportunities and priorities for improving key processes, sets targets for organizational performance, and defines system-level action plans to achieve those targets. Resource requirements for significant process improvements are addressed during the Resource Allocation Process. EC conducts performance reviews on a scheduled basis throughout the year to evaluate success of process improvements and to identify new gaps. Opportunities requiring minimal resources are directed to appropriate leadership or teams for action planning and deployment of key process changes; those requiring more significant resources may result in resource reallocation to facilitate rapid improvement.

4.2 Management of Information, Information Technology, and Knowledge

a. Management of Information Resources

a(1) Based on strategic direction and stakeholder input, the IMAC develops an annual IM plan. The IM Plan describes the structures, systems, and processes used to obtain, manage, and use information. It also serves as an ongoing guide to organizing and improving information availability and use within the organization. MHS provides data on an integrated, shared information continuum, facilitating user access.

The IMAC is responsible for identifying and meeting stakeholder data needs and requirements. These needs are determined through user input, including surveys, logged requests, pilot studies, and market research. Integrated data systems provide clinical, financial, operational, industry, and market data to support clinical and business decision making through: real-time information access; custom-designed reports using multiple report-writing tools; preset reports offering user choice in data field inclusion; and ad-hoc report requests.

To ensure data availability and accessibility, MHS transmits data electronically to authorized stakeholders, including information such as patient demographics, insurance, billing, and clinical information. Staff partners access needed data through several paths, including the local and wide area networks, browsers, and remote access servers. Hardware and software systems, designed around customer and user needs, provide flexibility and efficiency of information access. Business data is provided to users in a consistent format using Microsoft Excel or Access, providing analysis capability to those making the business decisions. MHS also uses the intranet and shared network folders to make information and documents, such as forms, newsletters, announcements, and job listings, available to users at their personal computers.

MHS maintains a secured electronic communication system to provide partners and physicians access to necessary computer applications at work and remotely in their homes. Clinical and administrative data are provided to users through remote access, such as digital radiography used at radiologists' homes. Online lab and radiology results can be accessed regardless of test/exam location. ChartView software for transcribed patient reports gives physicians and other authorized staff access to needed clinical data and information across all geographic sites. If information is required before transcription, physicians can use the network dictation system. MHS has also implemented an Enterprise Master Person Index system to integrate its hospital and clinic information systems, providing more efficient, timely data access to providers and users across the system and more seamless, quality care to patients. Non-electronic patient information is made available through the chart tracking and location process managed by the medical records department.

Patients, customers, suppliers, and partners increasingly request information through new channels. MHS meets these needs through its website which provides: 1) information on services, medical centers, physicians, and community education; 2) healthcare information, including health and wellness articles and drug references; 3) system news, including newborn announcements and pictures; and 4) employment opportunities. MHS has installed information kiosks in strategic, high-volume locations, and makes information available using printed publications for customers without internet access. MHS also partners with external sources such as WHA CheckPoint and PricePoint, to provide quality and charge data to the public.

a(2) Assessment of security, reliability, and user-friendliness of hardware and software begins prior to acquisition. Key requirements of users and customers are identified and prioritized using PDCA methodology. The IS department and appropriate teams evaluate multiple vendors through research, demonstrations, and site visits to acquire additional information about reliability and user-friendliness. These teams apply a set of rigorous standards defined by the IMAC to determine vendor reputation and viability and to ensure hardware and software fulfill requirements relating to data integrity, security, and HIPAA compliance. When appropriate, MHS conducts pilots to obtain end-user feedback and make adjustments before full implementation.

The MHS authorization process requires mandatory training and appropriate levels of security clearance before providing end-user access to information systems or data. New partners participate in orientation training and competency review before receiving network user names and passwords. Security of data as it moves throughout MHS's private network is protected by firewalls, antivirus management tools, and desktop management practices.

a(3) The MHS Recovery of IT Systems Plan, incorporated into the system-wide Emergency Operations Plan, outlines processes to ensure the continued availability of data and information in emergencies. The Recovery of IT Systems Plan, updated by the IMAC annually, includes processes for department-level downtime procedures and system support mechanisms. During contracting with key information systems vendors, MHS includes processes for vendor support in an emergency. Electronic data is backed up and stored off site so it is retrievable in a system failure. Redundant servers and other systems ensure the availability of key information systems, and scheduled testing ensures the process works or prompts improvement action.

a(4) The IMAC keeps data and information availability mechanisms current by overseeing software and hardware systems needs analyses; monitoring current and new services/ technologies; and sponsoring participation in user groups and conferences. IS representatives participate in annual regional and national health industry IS groups. The IMAC also sponsors partners to attend software- and hardware-specific training seminars and to participate in product development and enhancements. This provides opportunity for MHS to suggest feedback to vendors for hardware and software improvement, identify innovative IS products, and establish benchmarks by studying industry patterns and best practices.

To stay current with healthcare needs and fast-paced technological changes, EC conducts monthly meetings to review components of the IM Plan and the progress of new technology implementation. IS conducts an information technology evaluation to gather feedback from LG, partners, caregivers, and physicians. The IMAC prioritizes resource allocation for information technology advancements into short- and longer-term initiatives and makes recommendations to EC. Annually, the IMAC reviews and, as needed, adjusts the IM Plan. EC ultimately approves the Plan. MHS contracts with information technology vendors to ensure timely upgrades and to obtain information on new hardware and software technologies and processes. MHS participates in vendor beta tests to aid in software revisions and applications development.

Recent data and information availability improvements include:
- Picture Archiving Communications System to digitize radiographic capabilities, reducing use of film;
- Physician Portal to provide caregiver access to patient information across geographic areas;
- Bar coding patient care supplies;
- Patient medication profiling to ensure pharmacist review prior to administration;
- Computerized physician order entry for chemotherapy; and
- Electronic office-based clinical documentation system.

b. Data, Information and Knowledge Management

b(1) MHS employs a comprehensive approach to ensure quality data and information support effective management by fact. The IMAC integrates, monitors, and assures the quality of MHS information systems and evaluates data and information quality annually. The processes to validate information quality and data properties are driven by the IM Plan and include review by IMAC, the privacy officer, and the IS department. Changes in environment, such as technology, regulations, and new data sources prompt enhancements and review of data security and quality. Figure 4.2-1 summarizes the approaches used to validate information quality and data properties. Software improvements and enhancements are rigorously evaluated in testing environments before installation to validate system and data integrity.

b(2) Organizational knowledge is a critical asset that MHS manages to contribute to achievement of its mission and vision. MHS uses HR systems and programs, the cross-functional committee structure, and technology to manage organizational knowledge. Standardized HR systems and programs, such as COE-I, MILE, email, and newsletters, promote the building and ongoing management of knowledge assets. The membership and reporting structure of MHS' cross-functional teams facilitate knowledge sharing between committees, PI teams, and across the organization. The Mercy Partners intranet is a central repository for best practices and partner-centered knowledge to be shared throughout MHS. Partner knowledge is captured and transferred through participation on cross-functional teams, at VP Luncheons, and at COE fairs. The Best Practice Sharing Program is MHS's formal program to facilitate rapid identification and sharing of best practices. Best practices with system-wide applicability are standardized through action plans, COE programs, and policies. MHS identifies best practices through best practice submissions, the use of industry and internal benchmarks, and COE programs such as the Partner Idea Program and Quest for the Best. Best practices are also identified and shared at VP section meetings, LG meetings, department meetings, newsletters, and the best practices repository on the intranet.

Figure 4.2-1, Validating Information Properties

Property	Validation Process
Accuracy	Training; limited data entry fields; single-user data entry at point closest to data; data logic algorithms; audits; menus; validity checks
Integrity and Reliability	Training; audits; pilots; beta testing; daily system backup; help desk
Timeliness	Training; electronic reports; web-based data access; shared network folders; help desk
Security and Confidentiality	Training; permission process; firewalls; policies/procedures; password authorization/ expiration; audits; off-site system backup; regulatory compliance; privacy officer

Knowledge transfer to and from patients and customers is accomplished through effective voice of the customer inputs (Figure 3.1-2). MHS's patient surveying processes, market research and focus groups, and the Service Recovery Program are among the key methods used to learn from patients and customers. MHS shares knowledge with patients and families through patient care conferences and by involving patients in the development of care plans. Other patient and family teaching, including discharge instructions, provide opportunities for information exchange between patients and caregivers.

Partnering with suppliers provides for two-way knowledge sharing through identification of improvement opportunities and industry best practices, trainings, and inservices, and quarterly supplier performance review meetings. Report cards for key suppliers provide a formal tool for transferring knowledge and communicating expectations.

Executive representation on committees facilitates input and feedback into the SPP. Additional knowledge for use in the SPP is gathered at the annual LG retreat, where preliminary objectives are discussed for use in department strategic planning, monthly LG meetings, and VP section meetings. Knowledge from physicians, patients, and partners is reviewed and processed by committees that have direct links into the SPP. These committees provide feedback from knowledge owners in multiple steps of the SPP.

Category 5.0: Workforce Focus

One of MHS's four visionary strategies is to be a Best Place To Work, highlighting the importance of HR strategies and systems. Annually, HR develops action plans supporting these strategies, which are successfully deployed through the COE.

5.1 Workforce Engagement

a. Workforce Enrichment

a(1) The COE's Partnering Pillar serves as the foundation to ensure MHS partners achieve personal and organizational success. The Culture of Excellence Steering Committee (COE-SC) and the HR Planning Committee perform analyses, such as correlation and salience, on system-level partner feedback and indicators to determine factors affecting partner engagement and satisfaction. Requirements and processes to meet and exceed requirements are incorporated into the HR Plan and approved by EC.

While the factors may vary in importance for different workforce groups and segments, the process used to determine them is the same. Key partner feedback data and indicators are segmented by job type, core service, and demographics to support improvement efforts for various workforce groups and segments. The annual partner survey, a primary formal feedback tool, is segmented by length of service, service category, age, gender, ethnicity, location, and position type. Analysis is prioritized in the HR Plan. Since 2004, MHS has participated in the Great Place to Work Institute survey (100 BEST) to identify and benchmark key factors of staff engagement, satisfaction, and motivation. Participation in this process provides MHS additional segmented feedback. In 2006, MHS began administering an AMGA satisfaction survey for employed physician partners.

MHS informally collects additional inputs to validate factors affecting workforce engagement and satisfaction through two-way communication processes, such as partner forums and VP luncheons. HR committees also evaluate and monitor specific factors identified to affect engagement and satisfaction. These HR committees use various tools, such as tailored surveys, exit and stay interviews, focus groups, and work teams to collect, analyze, and improve workforce engagement and satisfaction.

a(2) The Four Pillars of Excellence cascade MHS's strategy throughout the organization, promoting commitment to high quality care, customer focus, partner cooperation and innovation, and cost consciousness. MHS's core values and organizational culture are reinforced through job standards aligned with the Four Pillars to facilitate accountability and motivation. In 2005, the BOD approved a modified, more succinct mission statement to enhance partners' understanding and engagement.

Figure 1.1-4 identifies MHS's methods and processes that facilitate cooperation, enhance effective communication, and support skill sharing throughout the organization. MHS employs the use of system-wide education programs such as the Safety, Skills, and COE Fairs to promote knowledge, skill, and best practice sharing. COE programs, such as the Partner Exchange and Leadership Renewal Programs, also support skill sharing across departments and jobs. Informal programs to support day-to-day skill sharing include mentoring, coaching, and participation on PI teams. MHS has expanded its use of technology and automation to enhance effective communication, cooperation, and skill-sharing across the organization by rolling out email access to all partners and enhancing the intranet website. The Mercy Learning Center (MLC) facilitates effective skill sharing across work units and locations by creating, collecting, and making educational information readily available online to all partners.

MHS's LG are trained on the Servant Leadership Philosophy (Figure 1.1-2) at the Mercy Institute for Leadership Excellence (MILE) and the Leadership Development Academy (LDA). This philosophy emphasizes the need for effective information flow and two-way communication with partners as an essential quality of an effective leader. LG members make daily rounds and practice an open-door policy to create a culture conducive to a high performing, motivated workforce. Department orientation plans convey essential information and skills to new staff. Department and section meetings offer routine opportunities for skill and knowledge sharing and promote a continuous focus on customer service.

During MILE, LDA, and quarterly LG education sessions, LG is trained on how to serve as effective mentors and coaches for partners. The annual Partner Performance Appraisal (PPA) process includes the development of individual partner goals through the Personal Development Plan (PDP), provides support for performance enhancement through the Performance Improvement Plan, and empowers partners to achieve high performance through encouraging feedback.

Through the Leadership Excellence Model (Figure 1.1-3), MHS' strategy and vision, established through best practice targets, are communicated to partners through system and department dashboards and individual PPAs. Use of benchmark and best practice goals foster innovation in the

Figure 5.1-1, COE Award/Incentive Programs and Objectives

Group	Award/Incentive Programs	Objectives
LG, Physicians, Partners	ABCD Program; Partner Recognition Dinner; Quest for the Best; Baskets for Champions, Partner Idea Program; STAR Program, Matched Savings Retirement Plan	Promote excellent services by rewarding/recognizing best practices, quality outcomes, innovation, teamwork, or partnering initiatives
Partners	Individual merit increases	Reward superior customer service performance
LG, Partners	Report cards/performance appraisals; bonuses dependent on organizational and individual achievement of targets.	Tie together system strategies and individual targets through the Four Pillars
Physicians	Physician Incentive Program (PIP)	Reward best practice achievers in Four Pillars

work environment to achieve desired outcomes. Innovative behavior is recognized and rewarded through COE programs, such as the Partner Idea and Best Practice Sharing Programs.

MHS's COE programs create an environment that values partner ingenuity and diversity by using methods to encourage partner input and involvement in organizational activities. Formal methods, such as the partner satisfaction survey segmented by various groups, and informal methods such as monthly VP luncheons, encourage open exchange of ideas. The Partner Idea Program is a formal system for encouraging and rewarding partners for their ideas. LG evaluates department-specific ideas, takes appropriate action, and shares results in department meetings. Other work systems that capitalize on partner ideas include mentoring, administrative rounds, and the Servant Leadership Philosophy.

The MHS Diversity Committee sponsors focus groups with diverse partners to identify system strengths and opportunities that capitalize on community and work group differences. The Committee also implements system-wide improvement opportunities. In 2006, MHS expanded this process to include focus groups at additional MHS sites and partners from various shifts. Focus group responses are provided to site-specific leaders to support their planning efforts.

a(3) The Leadership Excellence Model cascades strategic direction through system dashboards, department dashboards, and individual PPAs and PDPs, ensuring alignment and commitment to organizational goals. MHS's staff performance management system supports the COE strategy by rewarding and recognizing performance that contributes to achievement of department and system-level action plans. This system links partner compensation to high performance and reinforces the focus on customer service through Service Pillar goals. Performance expectations are aligned with the strategic direction of the organization, weighted according to the Four Pillars, and provide timely feedback to partners. Evaluations are conducted 90 days after hire and on annual evaluation dates. As part of the PPA, partners develop a PDP to identify personal and professional growth objectives.

MHS's compensation programs emphasize healthcare quality, patient-focused care, and service excellence by rewarding high performance through merit pay, promotions, career growth, and COE recognition initiatives. The Matched Savings Plan discretionary match rewards partners for achieving system dashboard patient satisfaction and financial goals (Figure 7.4-3). Career ladders also encourage and reward high performance by incorporating skills development, credentialing, education, PI projects, cross training, and leadership efforts as part of the criteria for advancement. MHS pays physicians on production, while PIP goals motivate and reward physicians for achieving system goals developed around the Four Pillars, including patient-focused quality initiatives and patient satisfaction. These goals align individual physician performance with COE initiatives.

b. Workforce and Leader Development

b(1) MHS system-level action plans, strategic challenges, and core competencies, approved through the SPP and budgeting processes, are summarized and presented to the Education Committee. The Education Committee prioritizes education needs in the Education Plan by analyzing and synthesizing this information with system-level strategic initiatives and challenges, budget and staff allocations, system action plans, partner feedback, and training needs associated with major technological advancements. Action plans developed for system-level strategic objectives identify needs for educational resources or training. The Education Committee facilitates development of action plans, incorporating MHS core competencies, to support system initiatives and evaluates their successful deployment.

The Education Committee coordinates the process for seeking and using partner input for determining education needs. The Committee develops, pilots, and administers partner feedback tools according to the best-determined process, medium, and target partner group. Feedback tools include partner surveys, a biennial staff and leadership development needs assessment, and medical staff Continuing Medical Education (CME) surveys. To address identified needs, the Education Committee evaluates feedback and identifies priorities for improvement for incorporation into action plans. The Education Committee has identified five short-term focus areas: workforce and leadership development; service excellence; clinical quality; cost efficacy; and information and technology. The Education Plan defines target audiences, subject-matter experts, delivery mechanisms, and performance measures and targets.

The MLC was a key system initiative identified in the SPP for FY 07. The MLC was installed in spring of 2007 and rolled out to partners after implementation. The system is designed to preserve knowledge content and automate and enhance the continuum of partner development and learning. This includes needs assessments, content development and management, course development and deployment, learning activity coordination, training assessment and evaluation, and education tracking and reporting. MHS provided all partners with email and computer access, enabling MHS to fully maximize the use of the MLC. The MLC provides a catalog of the broad training opportunities available to staff, including web-based, instructor-led, work-related development, and process updates. It also automates the monitoring and assessment of staff licensure and credentialing requirements to ensure staff needs are met and to support ongoing development. The Medical Staff Credentialing Committee ensures MHS physicians undergo a license review and professional credentialing at the time of hire, with re-credentialing conducted biennially thereafter.

In 2006, MHS enhanced its Exit Interview process to more systematically retain knowledge from partners departing from key positions. This process includes a guide to assist LG in developing a knowledge retention plan with input from the departing partner to ensure continuity of services. The plan provides various options for the partner to transfer

knowledge, including pool-based work arrangements, mentoring another partner, or capturing key knowledge in writing. In 2005, MHS introduced the Work-to-Retire program to provide partners approaching retirement age options to transition into retirement, including reduced work hours, pool status, work-at-home, or seasonal work schedules. Program benefits include flexible work schedules for retiring partners while maintaining benefit eligibility and allowing MHS to retain organizational knowledge.

MHS reinforces the use of new knowledge and skills through compensation and educational programs. The merit-based performance appraisal system evaluates partner effectiveness in demonstrating essential job skills. Individual development plans are created to ensure superior performance within job functions. Career ladders reward partners for applied learning. Additional education programs that reinforce learning include mock surveys, drills, recertification, random audits, fairs, and annual skills review. MHS's service excellence coaches provide education to improve customer service and monitor the effective administration of training, providing follow-up support to reinforce the use of new skills and knowledge.

b(2) The Cruise and Connect (C&C) Committee identifies and ensures the development of requisite skills and attributes for MHS leaders. C&C synthesizes MHS COE and servant leadership values with industry best practices to identify necessary leadership attributes. In 2004, the C&C Committee championed the development of MILE and LDA and, in 2007, added quarterly LG education to ensure ongoing leadership development. MILE is a full-day leadership orientation program designed to equip new leaders with the requisite skills and knowledge of MHS expectations, processes, and procedures. The LDA is a 10-session, 80-hour training program that focuses on key leadership attributes. In 2006, C&C expanded the LDA from semiannual sessions to five sessions a year to meet increased demand.

C&C Committee automated the leadership accountability system in 2005 to ensure the cascading of MHS core competencies and strategic challenges and the deployment of long- and short-term action plans. LG is held accountable through the automated system to support organizational performance improvement and identify innovative ways to achieve benchmark and best-practice goals. When performance does not meet target, LG develops action plans to support recovery. LG systems, such as the SPP and monthly LG meetings, support the development of organizational knowledge.

LG members receive annual ethical compliance training and are required to sign a commitment form. An LDA session is dedicated to ethical healthcare and business practices. Partners and volunteers are educated on ethical and compliance standards at COE-I as part of the CCP. Partners sign a commitment form upon hire and annually during PPAs.

MILE incorporates a breadth of development opportunities that include the day-long orientation; a library of video, audio, and book resources; just-in-time HR and service excellence training; web-based resources and training; and a partner survey toolkit to enhance leadership effectiveness. LG members are supported to find developmental opportunities outside of MHS through department education budget and tuition reimbursement.

b(3) The Education Committee uses the Kirkpatrick model to evaluate education effectiveness at an individual and organizational level. Training effectiveness is measured at any of the following four levels: 1) participant reaction to the program; 2) partner learning evaluations; 3) changes on the job; and 4) organizational impact. Education effectiveness is measured at least at the first level and additional levels as appropriate. The Education Plan identifies the level at which effectiveness of key education is measured. For training with organizational impact, indicators are identified to measure and evaluate effect of training on system performance. PPAs are used to measure the effectiveness of training on individual performance. The Education Committee has developed an assessment form to standardize education evaluation. The form assesses success in meeting educational objectives and quality of the delivery method. In 2005, the Education Committee began administering an Education Effectiveness Survey to LG to determine training effectiveness, delivery methods, and impact on performance improvements. This feedback validates the quality of MHS's education strategy and provides feedback for continued improvement.

b(4) MHS has identified five partner groups and tailored career progression processes to be supportive of their needs (Figure 5.1-2). Annually, partners identify career progression goals and develop a PDP, and are held accountable as part of their PPA. LG supports and motivates partners through this process by mentoring and coaching partners to ensure follow through. LG members are held accountable for providing these services through their annual evaluations. MHS provides educational assistance to those who wish to obtain formal education. Career ladders provide challenging career steps, encourage developmental knowledge, and reward top performers. The Career Mentor Program annually selects partners with career growth aspirations, assigns them a mentor, and offers financial assistance and career counseling.

MHS uses varied formal and informal processes to motivate staff to achieve desired career goals. MHS's RN Graduate Support Program provides recent nursing graduates with mentorship, resources, and education to facilitate transition to the workforce. MHS also sponsors scholarships for partners who are pursuing advanced career-related development goals and specifically for Masters' completion degrees. COE programs further reward individuals and groups to develop and achieve their full potential. Informal programs to motivate partners and support career development include career counseling, self-development seminars, workshop budgets, partner feedback mechanisms, and mentoring.

Annually, the CEO develops a senior leader succession plan. EC members mentor and support LG in career development and pursuit of professional and educational opportunities. MHS partners with the University of Minnesota Masters in Health Administration Program and the Notre Dame MBA

Figure 5.1-2, Career Progression and Succession Planning Groups and Processes

Group	Primary Objective	Processes	Support Processes
Executive Leaders	Ensure continuity in key positions	Cross training; Senior Leader Succession Plan	VP Area Reassignment, Collective Goals, VP Operational Meetings
Physicians	Ensure continuity in key positions	Annual identification of physicians to be included in recruitment plan	EC review of MD hiring plan
Leadership	Encourage growth; ensure continuity in key positions	Annual succession plan; Annual review of LG performance; VP identification and support of candidates for development	One-on-one VP meetings; LDA; MILE; annual review of LG performance
Supervisors	Encourage growth	Career ladders; performance evaluations	LG mentors; PDPs; LDA; MILE
Other staff	Encourage growth	PPA; Career Mentor Program; Career Ladders	PDPs; clinical programs; $ assistance

program to provide a fellowship program to graduating students. This approach supports internal growth opportunities while infusing new talent into leadership.

c. Assessment of Workforce Engagement

c(1) EC identifies key workforce engagement and satisfaction indicators for the system dashboard and establishes best practice targets. The HR Planning Committee synthesizes information from the SPP, partner feedback, industry best practices, and sub-committees to develop the HR Plan.

COE and HR committees are responsible for deploying action plans and assessing workforce engagement and satisfaction. The committees evaluate and synthesize feedback from formal and informal assessments. Formal assessments include the annual partner survey, the "100 BEST" and other surveys, and exit/stay interviews. Although the process for determining workforce engagement and satisfaction are the same, analysis of specific indicators within feedback tools support differentiated assessment of engagement and satisfaction factors. MHS views satisfaction as the end-process indicator and engagement indicators as in-process. For example, the partner survey question, "I feel that I am a valued member of the Mercy Health System Team," serves as the dependent variable that determines partner satisfaction. The questions, "I make suggestions for improvement in my area" and "Partners in my department are self-motivated to do their best," are independent variables that determine workforce engagement. Certain COE initiatives support and measure the level of workforce engagement, such as the Partner Idea Program. Formal assessment methods include analysis of workforce segments to identify workforce engagement and partner satisfaction factors for different workforce groups.

Informal assessment methods include department meetings and LG "cruising and connecting." These methods assist in identifying diverse workforce needs that are forwarded to appropriate committees to address. Responsible committees evaluate and design formal assessment tools for a diverse workforce. LG and HR monitor department-specific partner indicators, such as satisfaction, turnover, absenteeism, productivity, and complaints. Based on analysis of these system and department-specific indicators, HR conducts Partner Focused Assessment Surveys, including one-on-one meetings with department members, to identify improvement strategies. HR and LG members develop action plans and results are shared with the department. HR follows up quarterly to ensure implementation of plans.

c(2) MHS recognizes that a number of factors affect overall healthcare and business results, and industry research indicates a strong correlation between workforce engagement and satisfaction with organizational business results. An engaged and satisfied workforce is more likely to function efficiently and effectively, producing better outcomes. EC reviews results of key workforce engagement and satisfaction assessments annually, such as partner satisfaction surveys, turnover rates, competency reports, and other system-level indicators. Analyses of these indicators are used during the SPP to establish HR priorities, and system-wide dashboard goals are set under the Partnering Pillar and cascade to departmental dashboards, LG Report Cards, and action plans.

HR and COE committees identify key indicators to monitor work system improvements and correlate findings to organizational performance results. Areas with strong correlations support the identification of priority items. For example, the Wellness Committee analyzed segmented injury data and determined poor lifting technique to be the main reason for most workers' compensation claims, driving premiums higher. Implementation of injury prevention action plans has reduced injuries and MHS's indemnity claim rates, resulting in top-quartile performance and decreased workers' compensation premiums (Figure 7.4-17, 18).

5.2 Workforce Environment

a. Workforce Capability and Capacity

a(1) Leaders identify workforce capability and capacity needs during the SPP. This information is provided to the HR Planning Committee for further assessment and action planning to support both short- and longer-term strategies. Workforce capability and capacity needs are synthesized into the HR Plan that incorporates a summary of the needed skills, competencies, and education levels identified for both the short- and long-term changing staffing levels within departments and across the organization. With support from HR, LG develops job summaries that incorporate position requirements and COE expectations. System-wide job requirements and individualized competencies for each position are included in job summaries, identifying needed skills and requirements, certifications, specialized education or degrees, licensures, and fellowships. Department scope of service books identify position skills and characteristics based on

industry standards that incorporate job standards and PPA. These books also incorporate department staffing levels and plans based on historical data and future projection.

a(2) MHS's process for recruitment and hiring integrates a variety of approaches, including: newspaper ads; recruiting fairs; electronic job boards/postings; internal referrals; bonuses; and e-cards. MHS has implemented creative programs with area schools, including: teacher externships; Healthcare Career Showcase; Applied Learning Academy; Medical Explorers; high school mentoring; and provision of faculty and facilities for nursing schools. HR advertises for open positions using both global and targeted media. Using MHS's automated applicant tracking system, the Recruitment and Retention (R&R) Committee determines the effectiveness of recruitment mediums through analysis of referral sources and prioritizes the recruitment budget. The tracking system prioritizes information for interviews based on COE values and position requirements. Candidate information is made available to HR recruiters, the hiring manager, and staff. HR conducts reference, credentials, and background checks according to position standards and hires staff based on skills and knowledge defined in performance standards. A systematic interview process with standard questions ensures candidates meet COE expectations. The selection process includes peer and LG interviews that incorporate questions generated by the tracking system to support the hiring manager and ensure assessment of position requirements. The LDA trains leaders in effective interview, recruitment, and retention skills.

Through the COE, MHS retains a high quality workforce by sustaining a culture that supports and values partners. HR's strategy to continuously improve benefits and systems that support a work-life balance is critical in sustaining this culture. Partnering Pillar standards encourage staff to participate on PI teams and make suggestions for system improvements. The standards also promote MHS's performance improvement culture and ability to capitalize on diverse ideas. MHS's COE programs create an environment that values partner ingenuity and diversity by using methods to encourage partner input and involvement in organizational activities. Formal methods such as satisfaction surveys, and informal methods such as VP luncheons, encourage open exchange of ideas. The Partner Idea Program is a formal system for encouraging and rewarding partners for their ideas. LG members also evaluate department-specific ideas, take appropriate action, and share results in department meetings.

Feedback collected from Diversity Committee focus groups help identify opportunities to capitalize on differences in communities and workgroups. These opportunities are incorporated into site-specific plans. To ensure MHS staff represent the diverse ideas and cultures of recruitment communities, MHS maintains active involvement in local organizations, area schools, and the MHS Ambassador Program. To evaluate how well the workforce reflects the diversity of MHS patients and communities, the Diversity Committee annually compares MHS workforce demographics to community and patient demographics, creating action plans as needed.

a(3) MHS's COE serves as the foundation for managing work design. The Four Pillars cascade MHS's strategy throughout the organization, promoting commitment to high quality care, customer focus, partner cooperation and innovation, and cost consciousness. MHS's core competencies and organizational culture are incorporated into the design of MHS's work and reinforced through job standards aligned with the Four Pillars.

The Leadership Excellence Model cascades strategic direction through the system dashboard, department dashboards, and individual partner performance appraisals and development plans. This ensures alignment and commitment to organizational goals, thereby maximizing MHS's core competencies. LG incorporates system action plans into the design of partner jobs and skills through PPAs and PDPs. MHS's staff performance management system supports the COE strategy by rewarding and recognizing performance that contributes to achievement of department and system-level action plans. This system links partner compensation to high performance and reinforces the focus on customer service through Service Pillar goals on appraisals. Performance expectations are aligned with the strategic direction of the organization, weighted according to the Four Pillars, and designed to give timely and accurate feedback to partners. Evaluations are conducted 90 days after hire and on annual evaluation dates. To actively meet changing healthcare demands, departments use flexible scheduling plans that incorporate historical staffing patterns into industry benchmarks.

MHS's compensation programs emphasize healthcare service excellence and quality by rewarding high performance through merit pay, promotions, career growth, and COE recognition initiatives (Figure 5.1-1). Partners also receive recognition and reward through the Matched Savings Plan discretionary match, which is made upon achievement of system dashboard patient satisfaction and financial goals. These programs link partner compensation to high performance. Career ladders also encourage and reward high performance by incorporating skills development, credentialing, education, PI projects, cross training, and leadership efforts as part of the criteria for advancement. MHS pays physicians on production, while PIP goals motivate and reward physicians for achieving goals developed around the Four Pillars. These goals align physician behavior with COE initiatives.

a(4) The HR Planning Committee incorporates system strategic challenges related to the workforce to ensure a proactive approach in meeting any changing workforce capability and capacity needs. Based on the future needs, the Committee develops the HR Plan that directs resources, both human and financial, to effectively meet workforce capability and capacity needs.

The HR R&R and Wage and Salary Committees meet weekly to assess current and future workforce levels to mitigate potential reductions. HR actively participates in planning of any potential workforce reduction and employs the transfer and promotion policy that provides preferential treatment to partners in affected departments for placement in similar jobs

within the system. The Committees conduct formal and informal surveys to ensure MHS is competitive in the local, regional, and national markets, as appropriate. The R&R Committee has developed "hard-to-recruit" criteria based on open-positions data and competitive activity. This information is reviewed weekly to identify specific jobs and segments that need immediate and innovative attention to ensure service continuity. If the need for workforce reduction becomes necessary, MHS is able to leverage the integrated nature of its delivery model to redirect human resources to areas that have been determined to have the greatest need.

b. Workforce Climate

b(1) Cross-functional committees identify and address workplace health, safety and security. The Safety Committee maintains the EOC Plan and implements the Hazardous Material, Emergency, Safety, Fire Prevention, and Security Management Plans. This group meets monthly to review, track, and trend information gathered from various processes that incorporate staff input, including: 1) annual departmental risk assessments of ergonomic, safety, and security risk factors; 2) occurrence reports that identify security and patient and partner health and safety concerns; 3) environmental rounds reports completed semi-annually for patient-care areas, and annually for support areas, to identify location and job-specific health and safety concerns; 4) reports from location-specific sub-committees; 5) the security internal customer survey and nightly report; and 6) a workplace safety survey started in 2005 to measure the effectiveness of safety systems and programs. In 2006, the safety department piloted and implemented a new annual security risk assessment to identify and respond to job-groups and location-specific security concerns. MHS provides Targeted Aggression Control Training (TACT), which is divided into three progressive levels to meet varying security needs of partners in risk areas.

The Wellness Committee promotes programs that encourage healthy lifestyles and help prevent injuries on the job. This Committee reviews data, conducts focus groups, sponsors location-specific wellness groups, and facilitates the collection of health risk assessment information to identify risk behaviors of partners for program development. The Committee champions various health initiatives and annual wellness fairs. In 2005, the Injury Prevention Committee expanded ergonomic assessments across the system and implemented major initiatives including a Low-Lift Program for patient care partners and a Handle With Care training program for support partners. MHS also uses an early intervention program to proactively address ergonomic issues for partners reporting physical discomfort before actual injury. An ergonomic evaluation team reviews and recommends workstation improvements based on an occupational therapist's assessment with LG follow up.

MHS's Employee Assistance Program (EAP) Committee gathers partner input and reviews best practices associated with providing psychological and emotional support to partners. A full-time EAP coordinator provides services to help partners deal with personal and on-the-job concerns. MHS also sponsors an employee health nurse to educate and support partner initiatives for improving workplace systems.

Figure 5.2-1 lists key performance measures and improvement goals for partner health, safety, and security factors. MHS job codes include a physical demands category, and the automated job standard development system provides a tailored education plan to ensure training in specific workplace health and ergonomics issues. Partners undergo a pre-placement physical, followed by a department-specific orientation to the workplace. MHS partners are also categorized into OSHA risk categories, requiring personal protective equipment and special engineering controls. Responsible committees collect and segment data by department, job class, and location to identify priorities and differences in workplace factors, enabling focused improvements. Figure 5.2-2 identifies significant differences in workplace health and safety factors for different staff groups.

b(2) MHS offers comprehensive policies, services and benefits to: support partners from the day of hire to retirement; meet individual and family needs; and assist partners while at work and home. The HR department analyzes feedback from formal and informal sources, including surveys, idea programs, and focus groups to support diverse workforce needs. These analyses help determine system-wide and tailored policy, services, and benefit opportunities. Also, the HR staff visit departments through monthly HR House Calls to assess the value of these programs and to solicit suggestions. Customized benefits developed as the result of these processes have included: on-site concierge services; adoption assistance; a lactation accommodation policy; and wellness fairs tailored for female partners. Policies include flexible work arrangements, work-to-retire program, and leave sharing donation for ill partners. Tailored services include the Safe Handling Program, childcare resource and referral service, and the Employee Assistance Program. These policies, services, and benefits cater to a diverse workforce, particularly women, who represent over 80% of partners, and mature workers, a growing percentage of the workforce. In 2006, MHS was recognized by Working Mothers and by AARP for its efforts to meet the varying needs of its workforce (Figure 7.6-18).

Figure 5.2-1, Workplace Health, Safety, and Security

Methods	Key Measures and Goals
Health, Safety and Security	
Occurrence reports	Injury rates, OSHA Top Quartile
Workers Comp	Claims rate, Industry Top Quartile
100 BEST (safety)	Safe Workplace, HC BP
100 BEST (secure)	Secure Facilities, HC BP

Figure 5.2-2, Differences in Workplace Factors

Category	Health/Safety	Ergonomics
Caregiver	Infection Precautions	Patient handling
Svc Support	Hazardous material handling	Materials handling
Ofc Support	Work station set-up	Repetitive motion

Category 6.0: Process Management

MHS's core competencies and work systems support its commitment to the mission and vision. MHS uses a systematic approach, structured around the PDCA model (Figure 6.1-1), to design, manage, and improve its key work processes that produce value to patients and customers.

6.1 Work Systems Design

a. Core Competencies

a(1) MHS core competencies are those areas of expertise that are critical to accomplishing the mission and vision. MHS's senior leaders determine and reaffirm MHS's core competencies as part of the mission and vision review during the SPP. MHS's core competencies include: 1) partnering with physicians to create and maintain an effective *integrated healthcare delivery system*; and 2) engaging employees and physicians using the Servant Leadership Philosophy and the COE model, which provide a balanced approach to *patient-focused care.*

The integrated delivery system model has enabled growth and diversification of business lines, supporting the ability to effectively coordinate quality healthcare delivery across the continuum of care and supporting the mission, "to provide exceptional healthcare services resulting in healing in the broadest sense." Partnering with physicians supports a collaborative focus on quality healthcare services and information sharing across the four core services. The integrated delivery model supports coordinated transitions between departments, providers, and care settings to ensure efficient, effective, and patient-focused care.

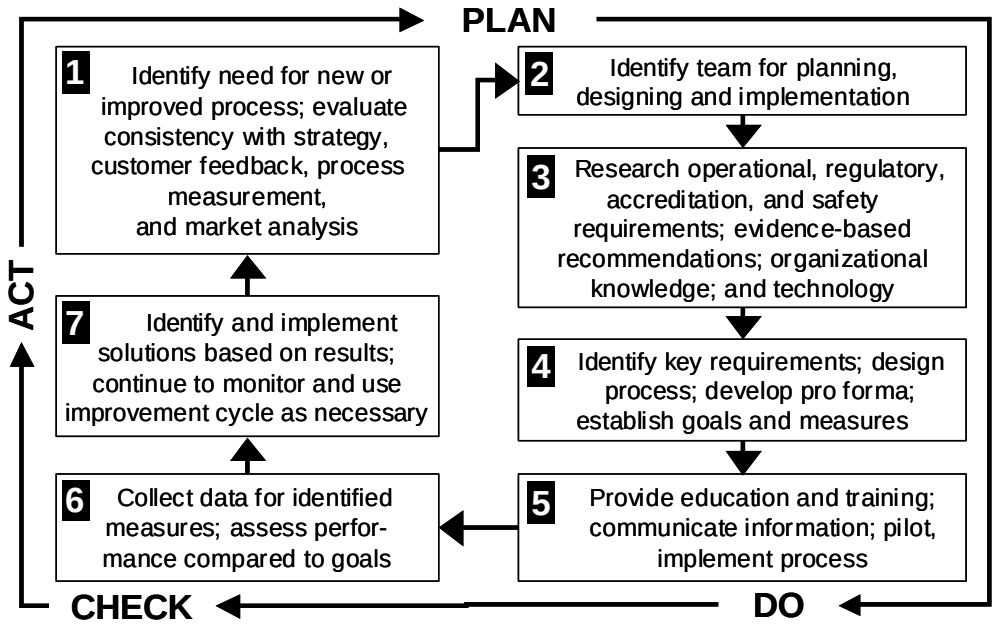
Through the use of the Servant Leadership Philosophy, leaders provide excellent service to partners, and partners provide excellent service to customers. Applying this philosophy, leaders are facilitators whose role is to serve those who provide value to patients. Caregivers provide patient-focused care by offering consideration for personal preferences, cultural traditions and family situations, and involving patients and their loved ones in care decisions to support healing in the broadest sense. The Four Pillars, enhanced by the system-wide partnering concept and supported through the Leadership Excellence Model, drive action plans designed to achieve the visionary strategic goals.

a(2) MHS designs its work systems to support the delivery of exceptional healthcare services across the continuum of care in an integrated delivery system that spans four core service areas. Work systems are organized in patient care and support departments. Senior leaders use the Leadership Excellence Model and the Performance Measurement System to align department activities with organizational strategic goals. Department leaders define the scope of services provided, develop and implement staffing plans for the scope of service, and develop and maintain system policies and procedures for system-wide functions and processes. The MHS General Administration manual includes policies and procedures that apply to all departments and locations. The Mercy Patient Care manual provides standardized policies and procedures for patient care processes throughout the system. The Ambulatory Care manual provides policies and procedures for clinic-based services. Department leaders maintain policies and procedures for processes that are unique to the services provided in their departments. When appropriate, departmental policies also apply to like departments within the organization. For example, laboratory policies and procedures are consistent across all laboratory departments.

MHS support and business departments are centralized to provide services system wide. The departments are organized under centralized leadership and provide standardized services and products at all locations. Department leaders identify supply chain requirements based on the scope of services provided. A centralized materials management department supports the supply chain acquisition and delivery process at MHS. Departments at multiple locations coordinate acquisition of equipment and supplies. For example, MHS uses Siemens as a key supplier of medical imaging equipment. Acquisition and support processes are coordinated for all radiology and radiation therapy locations throughout the system.

Through the SPP, budget allocation process, and use of financial pro formas, leaders assess MHS's capability and capacity to provide needed processes. External resources are secured when a process requirement exceeds internal capacity or capability or when a process can be performed more efficiently or effectively by an external provider. Some processes are provided using a combination of internal and external resources

Figure 6.1-1, Plan, Do, Check, Act Improvement Cycle



to balance workload fluctuations. For example, transcription services are provided internally, but an external contracted service is used to meet customer needs when workload increases beyond internal capacity.

b. Work Process Design

b(1) MHS's key work processes are those that are crucial to providing excellence in patient care, achieving exceptional patient satisfaction, being a best place to work, and maintaining long-term financial success. Key work processes are shown in Figure 6.1-2. MHS's core competencies and the Four Pillars are used as overriding factors in the design and management of key work processes to leverage the success of these processes in achieving the visionary strategic goals and mission.

The key healthcare processes span the four core services and facilitate the delivery of patient-focused care in the integrated delivery system. Through the CRM Committee, MHS systematically reviews current and potential customer feedback to understand changing patient requirements. That feedback is used to design and improve key processes to support patient-focused care. The physician partnership model supports consistent implementation of processes and shared information across the continuum of care. Support and business processes are centralized and standardized to support alignment with strategic goals and a consistent leadership accountability system throughout the organization.

MHS incorporates evidence-based information and best practices into the design of key processes to ensure safe,

Figure 6.1-2, Key Work Processes, Requirements, and Measures **AUR=Available Upon Request**

	Key Processes	Key Requirements	Key Measures	Figure Reference
Hospitals	Admission and Access	Effective	Mort. Rates, Infection Rates	7.1-1–2, 4, 7, 20
	Assessment		CMS Process Measures	7.1-3, 5-6, 8-9, 18-19
	Care and Treatment	Appropriate	Length of Stay	7.5-1–2
	Medication Management	Patient Centered	Satisfaction Scores	7.2-1–5
	Patient/Family Education	Timely	Timeliness of Antibiotics	7.1-5–6, 8–9
	Continuity of Care	Safe	Patient Safety Measures	7.1-15
	Ancillary Testing		Occurrence Reporting	AUR
Clinics	Access	Appropriate	Diabetes Measures	7.1-22–23
	Assessement	Timely	Childhood Immunizations	7.1-17
	Care and Treatment	Safe	Patient Safety measures	7.1-15
	Continuity of Care		Occurrence Reporting	AUR
	Ancillary Testing	Accessible	Clinic Access	7.5-3
		Patient Centered	Satisfaction Scores	7.2-1, 6–7
Post Acute/ Retail	Access, Continuity of Care	Effective	Improve. in Pain, Dyspnea, Transfer	7.1-21
	Assessment	Appropriate	OASIS Measures	AUR
	Care and Treatment	Safe	Occurrence Reporting	AUR
	Medication Management	Patient Centered	Satisfaction Scores	7.2-1, 8
Insurance	Quality Health Mgmt	Efficiency	Administrative Expense	7.5-6
	Credentialing; Claims Mgt	Effectiveness	HEDIS measures	7.1-17, 23, 25
	Customer Svc, Enrollment		CAHPS satisfaction	7.2-1, 9 –10
System Business and Support	Delivery Process	Availability	Fill Rates	7.5-17
	Supply Acquisition	Timeliness	Electronic Ordering of Supplies	7.5-17
	Facilities		Delivery Timeliness	7.5-20
	Environmental Services		Days in AR	7.5-9
	Food Service		Medical Record Review	AUR
	Maintenance/Safety/Security	Efficiency	Pharm Delivery, Contract Compliance	7.5-19
	Recruitment and Retention		Biomed Efficiencies	7.5-11
	Education and Training		Energy Savings	7.5-18
	Incentives and Rewards		Pounds Infectious Waste	7.6-13
	Health Information Mgmt		Vacancy Rates	7.4-10
	Transcription		Lost-Time Injuries	7.4-17
	Information Technology		Administrative/General Expense	7.5-5
	Revenue Cycle Mgmt		Avg Charge/Discharge	7.6-6
	Accounts Payable/Payroll		Operating Margin	7.3-2
	Patient Accounting		Growth in Equity	7.3-3
	Investment Management	Customer Sat	Valet Parking Satisfaction	7.5-13
		Motivation	Turnover, Satisfaction	7.4-1, 4, 5
			ABCD Awards	7.4-3
		Competency	Education Hours/FTE	7.4-8
			Competency Rates	7.4-9
		Accuracy	Transcription Quality	7.5-10
		Privacy, Security	HIPAA Violations	7.6-12

timely, and high quality care. In 2006, MHS introduced Rapid Response Teams (RRTs) after review of best practice information from the Institute for Healthcare Improvement (IHI). RRTs are called at the first signs of patient distress to rapidly treat patients, avoiding a Code Blue. The team consists of an ICU RN and a respiratory therapist who meet with the bedside nurse to assess patient status and initiate treatment using medical-staff approved protocols. Code Blue calls have decreased 50% since implementation. Throughout MHS's key communities, key processes enable the delivery of care close to home and provide value through convenient access to high quality care across the continuum. The integrated delivery system strategy has facilitated growth and diversification of business lines as well as the ability to effectively coordinate quality healthcare delivery across the continuum of care. Centralization and standardization provide efficiencies and consistent quality of service.

b(2) MHS uses the PDCA cycle for process design and improvement, identifying key process requirements during the Plan phase of the cycle. MHS uses feedback and data from internal and external customers, suppliers, and partners. Customer group requirements are captured from CRM Committee analyses and team research. LG, partners, and physicians provide input regarding evidence-based information, best practices, and regulatory and accreditation requirements. Internal input on process requirements is gathered annually through LG SWOT analysis and through internal customer surveys. Teams aggregate and analyze this information during the Plan phase and use the information to define key requirements and establish targets and stretch goals. Figure 6.1-2 shows key process requirements.

b(3) When designing processes, team research includes evidence-based care and safety recommendations, best practice information, regulatory and accreditation requirements, technology options, payor requirements, benchmarks and comparisons, industry trends, and results from measurement systems. Research includes partner, physician, and key supplier input to capture organizational knowledge and ensure MHS processes are designed to provide exceptional healthcare services. Financial pro formas are used to identify cost-effective and efficient options. Key requirements such as cycle time, productivity, efficiency and effectiveness are evaluated during the Plan phase. Evidence-based information is incorporated into the design to support desired healthcare outcomes. As shown in Step 4, during process designing, the team identifies measures to monitor progress toward meeting key requirements. Using best practice and benchmark information, the team designs processes, incorporating the information gathered during Step 3 of the PDCA cycle to maximize efficiency and effectiveness. Before a new process is introduced, EC and the team consider research information, discuss feasibility, and evaluate if need is consistent with strategy. Once EC approval is obtained, the team designs the process using information gathered during the Plan portion of the PDCA cycle.

c. Emergency Readiness

MHS uses a system-wide Emergency Operations Plan (EOP) to ensure continuity of healthcare and support operations in the event of a disaster or emergency. The EOP is activated by a member of EC when a situation arises that is beyond MHS's capability to respond with normal staffing levels or has the potential to burden or disrupt normal operations. The EOP is designed to respond to all types of events or emergencies and only those portions or functions of the plan needed for a specific emergency are activated. To coordinate with community organizations, the EOP incorporates the Hospital Incident Command System (HICS) predictable chain of command system that allows for adaptability and scalability to address any type of event. The HICS comprehensive response ensures healthcare and support services for emergency patients, routine patients, staff, and communities. HICS mobilizes an Incident Command Team that assesses and manages staffing needs, disaster response, and operational management to recover and stabilize operations. Team members are guided by job action sheets that provide step-by-step prompts of the actions that may be needed related to specific roles and responsibilities within the team. When necessary, the Incident Commander, in consultation with local authorities, makes a decision to shelter in place or evacuate considering the circumstances of the incident. Should evacuation become necessary, MHS has adopted the Wisconsin Health Resources and Services Administration hospital evacuation policy.

The EOP includes a Recovery of IT Systems Plan. The plan identifies significant systems and applications and specifies their function. The plan provides vendor contact information, internal recovery contacts, process experts, data and programming recovery processes, alternate sites, and hardware and software replacement processes. The Emergency Management Committee conducts hazard vulnerability analyses to evaluate organizational preparedness and to identify opportunities for prevention or improvement.

6.2 Work Process Management and Improvement

a. Work Process Management

a(1) To assure broad input across the integrated health care system, EC has created standing committees or appointed project-specific teams to ensure that work processes meet design requirements. During the Plan phase of the PDCA cycle, these teams develop an implementation plan to address education, training, and a timeline for full implementation. When feasible, the process is piloted. Leaders use the Performance Measurement System to collect and analyze data, compare performance to established expectations, and make necessary process modifications. Data collection and analysis is ongoing to assess performance compared to goals. Leaders and process owners define the in-process measures, frequency of data collection, and performance level required. Caregivers and staff collect data on a day-to-day basis for LG and process owner analysis.

Patient input is solicited during clinical leader rounds. Inpatient caregivers use daily patient and family input to modify care plans to meet identified needs. Each week, EC receives a narrative and trend reports of all patient concerns. Leadership receives a biweekly patient satisfaction report. Suppliers provide MHS with information about new or

changing products, services, and support to enhance the use of existing technology. Input from these groups is addressed in Step 1 of the PDCA cycle, Step 4 when requirements and measures are identified, and Steps 6 and 7 when results are analyzed. Figure 6.1-2 shows key measures used to evaluate work processes.

a(2) Individual patient expectations and preferences are considered at the time of care delivery beginning with patient assessment. Care team members identify needs, develop individualized care plans, and involve patients in decisions about their care. MHS uses patient participation in the plan of care to enhance delivery of care and influence desired outcomes. To explain likely outcomes, address concerns, and set realistic expectations, caregivers involve patients and families in decision making through patient care conferences, informed consent procedures, and pre- and post-surgical consultations. Caregivers provide written and verbal patient education at all sites of care.

a(3) MHS uses standardization, system-wide functions, automation, technology, and knowledge from industry experts to minimize cost and reduce errors and rework for support processes. For example, on-line ordering for office supplies is standardized throughout the system, reducing costs for ordering and inventory. The Product Standardization Committee identifies and selects safety devices using front-line staff to evaluate alternative products. The products are used system wide to standardize practice, thus reducing the risk of exposure and the cost of post-exposure follow up and treatment. MHS assures key support services are consistently provided across the geographically dispersed organization by centralizing support functions. Centralization minimizes cost by avoiding duplication of administrative functions and taking advantage of economies of scale. For example, audits for registration accuracy are performed for all registration locations from one centralized department. MHS uses system-wide functions such as internal audit, safety and security, facilities, and biomedical services. Leaders in these areas complete department and system-wide inspections, drills, and partner competency reports. MHS uses an information system module that provides a master patient index identifier for patients across the hospital and clinics. The technology provides efficient access to complete medical information at all locations and enhanced search functions that reduce errors during registration. Automation of support processes, such as electronic signature and inventory management, enhances communication and efficiency across sites. Through its purchasing group, HPG, MHS receives discounts and reduces costs associated with product inspections.

MHS leaders focus on preventing medical errors by promoting a culture of patient safety. A Patient Safety and Medical Error Reduction Plan is developed by the Patient Safety and Error Reduction Committee. This interdisciplinary team uses the plan to coordinate patient safety activities throughout the system. The Committee oversees the occurrence reporting process that provides a blame-free mechanism to identify, communicate, and analyze occurrences and medication events to support a safe environment, reduce system errors, and encourage organizational learning to improve patient safety. The Committee also coordinates the implementation of evidence-based patient safety recommendations, data collection and analysis, education and training, and the intense analysis of significant events and undesirable trends. FMEA, a proactive method to prevent errors in high-risk processes, has been used to improve processes such as chemotherapy administration and insulin therapy. Decision support technology, such as profiling for drug-to-drug interactions and allergies, is used to prevent errors at the point of care. MHS recently implemented medication profiling, a technology-based process that helps avoid medication errors by restricting access to medications, allowing caregivers access to only those medications that are ordered and reviewed for the patient.

b. Work Process Improvement

During the annual SPP, leaders and process owners use the following inputs to identify improvement opportunities: market research and customer feedback; physician need analyses; technology assessments; staffing strengths and weaknesses; financial performance; SWOT analyses; and other internal and external factors. Throughout the year, MHS uses the Performance Measurement System to ensure key performance requirements are met. Measures are reviewed by patient care, business, and support leaders; departments of the medical staff; and the Quality Council. Departmental performance measure assessments are completed through the dashboard review process between senior leaders and LG. Department dashboard indicators roll up to system dashboard indicators, which are reviewed by EC at a frequency appropriate for the indicator. Many of these indicators are reviewed bimonthly at BOD committee meetings. MHS leaders also monitor and analyze in-process measures to ensure department and unit processes are performing as expected. Leaders and process owners define the in-process measures, frequency of data collection, and performance level required. Caregivers and staff collect data on a day-to-day basis for LG and process owner analysis. When a measure indicates less than optimal performance, process owners identify causes, implement solutions, and continue measurement for effectiveness. Leaders review evidence-based information, best practices, and technological advances to identify improvement opportunities. As opportunities are identified, individuals and teams use the PDCA cycle to incorporate the lessons into existing processes. MHS uses a systematic process to review and revise policies, procedures, and protocols to ensure continuous compliance with practice standards and regulatory and accreditation requirements. These processes standardize methods to reduce variability across the system.

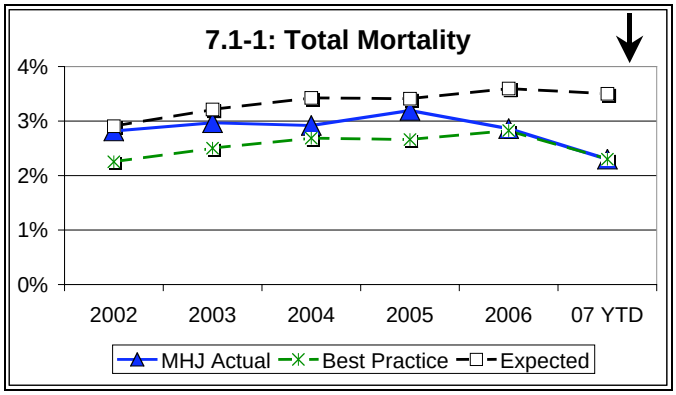
Successful improvement initiatives are shared system wide through newsletters, cross-functional teams, medical staff sections, and LG, team leader, section, and department meetings. Policies, procedures, and protocols are shared via the intranet, allowing rapid communication of revisions to support consistent deployment. The Best Practice Sharing Program further promotes organizational learning by facilitating identification and sharing of best practices.

7.1 Health Care Outcomes

Results in the Quality Pillar represent healthcare service delivery for high volume or high-risk acute conditions and outcomes, high volume chronic conditions, and our commitment to patient safety. The Pillar reflects our mission to provide exceptional health care services, resulting in healing in the broadest sense.

MHS participates in quality initiatives such as the Maryland Indicator Project (MIP), WHA CheckPoint, and CMS Quality Compare to obtain comparative data, evaluate performance, meet regulatory requirements, and provide public reporting information. Measures mandated by regulatory, accreditor and payor requirements are indicated with an asterisk (*) in the chart title. Comparative data are published when volumes meet set CMS thresholds. Missing data for MHH or MWH means there are no or few qualifying cases for the period. Low case rates may contribute to significant fluctuations in data due to a small sample size; this is particularly true for 2007 data.

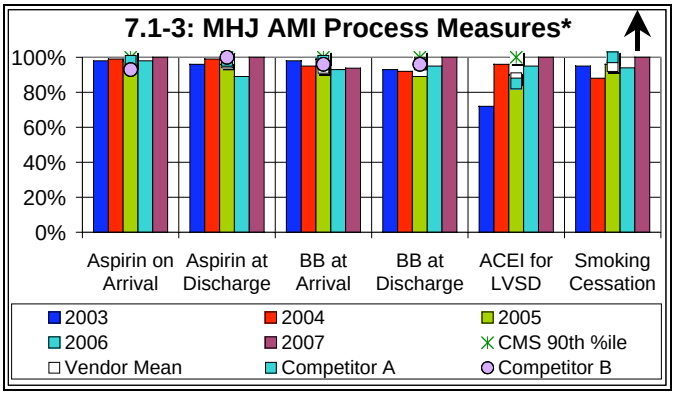
Figure 7.1-1–2, Total Mortality: Mortality is an overall outcome indicator of quality of care. MHS uses CareScience databases for risk-adjusted mortality outcomes. Based on the admitting diagnosis, complications and co-morbidities of inpatients, a predicted mortality rate called the expected rate is calculated. The expected rate increases as the complexity of the patient's care increases. The database also provides best practice comparisons to the top 15% of hospitals. To compare to competitors on a relative basis, deviations from expected and best practice are reviewed. Deviations of zero or below show better than expected performance. Similar comparisons are available for other process measures; examples are shown due to space constraints.



7.1-2: CAH Total Mortality						
	MHH			MWH		
	Actual	Expect	BP	Actual	Expect	BP
2004	0.7%	1.2%	0.9%	NA	NA	NA
2005	0.9%	1.2%	0.9%	NA	NA	NA
2006	2.1%	1.4%	1.1%	1.2%	1.0%	0.8%
2007 YTD	0.7%	1.6%	1.2%	1.4%	0.6%	0.4%

Acute Care:

Figure 7.1-3–4, AMI: Acute Myocardial Infarction (AMI) is a high-volume acute condition. Monitoring in-process measures for AMI improves outcomes for patients. These in-process measures are evidence-based treatments and are recommended by state and national regulatory agencies. MHS implemented standard order sets, concurrent review with feedback to physicians and nursing staff and focused education with staff and physicians to improve rates.



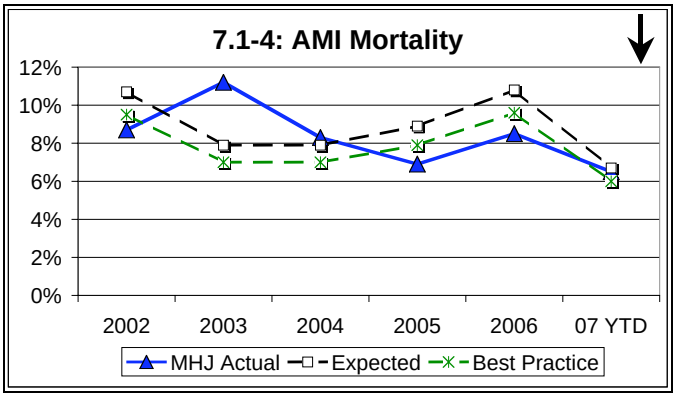
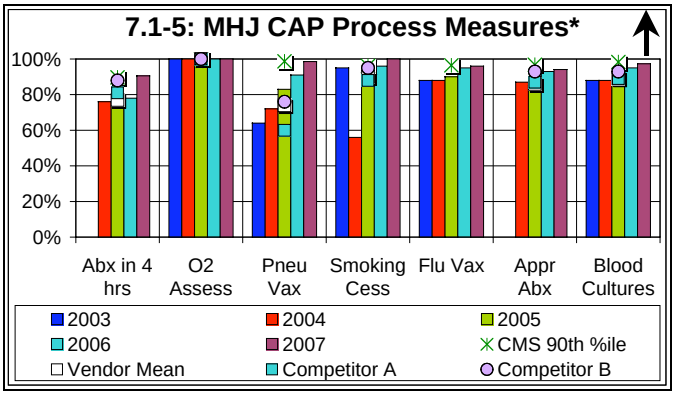
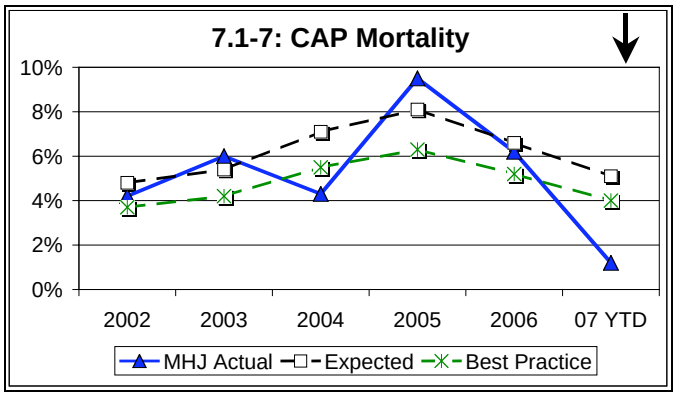


Figure 7.1-5–7, CAP: Pneumonia is a high-volume condition at MHS hospitals and monitoring process measures improves outcomes. MHS uses a physician-driven care protocol for CAP and updated the form in 2006 to include MHH best practices. The addition of a Quality Measures Coordinator has allowed for concurrent review of CAP patients to ensure effective coordination of treatment. The antibiotic team reviews patients and makes recommendations for changes to antibiotics. MHS also implemented standing orders for influenza and pneumococcal vaccinations and focused on antibiotic administration in ED. A physician-level review of mortality in 2005 resulted in modifications to the CAP order sets to conform to recommended treatment plans resulting in better adherence to the core measures and lower mortality.

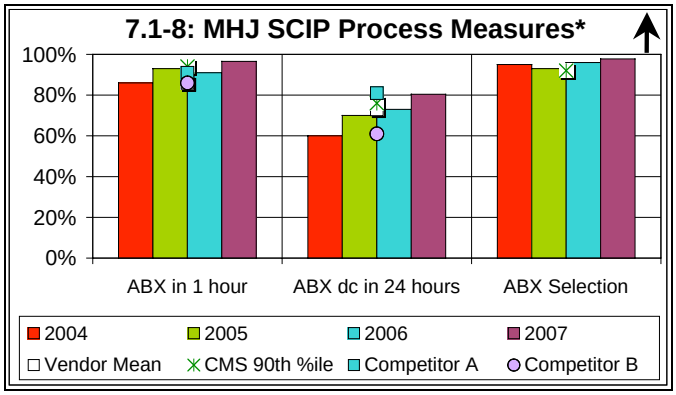


7.1-6: CAH CAP Process Measures* (%)								
	MHH					MWH		CMS
	03	04	05	06	07	06	07	90th%
Abx in 4 hrs		86	97	97	100	100	100	93
O2 assess	100	100	100	100	100	100	100	100
Pneu Vax	67	86	100	84	100	81	100	93
Smoke Cess.	50	67	100	100	100	50	100	100
Flu Vax				75	88	100	100	
App. Abx		83	93	100	100	100	100	93
Bld Cultr	90	75	86	96	100	100	100	100

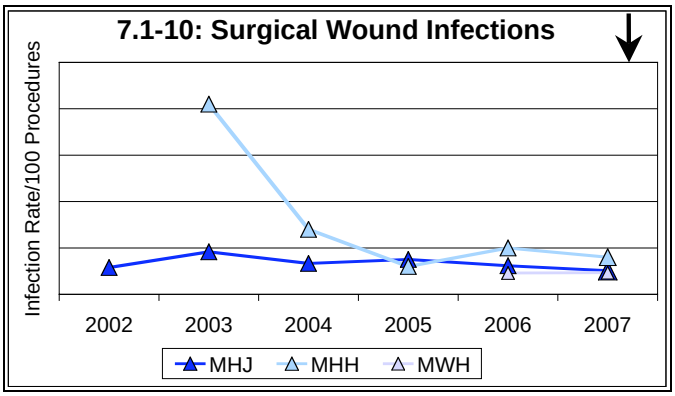


Infection Control:

Figure 7.1-8–11, SCIP: Antimicrobial prophylaxis for surgical procedures significantly reduces infections and resulting morbidity and mortality. MHJ implemented a multi-disciplinary process in 2003 and created a protocol to administer prophylactic antibiotics 60 minutes before procedure start. Initial order sets with preoperative antibiotics listed aid the physician in timely ordering. Timeliness of postoperative antibiotic therapy is addressed through surgical nursing staff education. Process measures and infection rates are segmented for analysis by surgery type. Hip replacements and hysterectomies are examples of high volume surgeries that are segmented. Mortality deviations for both surgeries have been below zero since SCIP process measure adoption.



7.1-9: CAH SCIP Process Measures* (%)								
	MHH					MWH		CMS
	03	04	05	06	07	06	07	90th%
Abx in 1 hr		0	100	95	100	92	88	94
DC 24 hrs		0	35	78	87	95	94	76
Abx Select				100	96	100	100	92



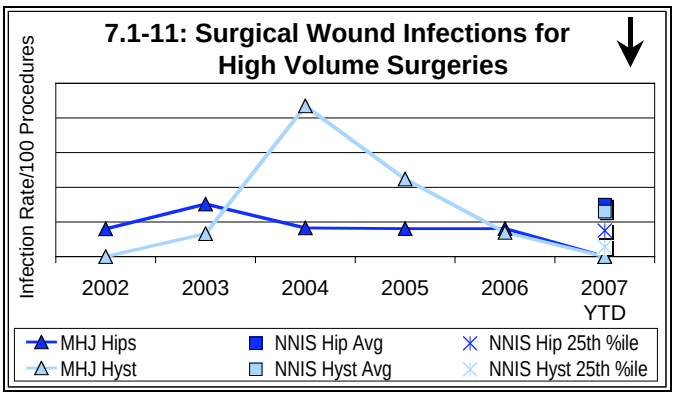
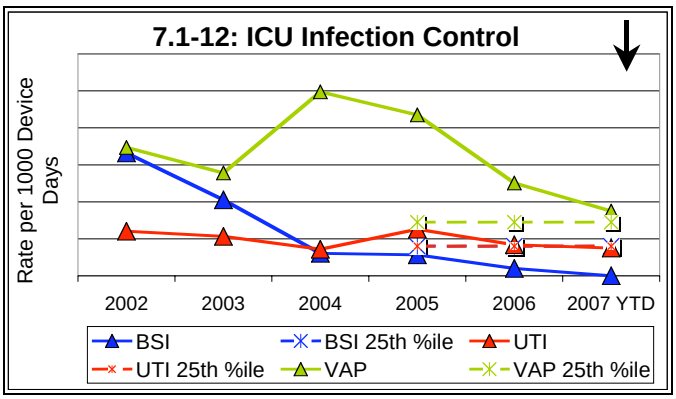


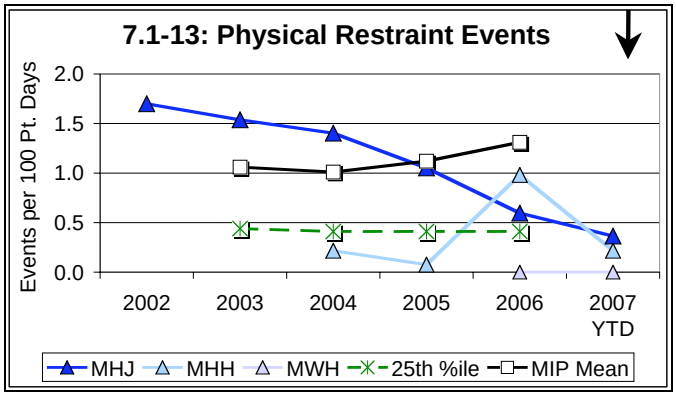
Figure 7.1-12, ICU Infection Control: ICU patients are at higher risk of developing nosocomial infections due to frequent exposure to invasive devices and the presence of severe underlying disease conditions. Data is monitored to enable rapid response to adverse outcomes and is compared to NNIS. In 2003, after review of data and current practice and identification of a best practice in our region, the Biopatch with Chloroprep was introduced for use in all central line catheter insertions. In 2005, protocols for insertion processes were enhanced to address barrier protection device use during central line insertion. In 2001, MHS launched a PI initiative to reduce catheter-associated urinary tract infections (UTIs) by changing to an antimicrobial catheter. The "ZAP the VAP" initiative began in 2003 and included changes to order sheets and documentation tools and interdisciplinary staff education. A focus on oral care and elevating the head of the bed contributed to improved results.



Patient Safety:

Figure 7.1-13, Restraint Use: Use of restraints is a key measure in balancing patient rights and safety. The restraint team focuses on events and provides staff education related to

restraint use and patient safety. Admission risk assessments allow for early interventions to avoid restraint use. Nursing leadership evaluate events concurrently to assess alternatives.



7.1-14: Restraint Use per Patient Day*						
	2002	2003	2004	2005	2006	07 YTD
MMTC	0	0	0	0	0.03	0
MHCC	0	0	0	0	0	0
Psych	0	0	0.04	0.05	0	0

Figure 7.1-15, Patient Safety: Before surgery, OR teams take a timeout to verify the correct patient, procedure, and operative site, and that necessary equipment and documents are in the room. MHS provides ongoing education to surgeons and staff to reach the target of 100% and has implemented "timeout tents" in the surgical packs to remind staff. MHH adopted the MHJ verification process in 2004. In 2003, as part of a national initiative to improve medication errors, MHS established a list of "do not use" abbreviations. Education and monitoring has decreased the use of these abbreviations and the likelihood of hospital and clinic medication errors.

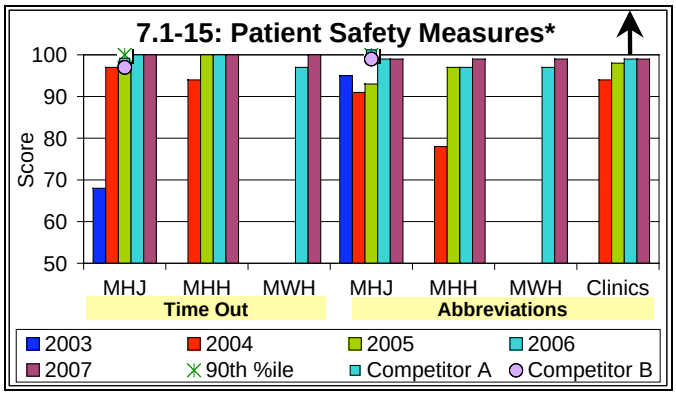
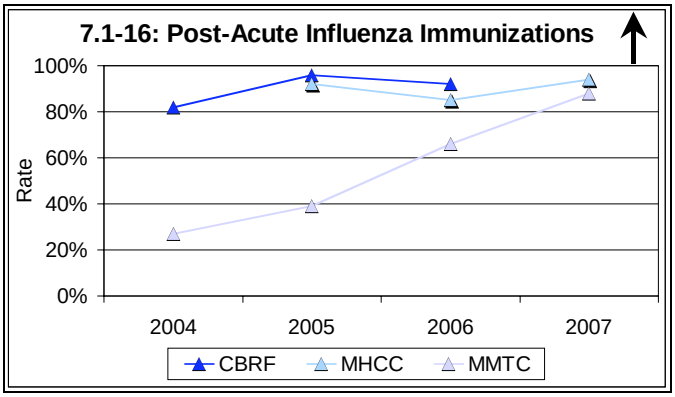
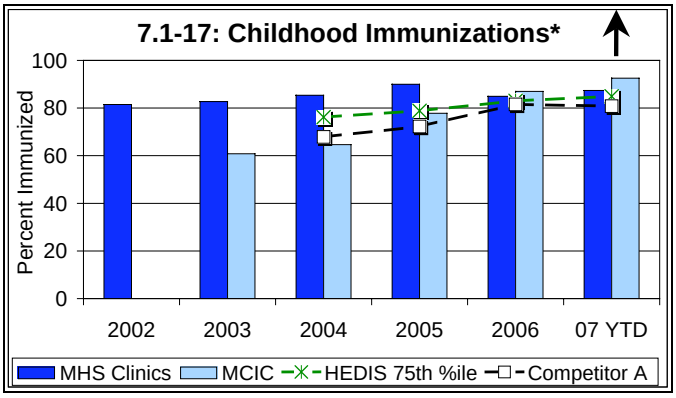


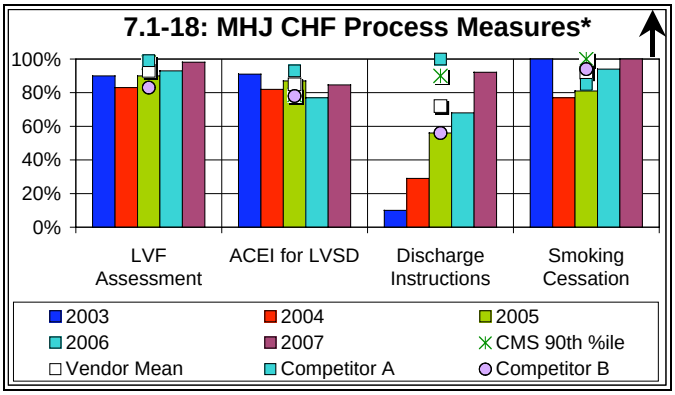
Figure 7.1-16–17, Immunizations: Immunizations affect patients across the continuum of care, and immunization status has a significant impact on public health. Appropriate immunizations are defined by the level of care. In long-term care settings, elderly patients receive influenza immunizations. For acute CAP patients, influenza and pneumococcal vaccinations are important (Figure 7.1-5). MHS partners also receive immunizations as appropriate to their level of patient contact (Figure 7.4-16). In MHS clinics and at MCIC, childhood immunizations ensure the youngest patients receive appropriate protection. MCIC uses an immunization database and implemented a case management process for management of at-risk children. NCQA recognized MCIC as a best practice for improved immunization results.





Chronic Care:

Figure 7.1-18–20, Congestive Heart Failure: CHF is a high volume, chronic disease. CHF patients often present with multiple comorbidities and are often non-compliant with required lifestyle changes. CHF measures and standard order sets focus care for optimal patient management. Concurrent review focuses on documentation of LVF assessment and ACEI for LVSD. The reviews identify information from previous visits, which can be used to improve care. MHS' integrated system includes the implementation of telemonitoring for CHF patients through MAC, which leads to greater patient compliance as they monitor and send their vital statistics to healthcare staff daily. Staff contact the patient's nurse or physician when warning signs and symptoms present.



7.1-19: CAH CHF Process Measures* (%)								
	MHH					MWH		CMS
	03	04	05	06	07	06	07	90th%
LVF Assessment	65	54	83	95	100			99
ACEI for LVSD	100	100	100	100	100			100
DC Instructions	36	36	83	50	86			92
Smoke Cessation	25	100	100	NC	100			100

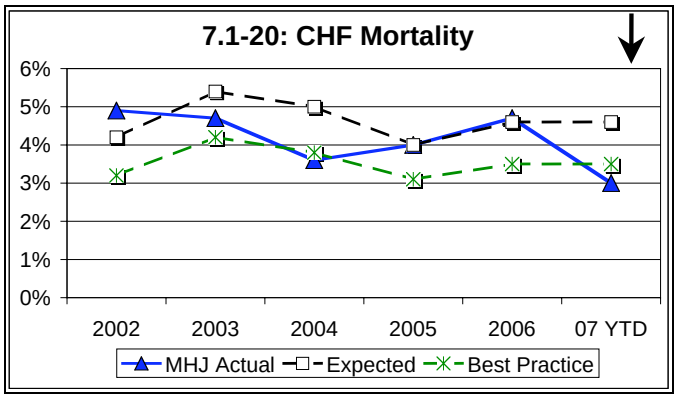


Figure 7.1-21, Home Health Outcomes: MAC participates in national projects to benchmark home health quality. MAC focus areas include improvement in pain, dyspnea, and ambulation. Through the performance measurement system, improvement opportunities in these areas were identified. A multi-disciplinary team made process improvements through staff education on appropriate assessment and documentation and created standardized patient assessment questions. Results are reviewed with staff at quarterly meetings.

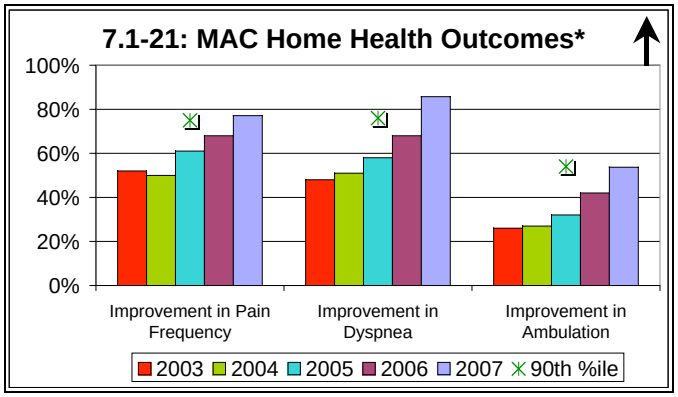
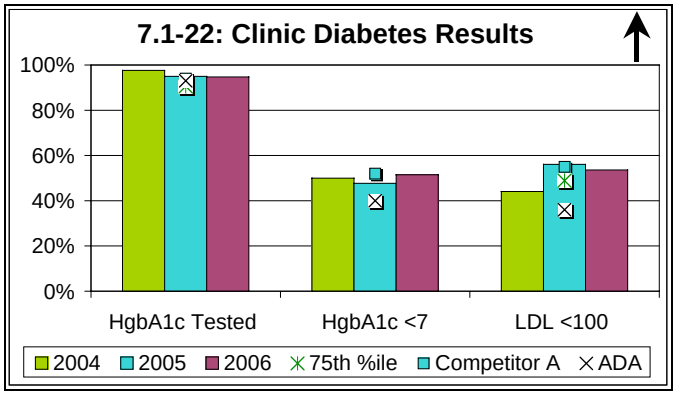


Figure 7.1-22–23, Diabetes Care: MHS is part of a statewide collaborative to reduce the impact of diabetes complications through preventative care and diabetes testing. MHS uses a diabetes flow sheet and tracks its use in clinics. MCIC participates in the HEDIS project and is part of the Wisconsin Diabetes Collaborative to share strategies and best practices. MHS subsequently developed the Regional Diabetes Care Center, which provides comprehensive diabetes testing, education, and supplies under one roof.



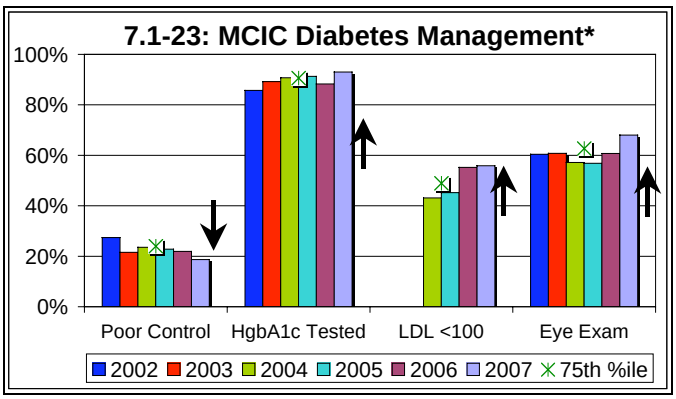
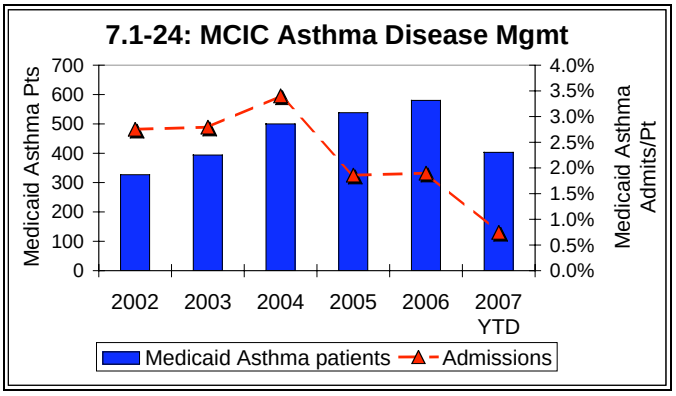
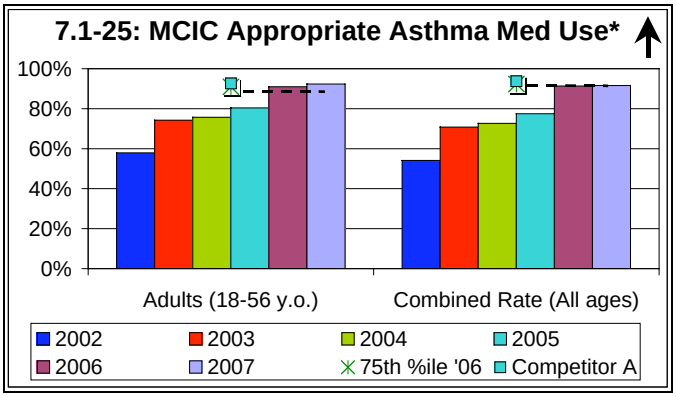


Figure 7.1-24–25, Asthma Disease Management: MCIC created its Asthma Disease Case Management Program in response to data showing a large asthma population. The program provides case management services to enrollees based on disease severity. Case managers educate enrollees about triggers in the home, share ozone alerts, and provide education for medications and equipment. The Medicaid population is generally a less compliant population with fewer resources. Although Medicaid asthma enrollees increased, hospital admissions for these patients have remained steady.





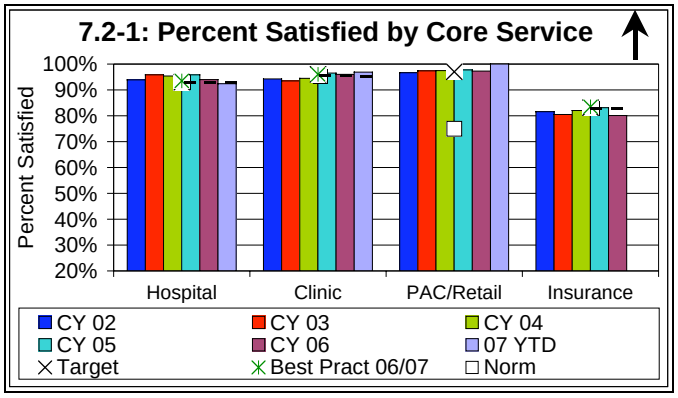
7.2 Patient and Other Customer-Focused Outcomes

MHS has identified its patient satisfaction targets as the top quartiles of Press, Ganey (PG) for hospital; AMGA for clinic; and NCQA CAHPS for MCIC.

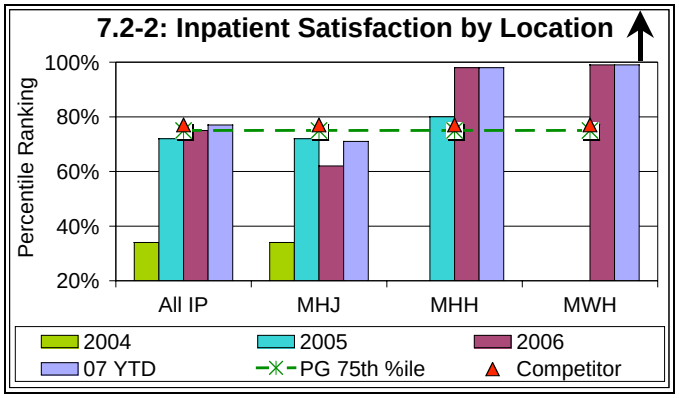
7.2a(1) Customer Satisfaction:

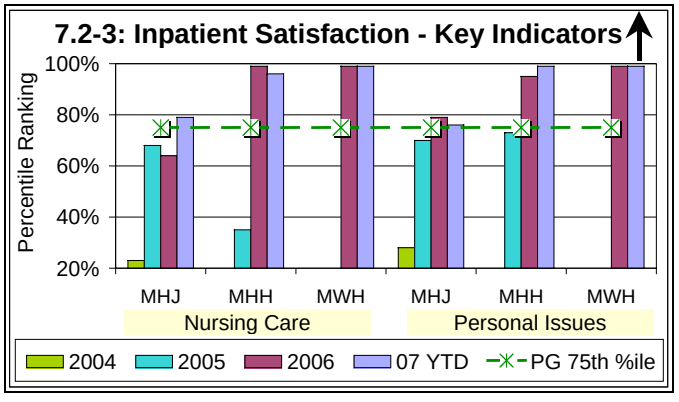
Figures 7.2-1, Satisfaction by Core Service: Since 2002, MHS has used an internal, rapid-cycle surveying process for all patient service areas to measure percent satisfied, the top two ratings on each survey. This process enables MHS to

measure customer satisfaction consistently across the system. The percent satisfied measure is one factor used to determine the annual discretionary contribution to the Matched Savings Plan. In 2006 the hospital satisfaction survey distribution and collection methodology changed, which studies show negatively impacts results. However, hospital percentile rankings vs. the PG database have been increasing steadily. See 7.2-9 for insurance satisfaction discussion.

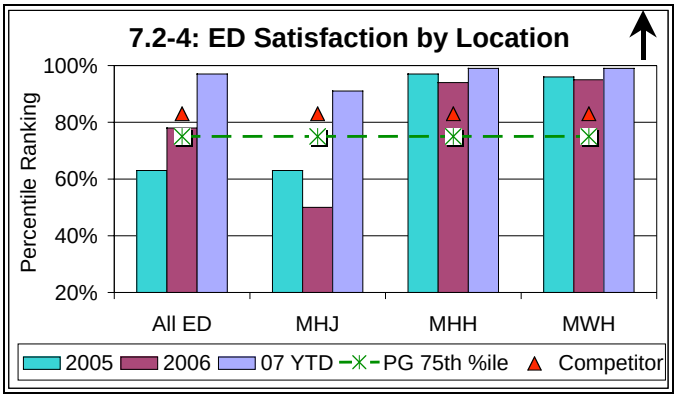


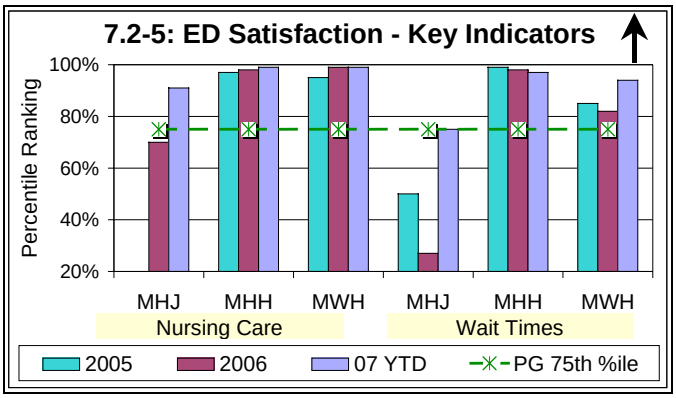
Figures 7.2-2–3, Inpatient Satisfaction: MHS began using PG to benchmark inpatient satisfaction in 2004 and ED satisfaction in 2005. In FY 06, MHS began requiring top quartile targets on dashboards, report cards, and PIPs to increase focus on best practice performance. Satisfaction with *Nursing Care* and *Personal Issues* are highly correlated to inpatient satisfaction, and *Nursing Care* and *Wait Times* are highly correlated to emergency services satisfaction. In 2006, EC commissioned a team to focus on improving MHJ inpatient satisfaction. Several initiatives were implemented, including increased nursing leadership rounds, addition of a patient representative, communication boards, discharge phone calls, and thank-you notes to patients after discharge.



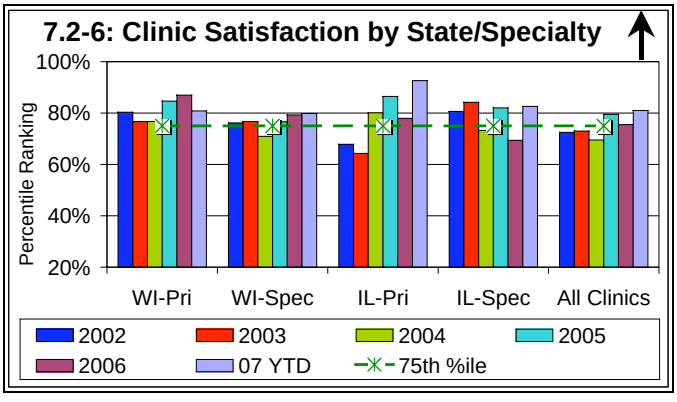


Figures 7.2-4–5, ED Satisfaction: Significant growth in emergent care visits has challenged MHS to meet wait time requirements. In 2006, an action plan was implemented, including a major renovation at MHJ and relocation of the urgent care and pain clinics. These changes resulted in additional ED space and enhanced patient flow. In early 2007, a patient greeter was added to support communication of information and delays.





Figures 7.2-6–7, Clinic Satisfaction: Analysis of satisfaction results consistently identifies *Personal Manner of Physician* and *Courtesy of Staff* as significant contributors to overall satisfaction. In 2005, service excellence training was provided to clinic staff, and reception and waiting areas were evaluated for convenience and comfort. While overall satisfaction for 2006 remained steady at the 75th percentile, clinic directors identified coverage gaps and scheduling issues in specific areas. Improvements included: hiring additional specialists; phone triage and scheduling process changes; and a 30-minute service commitment at all urgent care clinics. Construction projects contributed to decreases seen at the Illinois specialty clinics. Early 2007 results show improvement.



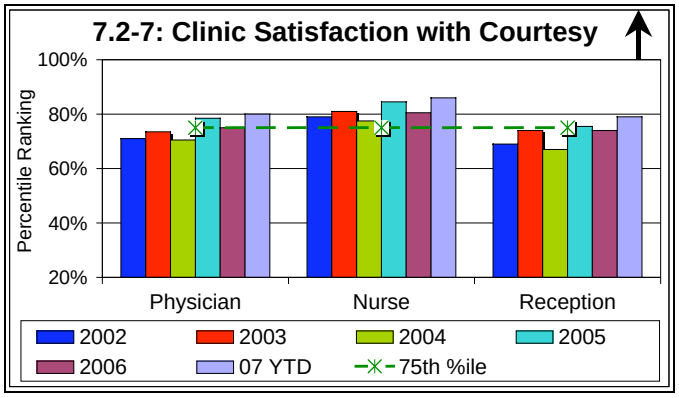
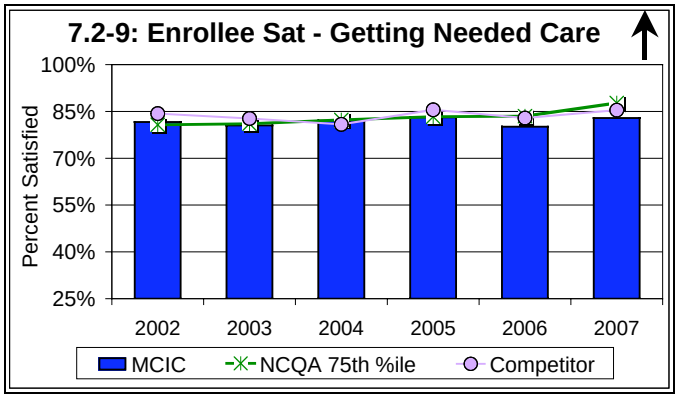


Figure 7.2-8, Post-Acute Care/Retail Satisfaction: MAC, MMTC, MHCC, and retail pharmacies conduct satisfaction surveys. Decreases in retail satisfaction are attributed to a change in the survey scale to match that for clinics and lower satisfaction at the Milton pharmacy due to implementation of mail order services. Mail order services will be relocated to the Mercy Health Mall in June where facilities and staffing will allow more effective management of this process.

7.2-8: Post-Acute Care and Retail – Percent Satisfied						
Service	**CY 02**	**CY 03**	**CY 04**	**CY 05**	**CY 06**	**07 YTD**
LTC	NA	NA	98%	98%	100%	100%
MAC	97%	97%	97%	97%	96%	100%
Retail Pharm	93%	96%	98%	98%	95%	99%

Figure 7.2-9–11, MCIC Enrollee Satisfaction: As part of its integrated delivery strategy, MHS launched its own managed care company in 1994. MCIC formally evaluates enrollee satisfaction annually and determines key customer requirements based on correlation analysis of the results and employer/agency focus group and survey feedback. *Getting Needed Care* is a primary indicator reflecting the key requirements of access to care and network availability. Figure 7.2-10 shows additional indicators that address network quality, also a key requirement. When Q4, 06 system dashboard results placed MCIC satisfaction in the red, an action plan was developed that included additional segmentation and analysis and the creation of an Access to Care team. Because physician availability and access to care are highly correlated with the Getting Needed Care indicator, MHS has made improvements to address provider coverage gaps and scheduling issues at MHS clinics.



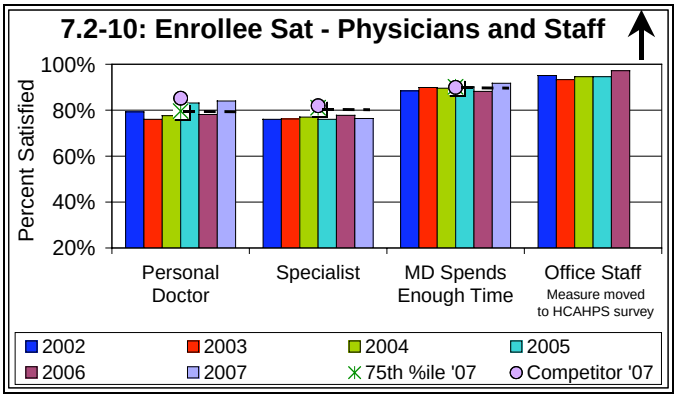
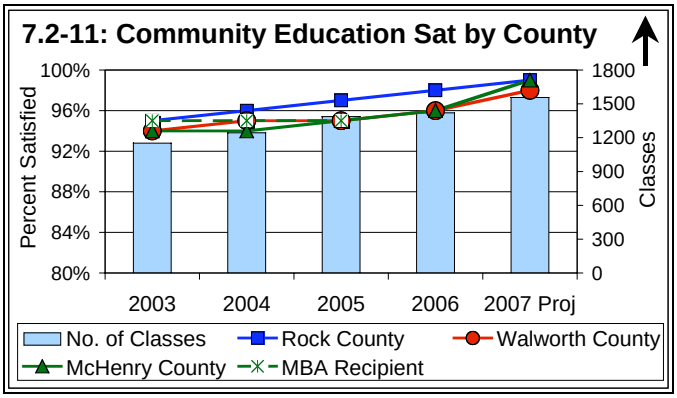
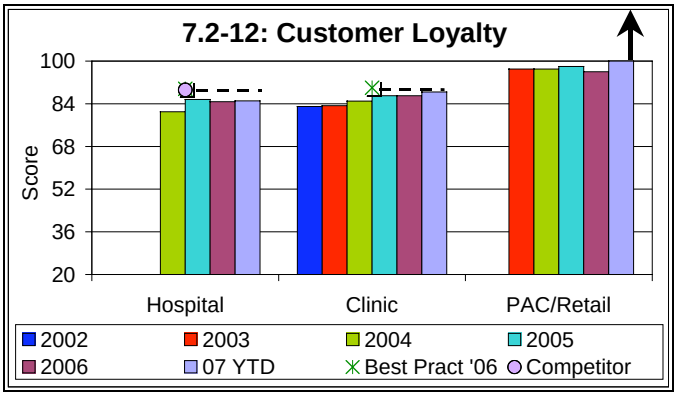


Figure 7.2-11, Community Education Satisfaction: MHS began surveying community education participants in 2003. Satisfaction has increased along with the number of educational offerings.



7.2a(2) Customer Loyalty and Retention:

Figure 7.2-12–13, Customer Loyalty: *Likelihood to Recommend* is a key loyalty indicator and a reflection of overall satisfaction. MCIC measures customer loyalty by duration with the health plan and employer retention.



7.2-13: MCIC Customer Loyalty						
Enrollee Duration With Plan, 5+ Years						
	2002	**2003**	**2004**	**2005**	**2006**	**2007**
MCIC	--	47.1%	51.3%	59.0%	63.1%	No longer
CAHPS Avg	--	--	40.4%	42.2%	42.2%	reported
Employer Retention						
MCIC	81.2%	87.6%	87.1%	91.5%	93.6%	94.4%

Figure 7.2-14, Community Perception of Value, Loyalty: MHS uses an independent market research firm to assess its community image and to determine community loyalty for its

hospitals, clinics, and post-acute care services. MHS services primarily ranked first or second in their relative service areas.

7.2-14: Community Loyalty (Ranking)									
	Rock County			Walw County			McHen Cnty (Clinics)		
Hospitals/Clinics	05	06	07	05	06	07	05	06	07
MHS	#1	#1	#1	#2	#2	#2	#2	#2	#2
Competitor A	#2	#2	#4	#4	#3	#3	--	--	--
Competitor B	#3	#3	#2	--	--	--	--	--	--
Competitor C	#4	#4	#3	#3	#4	#3	--	--	--
Competitor D	--	--	--	#1	#1	#1	--	--	--
Competitor E	--	--	--	--	--	--	#1	#1	#1

Figure 7.2-15, Service Recovery Score: The SRS score evaluates the effectiveness of resolving concerns. EC has set the SRS target at 85 out of 100 points, weighting response time at 25% and problem resolution at 75%. Requiring SR scores on clinical LG report cards maintains focus on complaint management effectiveness. Steady improvement in the SR score reflects the effectiveness of service excellence and recovery education provided to LG and partners.

7.2-15: Service Recovery Score						
Indicator	2002	2003	2004	2005	2006	07 YTD
Concerns per 1,000 Pts	1.9	1.6	1.5	1.6	1.8	2.1
Service Recovery Score	89.9	87.3	89.8	90.7	91.9	94.1

7.3 Financial and Market Outcomes

MHS benchmarks financial indicators with top quartile comparisons from Ingenix and MGMA, Moody's healthcare comparisons, and market data from state organizations.

7.3a(1) Financial Results:

Figure 7.3-1, Growth in Net Revenue: MHS's integrated delivery strategy has resulted in stability and steady revenue growth. Diversification protects operations from revenue swings in different sectors and contributes to long-term financial viability. MCIC supports this strategy through direct contracting with employers and generation of system referrals. The primary purpose of MCIC is to increase usage of MHS's provider network, not profits.

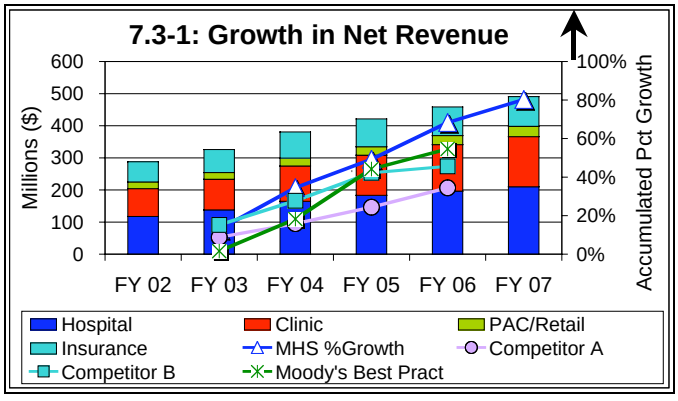
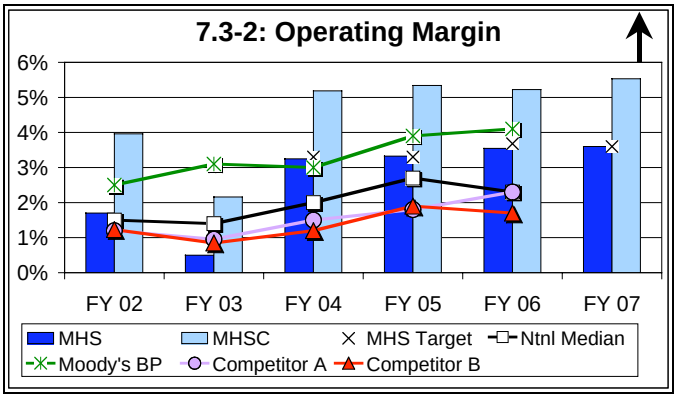
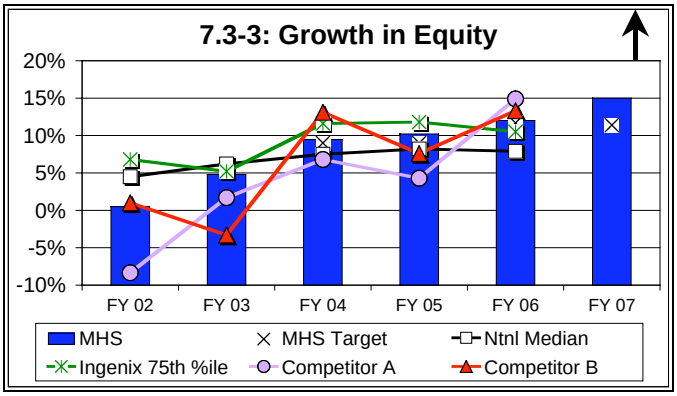
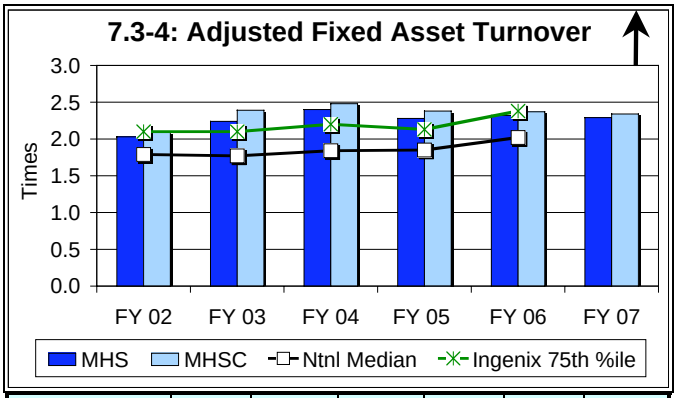


Figure 7.3-2–4, Financial Measures: *Operating Margin* measures an organization's ability to generate needed cash for future capital investment and pay back long-term debt, a primary concern of bondholders. *Growth in Equity* measures the change in the value of the organization and governs how much debt can be increased in order to maintain the target debt/equity ratio. *Fixed Asset Turnover* is an indicator of asset utilization, with higher values indicating more efficient use of assets to deliver needed care. The generation of income from the use of fixed assets assures that funds needed for future replacements and services are available. Competitor data is not price-level adjusted, and is shown separately in the table below. Favorable results in these measures are attributed to revenue growth, positive investment returns, and cost-effective operations.







System	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07
MHS	2.5	2.7	3.0	2.8	2.9	2.8
Competitor A	1.7	1.6	1.6	1.7	1.9	
Competitor B	1.6	1.5	1.7	1.9	2.0	

Figure 7.3-5, Physician Practice Measures: In 2002, MHS began benchmarking its clinic operations with MGMA. The physician partnership model motivates physicians to improve productivity and efficiency. MHS's production-based compensation plan includes review of production reports with physicians and an annual settlement process. MHS manages

the clinic practice so physicians can focus on increasing patient load, nursing supervision, and charge submission.

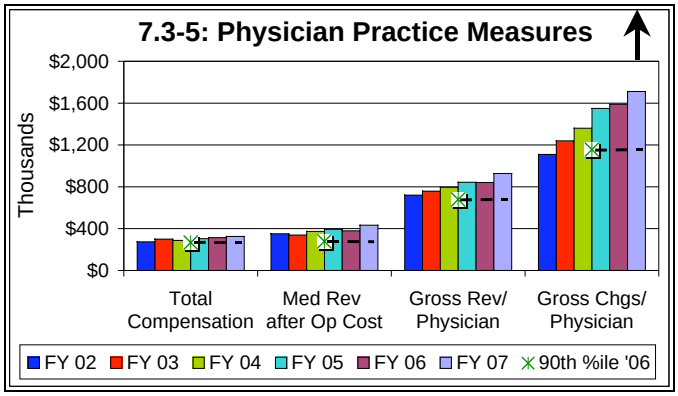
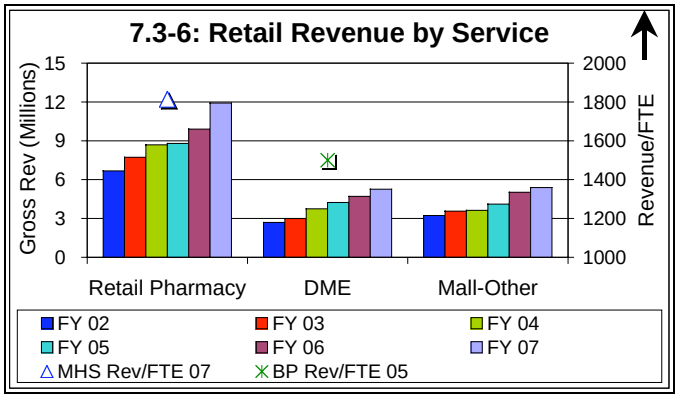


Figure 7.3-6, Retail Revenue: MHS's retail business complements its other services. Product diversification attracts an expanded customer base, increasing awareness of Mall services, including complementary medicine, DME, and retail pharmacy. Factors impacting increased revenues include: marketing of a comprehensive drug program to assisted living providers; relocation of complementary medicine services to a new clinic area with improved reception; enhanced chiropractor, massage therapy, and acupuncture services; and addition of mail order services. MHS's DME business continues to show strong growth as the result of efficient FTE management.



7.3a(2) Market Results:

Figure 7.3-7, Volumes Growth: Consistent growth in physician practices and managed care enrollment generates referrals for admissions, surgeries, and ancillary services. MHS tracks volumes to measure organizational success, monitor progress, and project revenue during budgeting.

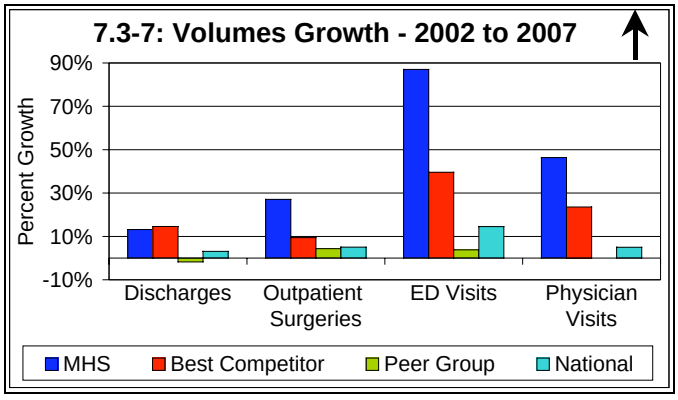
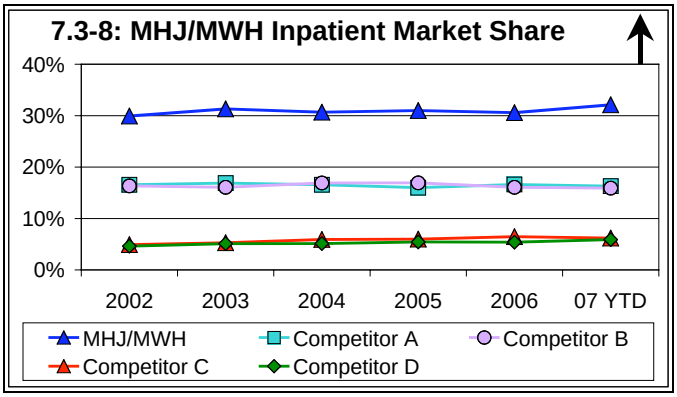


Figure 7.3-8–9, Wisconsin Market Share: MHJ has maintained inpatient market share in its two-county, Wisconsin service area (Rock and Walworth Counties), despite competition from big-market competitors out of Milwaukee and Madison. The 2007 increase is anticipated subsequent to opening hospital beds at MWH and a decrease in referrals to a competitor facility. Since adding these beds, transfers to the competitor facility have decreased by 10% (Figure 7.6-4). Outpatient surgery increases have resulted from employment of new specialists generating additional general surgery, gastroenterology, orthopedic, and urology procedures.



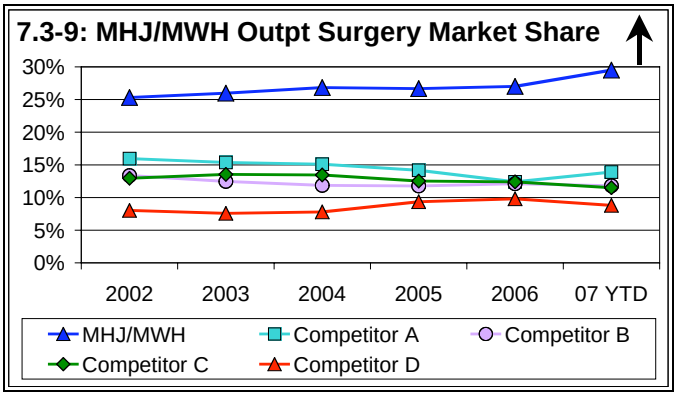
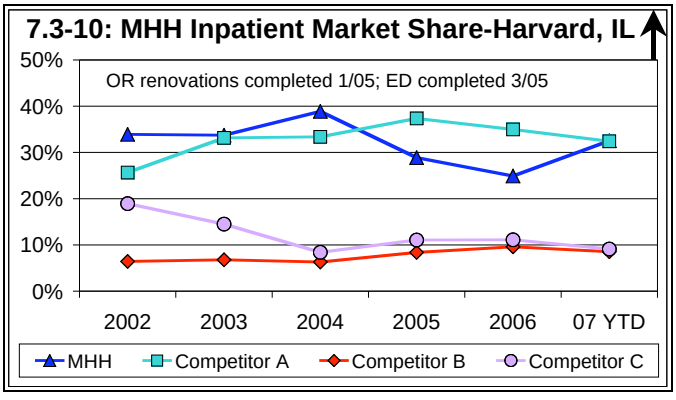
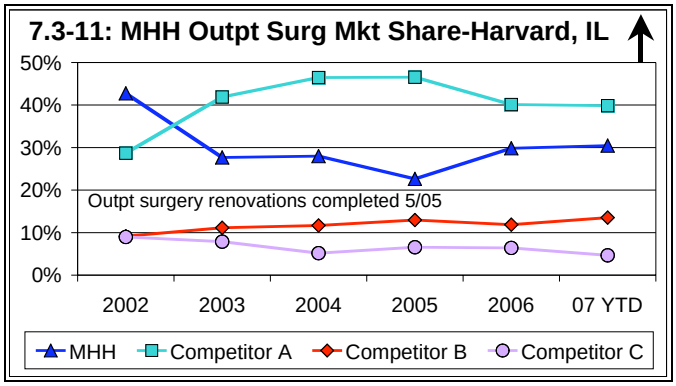


Figure 7.3-10–12, Illinois Market Share: Physician practice acquisitions led to a market share increase in 2004; however, renovations begun in August 2004 resulted in decreased utilization. Renovations were completed in early 2005, and activity is again increasing. The increase in outpatient surgery market share is attributed to the hiring of two additional general surgeons in 2006.





7.3-12: MHH Volume Statistics

Statistic	CY 03	CY 04	CY 05	CY 06	07 Proj	Proj Inc 06-07
Discharges	668	840	519	518	540	4.2%
Outpt Surg	154	479	959	1,384	1,509	9.0%
ED Visits	4,695	4,451	4,986	5,316	5,452	2.6%

Figure 7.3-13, Physician Office Visit Market Share: MHS's strategic efforts to acquire physician practices and employ additional physicians have positively affected market share growth in all markets. As shown in Figure 7.3-7 physician visits have increased notably since 2001.

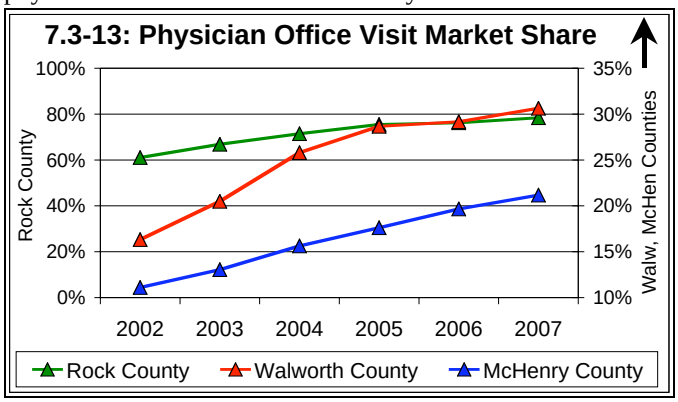
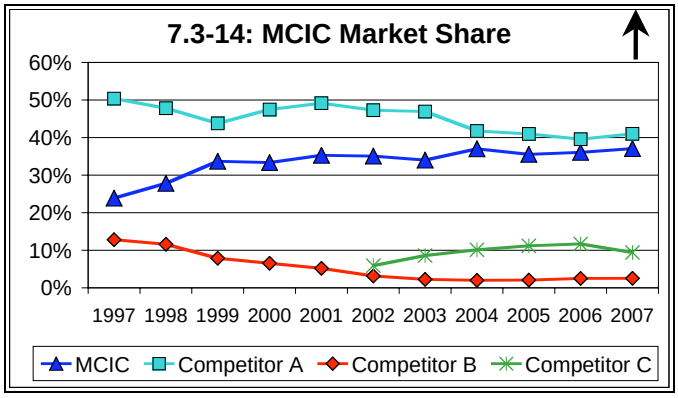


Figure 7.3-14, MCIC Market Share: In 2003, MCIC introduced MercyPlus, a PPO-like product, and experienced enrollee growth as the result of increased sales.



7.4 Workforce-Focused Outcomes

To evaluate progress in achieving the goal of being a best place to work, MHS benchmarks itself with Baldrige recipients, the Great Place to Work Institute (100 BEST), ASHHRA, BNA, AMGA, and NewMeasures, Inc (NM).

7.4a(1) Workforce Engagement and Satisfaction:

Figure 7.4-1, Partner Turnover: MHS measures its ability to sustain a well-staffed, satisfied workforce through analysis of turnover information. Proactive retention initiatives, HR processes, and departmental action plans have been implemented to reduce turnover and increase satisfaction.

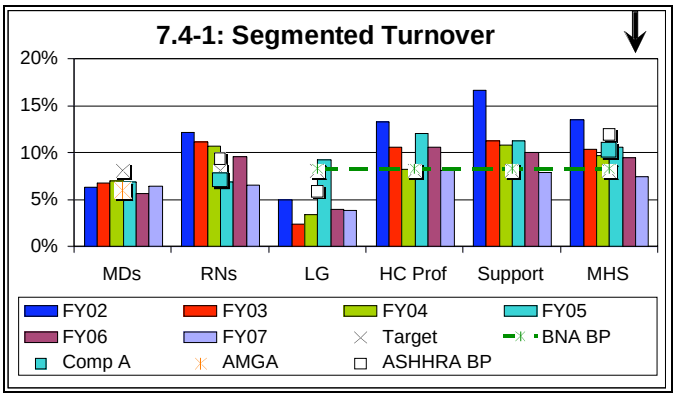


Figure 7.4-2, Workforce Engagement: Annually, MHS assesses and implements action plans to improve workforce engagement. Analysis of the partner survey system wide and departmentally has resulted in the implementation of departmental partner idea programs, enhancement of two-way communication systems to encourage involvement and feedback, and increased departmental COE and service excellence training to improve workforce engagement.

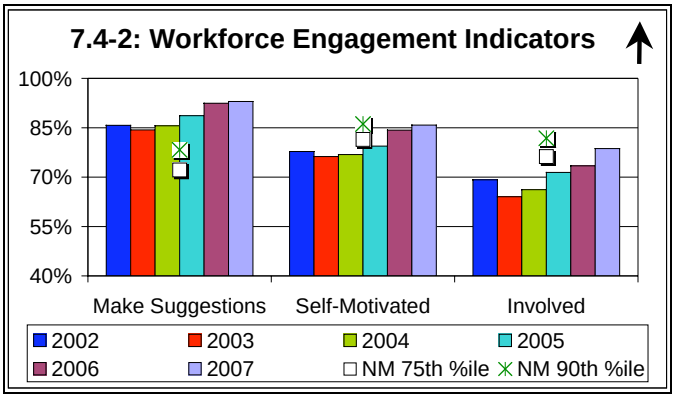
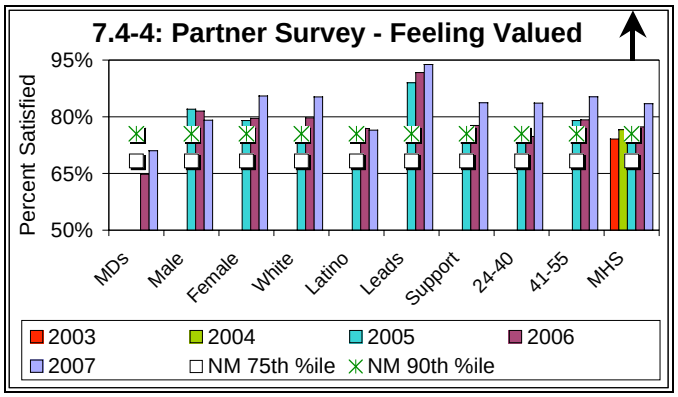
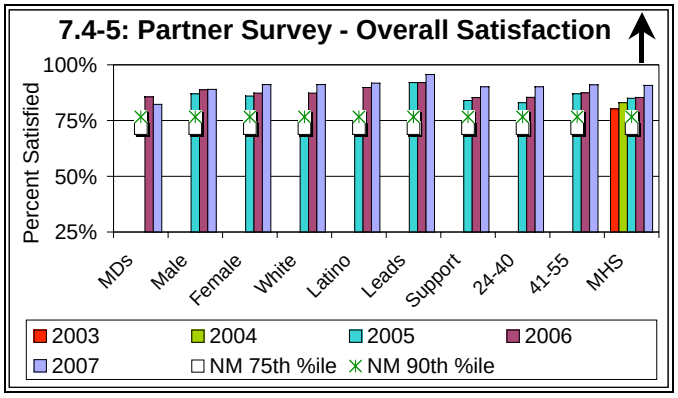


Figure 7.4-3, COE Initiatives: COE initiatives are designed to motivate and reinforce positive behavior through reward and recognition and are a measure of workforce engagement. Integrating partner feedback into the design of COE programs, increased publicity, and ease of participation have improved the effectiveness of COE initiatives. COE behaviors are reinforced through the discretionary match, which is made when the system achieves system-wide financial and customer satisfaction goals.

7.4-3	ABCD Program	Idea Program: # of Ideas/Days to Close	Matched Savings
2002	5,275	91 / 131.8	Data removed
2003	5,668	77 / 158.4	
2004	6,408	151 / 129.5	
2005	7,562	152 / 78.9	
2006	8,939	201 / 57.1	
2007 Proj	9,500	250 / 30	
5-Yr ↑	80%	174% / 77%	63%

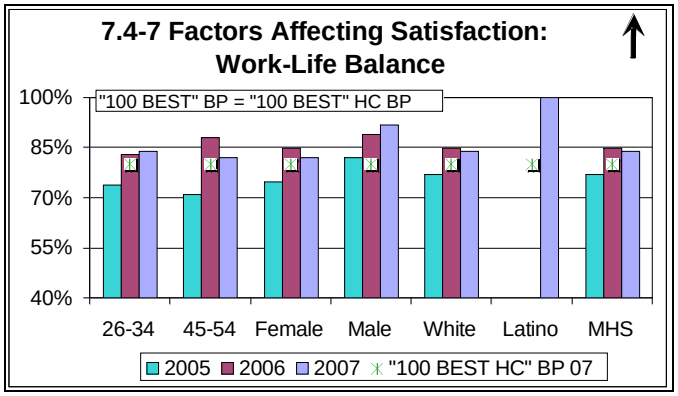
Figures 7.4-4–6, Partner Satisfaction: In 2006, response rate reached its highest level of 75% after providing a web-based survey option, exceeding 71% for a Baldrige recipient and 48% for a competitor. MHS ranks in the 96th percentile for *Feeling Valued* and 95th percentile for *Overall Satisfaction*. AMGA benchmarking data provides percentile raking based on top-box responses only. Physician satisfaction ranks above the AMGA 95th percentile. COE improvements, benefit enhancements, and leadership development have enabled MHS to maintain top-decile levels in partner satisfaction.



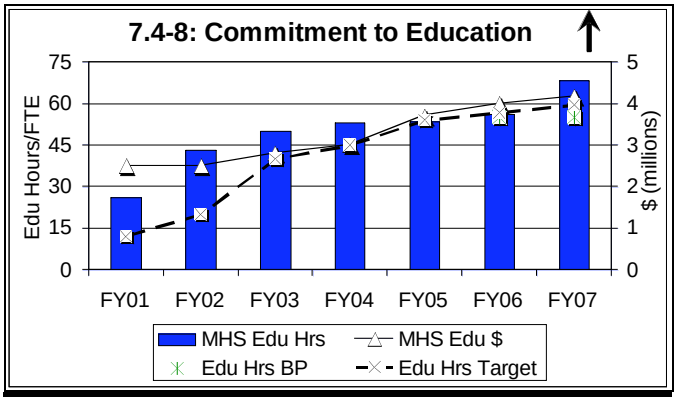


7.4-6: MD Overall Satisfaction	2006	2007
Overall Sat (% Excellent)	49.7%	51.4%
AMGA 95th Percentile (% Excellent)	47%	50%

Figure 7.4-7, "100 BEST" Factors Affecting Satisfaction: Analysis of partner feedback and industry literature indicates employee work-life balance is a key driver of engagement and satisfaction. The R&R Committee uses partner feedback to enhance work-life benefits and makes improvements through the SPP. In 2005, MHS implemented concierge services to help partners optimize their work and personal schedules.



Figures 7.4-8, Commitment to Education: To support its vision, MHS continues to increase its investment in education and development. To enhance LG development, MHS increased the number of LDA offerings in 2006. MHS uses pre- and post-tests to assess training and participant feedback to ensure continued improvement. LDA satisfaction has been at or above 99%. Increased educational programming, resources and financial support, and report card account–ability, have resulted in increased education hours/FTE. MHS continues to increase internally sponsored CME opportunities. Total CME hours has more than doubled to 3,152 by end of 2006 from 1,273 in 2002. MHS facilitates career progression for partners through a commitment to educational and development support, succession planning, and increased use of career ladders. A total of 67% of LG have been promoted from within, compared to 49% for a Baldrige recipient.



	2002	2003	2004	2005	2006	07 Proj
Career Ladders	344	957	1,237	1,566	1,575	1,585
5-Yr ↑						361%

7.4a(2) Workforce Capability and Capacity:

Figure 7.4-9, Staff Competency: PPAs are integral to ensuring qualified caring staff provide high quality healthcare and a key measure of workforce capability. Enhanced leadership effectiveness through training, support to partners through PDPs, PIPs, and increased educational opportunities continue to improve overall staff competency. Semi-annually, HR reports staff competency to the BOD. Physician competency is assessed through the re-credentialing process and has been at 100% for over six years.

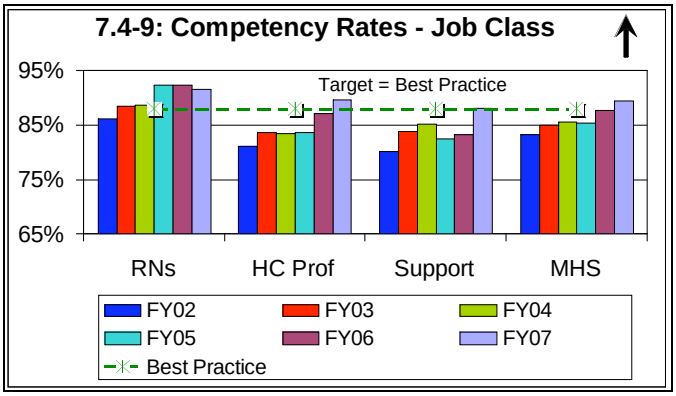


Figure 7.4-10, Vacancy Rates: Partner feedback identified adequate staffing as a key driver of retention and satisfaction. Vacancy rates are a key measure of workforce capacity. Focused recruitment strategies, automation and standardization of the candidate selection process, and commitment to the COE have contributed to decreased vacancy rates. MHS's RN vacancy rate of 4% is notably less then industry levels for RNs at 8.5% and a competitor's RN vacancy rate of 7.1%.

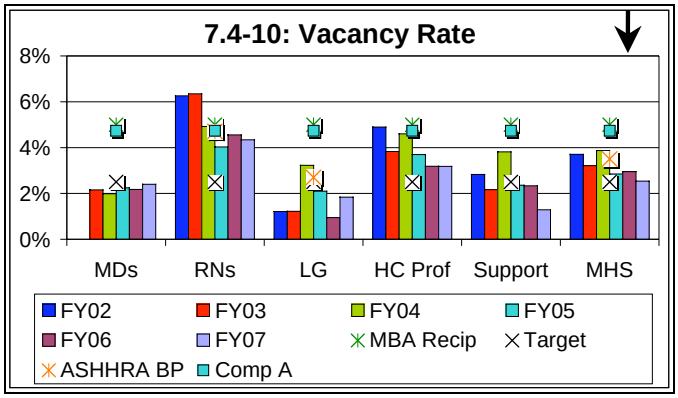


Figure 7.4-11, Retention Rates: Enhancement of COE strategy through education, reward/recognition programs, enhanced work-life benefits, leadership effectiveness, and tailored services, contributes to partner retention.

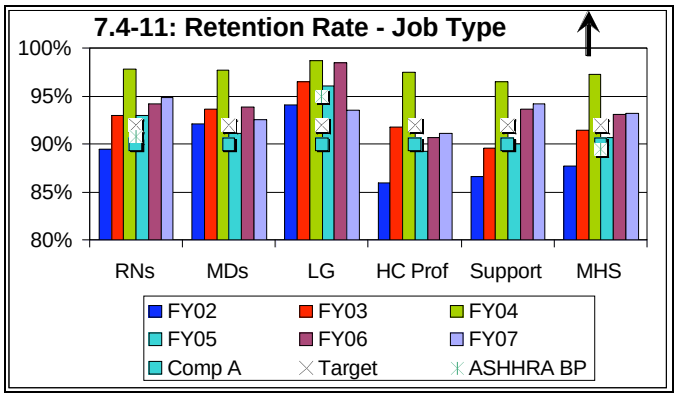


Figure 7.4-12, Performance Appraisals: Timely completion of performance appraisals ensures that important communication, mentoring, capability assessment, goal setting, and career progression occur. To ensure accountability, this indicator is included on LG report cards. Training is provided to support effective use of the evaluation system.

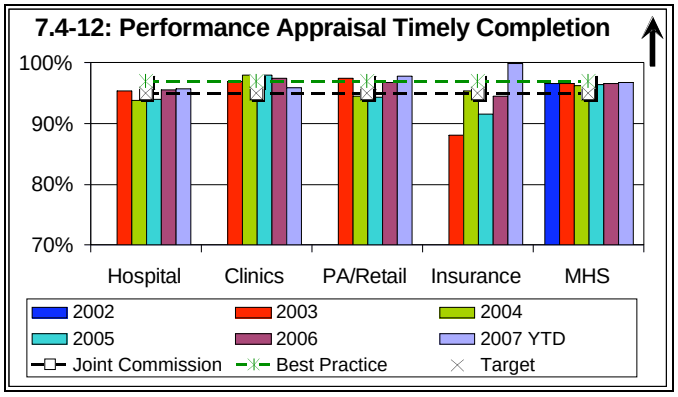
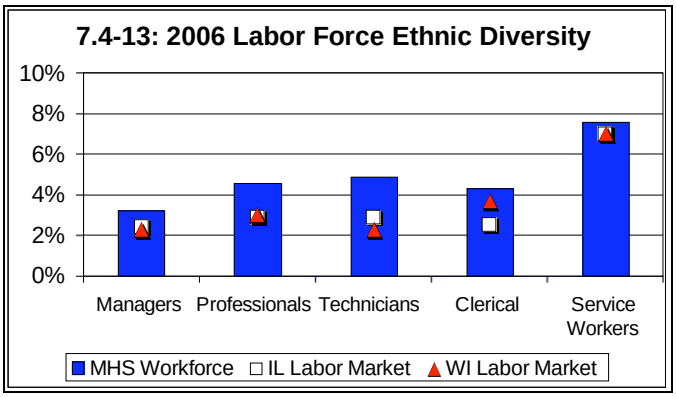


Figure 7.4-13–14, Diversity: Although MHS views diversity in a broader sense, ethnicity is an important component. MHS policies and procedures are designed to ensure work systems treat partners fairly, regardless of differences in age, gender, sexual orientation, ethnicity, and other diversity factors. Policies and procedures are developed with partner input using various methods (surveys, focus groups). Partner perception of fair treatment is a "100 BEST" measure and is considered an indicator of diversity strategy effectiveness.



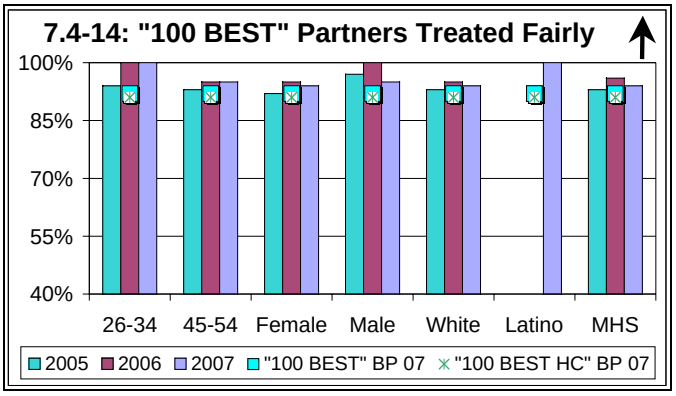
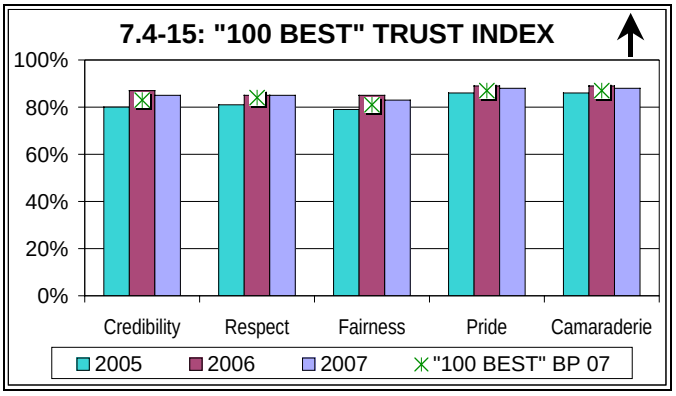


Figure 7.4-15, "100 BEST" TRUST Index: The Best Places to Work Institute identifies five key organizational culture/climate categories that determine a company's overall strength to be a great place to work. These five areas comprise the TRUST Index, the overall measure of staff satisfaction. MHS's high Index scores reflect commitment to organizational strategy, strengthening the COE by continually enhancing feedback responsiveness; education and training; reward and recognition programs; and leadership excellence.



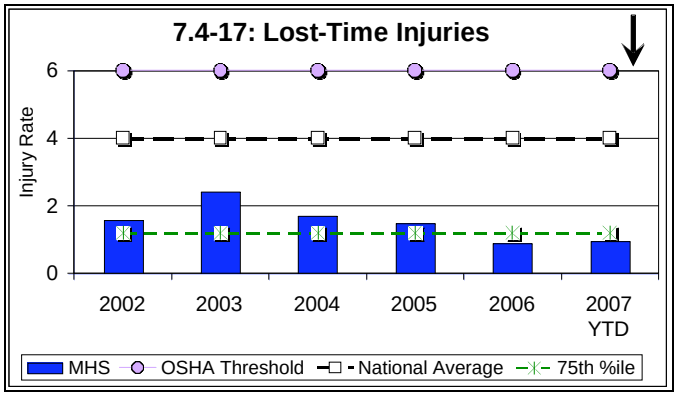
7.4a(3) Workforce Climate:

Figure 7.4-16, Partner Wellness and Safety: Providing a safe and healthy work environment is part of MHS's vision. Safety Fair training, ergonomic evaluations, and flu shots are

key processes that contribute to a safe, healthy work environment. Expanding Safety Fair sites and delivery modes has increased attendance. Other forums, such as the Wellness and Low Lift Fairs, provide education to partners on the benefits of early intervention. As a result, all in process measures have steadily increased.

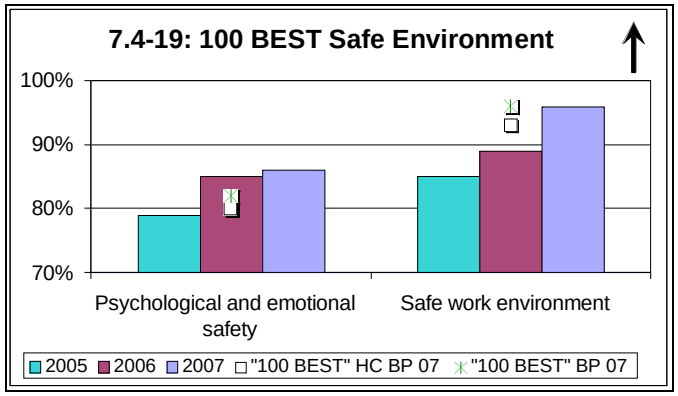
7.4-16	Safety Fair Attendance	Ergonomic Evaluations	Flu Vaccination Rate
2002	84%	63	31%
2003	91%	68	36%
2004	93%	115	29%
2005	95%	206	39%
2006	98%	225	61%
2007 Proj	100%	250	65%
5-Yr ↑	17%	296%	110%
		National Benchmark	36%

Figure 7.4-17—18, Lost-Time Injuries and Claims Rate: MHS's end-process measure for safety initiatives is lost-time injuries. Keeping partners healthy and at work ensures adequate (capacity) and competent (capable) staff to provide quality healthcare. Segmented workers compensation data analysis indicated patient-handling injuries as the most common cause for partners missing work. MHS implemented the Low Lift Program in 2005, including new procedures, equipment, and staff education. Increased emphasis on ergonomic evaluations and MHS's "Handle With Care" education initiatives helped reduce the number of injuries and vastly reduced claims, resulting in top quartile performance.



7.4-18: Injuries Claim Rate	2004	2005	2006	07 Annzd
Claims Rate	2.48	0.97	0.67	0.48
Top Quartile Rate	2.25	2.25	1.65	1.38

Figure 7.4-19, Partner Wellness and Safety: Providing a safe and healthy work environment is part of MHS's vision statement. The "100 BEST" survey measures partner confidence in MHS's ability to provide an emotionally and physically safe work place. Safety systems and policies, drills, partner involvement, site-specific safety teams, and annual safety and security risk assessment surveys help to identify and respond to safety and security concerns and proactively ensure a safe and secure work environment.

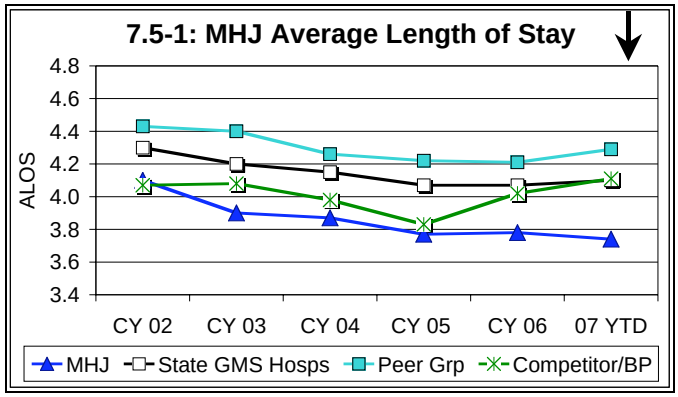


7.5 Process Effectiveness Outcomes

MHS measures organizational effectiveness and efficiency through use of system and department dashboards. Departments monitor indicators based on relevance to their area.

7.5a(1) Work Systems Performance Results:

Figure 7.5-1–2 ALOS: ALOS reflects patient average length of stay and is affected by illness severity. Effective inpatient management and use of protocols have led to decreased ALOS despite an increase in case mix index. Proactive efforts to reduce infections and complications have also affected this measure. Increases at MHH and MWH reflect the ability to retain higher-severity patients.



7.5-2: CAH Average Length of Stay	CY 02	CY 03	CY 04	CY 05	CY 06	07 YTD
MHH	2.5	2.3	2.2	2.7	2.6	2.8
IL CAH Peer Group	3.4	3.2	3.3	3.3	3.3	3.3
MWH					3.3	2.7
WI CAH Peer Group	3.4	3.3	3.3	3.1	3.2	3.3

Figure 7.5-3, Clinic Access: Access is a measure of the patient's ability to seek and receive care with the provider of their choice, at the time they choose, regardless of the reason for their visit. Counting the third next available appointment is the industry's standard measure of access to care indicating how long a patient waits to be seen. Open-access scheduling is one way that MHS meets patient's access needs.

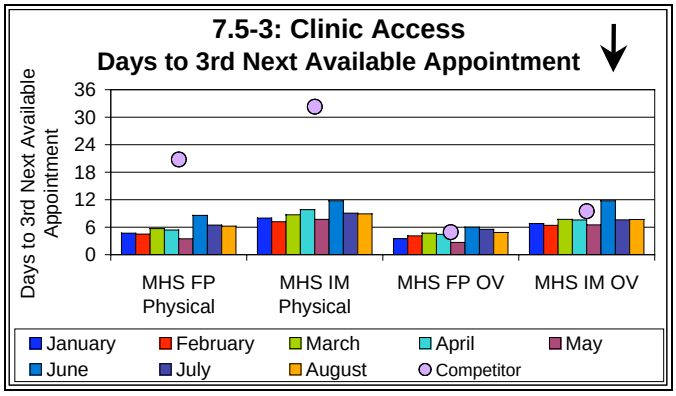
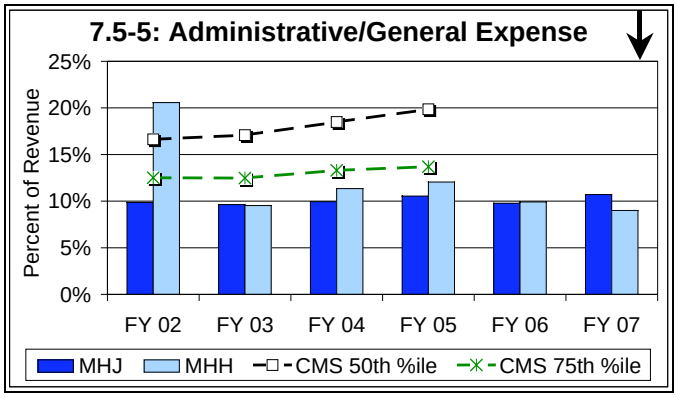


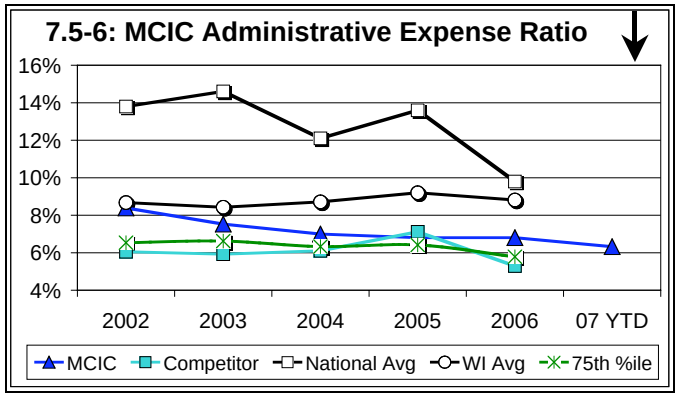
Figure 7.5-4, Emergency Management: MHS's emergency management plan addresses the four phases of Emergency Management: preparedness, mitigation, response and recovery. MHS participates in community and regional emergency management planning and drill exercises to ensure preparedness and continuity of preparation efforts. MHJ recently completed a Wisconsin readiness survey and was ranked 2nd highest out of 23 hospitals in terms of preparedness and MWH 12th highest.

7.5-4: Emergency Management

		2002	2003	2004	2005	2006	07 proj	Req
Emergency Mgmt Drills	MHJ	2	2	2	2	2	2	2
	MHH	2	2	3	2	3	2	2
	MWH	2	2	2	2	2	2	2
Fire Drills	MHJ	12	12	12	12	12	12	12
	MHH			16	16	11	16	12
	MWH	12	12	12	12	12	12	12
	Clinic	39	40	48	47	38	40	0
Community Drills	MHJ	2	2	2	2	2	2	0
	MHH	2	1	1	1	2	2	0
	MWH	0	0	1	1	2	2	0

Figure 7.5-5–6, Administrative Expenses: MHS's service integration strategy has allowed MHS to streamline operations and avoid unnecessary duplication of services. An initial decrease in expenses after the affiliation with MHH in 2003 was the result of reorganization. MCIC has capitalized on the built-in relationship with provider sponsors to eliminate unnecessary costs. This allows MCIC to pay competitive rates to its providers while maintaining a competitively priced product.





7.5a(2) Work Process Results:

Figure 7.5-7 Critical Imaging Equipment Uptime: Equipment reliability and efficiency are measured by equipment uptime. Equipment uptime is reviewed with the vendor and can be segmented by site, modality and piece of equipment if there is a problem. Corrective and preventative maintenance reports are segmented by type and cause of error. Results are reviewed with the vendor at quarterly vendor meetings and more frequently if necessary.

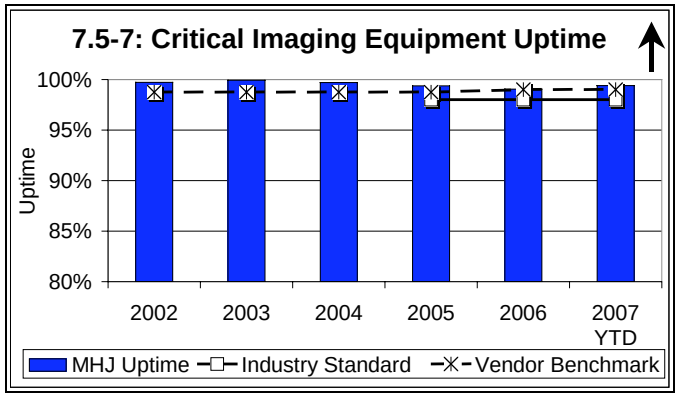


Figure 7.5-8, Critical Test Result Turnaround Time: Critical test results are findings that warrant rapid communication to caregivers. MHS has standard processes in place to ensure results for critical radiology and lab tests are reported to caregivers promptly, resulting in more timely treatment for patients.

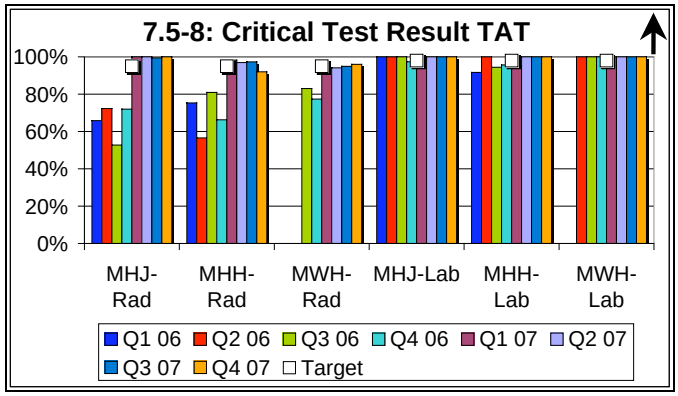


Figure 7.5-9, Days in Accounts Receivable: Effective management of accounts receivable maximizes available cash for investment and capital needs. Focus on reducing AR days required the implementation and modification of many

systems. In 2005, MHS implemented an open-item physician billing system, resulting in more user-friendly billing statements for patients and enhancing management capabilities to track outstanding patient accounts. Other improvements included: establishing guidelines for follow-up with third-party payors; better use of collection agencies; and use of the Community Care Program. In response to regulatory changes, MHS began offering extended payment plans in FY 07. This has resulted in a slight increase in Days in AR.

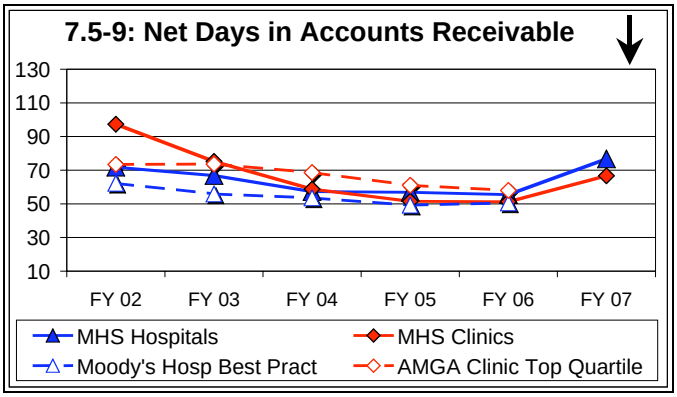


Figure 7.5-10, Transcription Productivity: Transcribed medical reports are a vital communication method between care providers. Transcription volumes have grown along with the system, necessitating process changes to improve efficiencies such as addition of team leader positions, use of automated pool assignments and use of contracted services. Despite rapid growth in volumes, customer satisfaction with courtesy and efficiency in the department has been increasing. Quality is measured for individuals, department, and contracted services and requirements are shared through orientation, training and results of quality reviews. Career ladders allow transcriptionists with consistent quality and volume, the option to utilize MHS' home transcriptionist program.

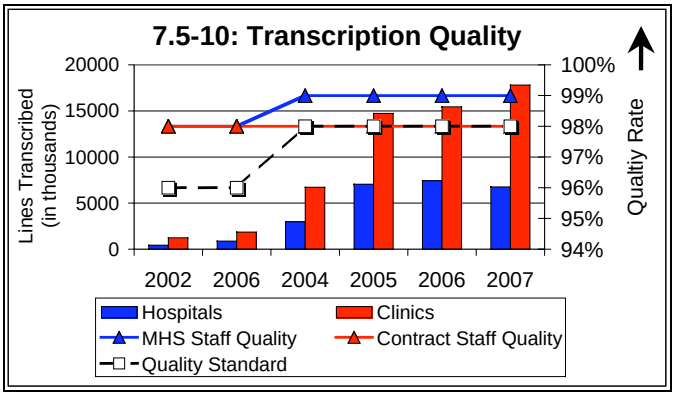


Figure 7.5-11, Biomedical Efficiencies: Despite growth in inventory and work order requests, the biomedical department consistently completes 100% of critical work orders on time. The department routinely studies contracts to determine if outsourced equipment repair can be completed internally. Biomedical recently took over the repair of computed radiograph equipment, resulting in over $86,000 savings in a twelve-month period. Additionally, a computerized maintenance management system was implemented in 2006 to track assets, inventories, and maintenance levels and proactively target equipment for replacement.

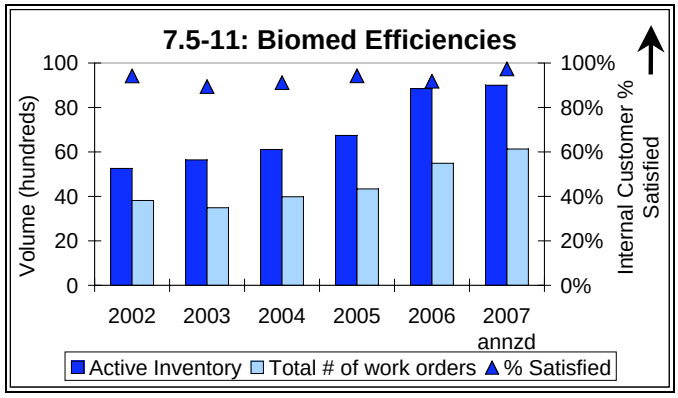


Figure 7.5-12, Marketing Turnaround Time: In 2004, analysis showed an increase in marketing turnaround time and a decrease in internal customer satisfaction with service timeliness. A PI team identified opportunities to improve workflow. Process changes included improvements in the internet-based project tracking system, daily project tracking, and addition of weekly creative meetings.

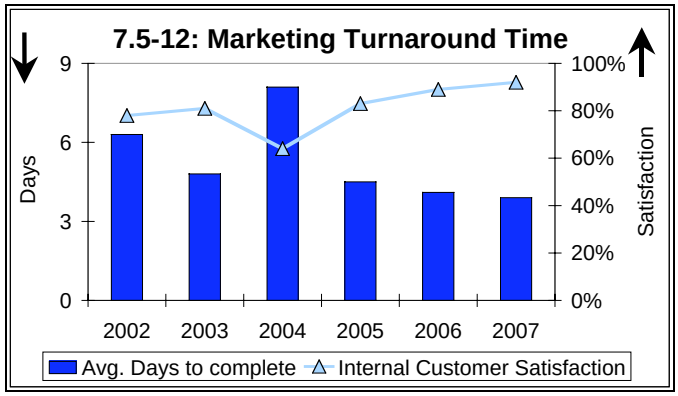


Figure 7.5-13, Valet Parking: Review of customer comment data showed an increase in complaints about parking at MHJ. Using the PDCA model and analysis of best practices at other organizations, the valet parking service was initiated in 2003. The valet service is re-evaluated based on customer feedback and improvements to the process have included contracting with a valet company to improve customer service, moving the valet station to a more visible area and providing patient assistance into the building.

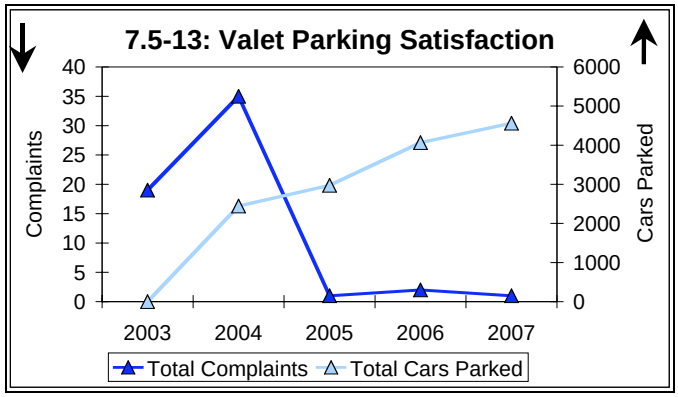


Figure 7.5-14, Interpretive Services Savings: To accommodate diverse patient needs, MHS uses the Language Line at all facilities to effectively communicate with non-English-speaking patients. Because the service is required and not reimbursed, efficiency is essential. MHS negotiates with

vendors to provide a cost-effective service while increasing the language translations provided. Additionally, MHS offers conversational Spanish classes to partners, resulting in less dependency on the Language Line in non-medical situations.

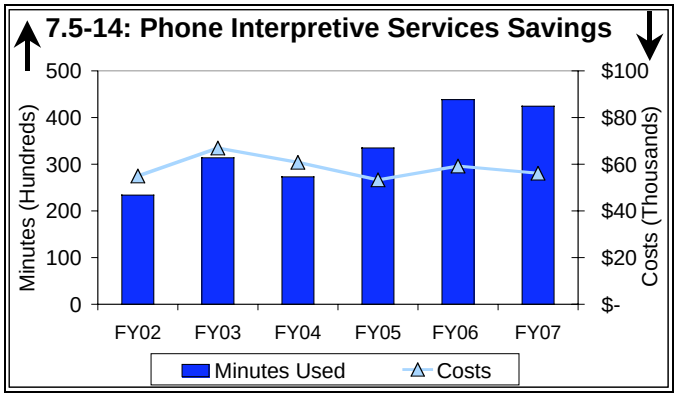


Figure 7.5-15: Supplier Report Cards: MHS uses Supplier Report Cards as a tool to communicate results of strategic business service indicators. Progress is tracked similar to that of the dashboard alert system. Leaders meet with vendors quarterly to discuss results, identify opportunities and develop action plans for red measures. Red or yellow measures provide opportunity for innovation with suppliers.

7.5-15: Supplier Report Cards

Indicator	Q3	Q4	Q1	Q2	Q3	Q4	Indicator	Q3	Q4	Q1	Q2	Q3	Q4
Supplier A							**Supplier F**						
Quality							Quality						
Service							Service						
Partnering							Partnering						
Cost							Cost						
Supplier B							**Supplier G**						
Quality							Quality						
Service							Service						
Partnering							Partnering						
Cost							Cost						
Supplier C							**Supplier H**						
Quality							Quality						
Service							Service						
Partnering							Partnering						
Cost							Cost						
Supplier D							**Supplier I**						
Quality							Quality						
Service							Service						
Partnering							Partnering						
Cost							Cost						
Supplier E													
Quality							*Color Codes for % of Target*						
Service							*Green > 98%;*						
Partnering							*Yellow 93% to 98%; Red < 93%*						
Cost													

Figure 7.5-16: Days of Sales Outstanding: In 2004, MHS encountered issues with invoice inaccuracies from its largest vendor, Cardinal Health, resulting in delay in payment from MHS. MHS worked with the vendor to resolve the issues and developed an accountability mechanism to facilitate more precise tracking of invoices. MHS has an agreement with Cardinal not to exceed three days of sales outstanding.

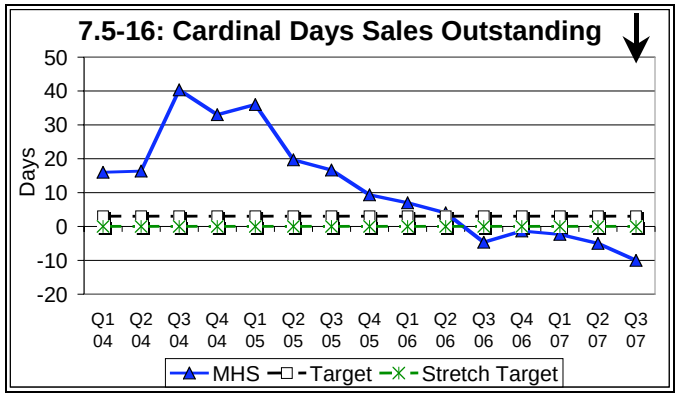


Figure 7.5-17, Supplier Efficiency: Obtaining supplies reliably and effectively is critical to avoiding service delays and providing superior quality care. MHS works with Cardinal Health to ensure supply orders are filled in a timely manner. On-site support from suppliers facilitates quick problem solving and improved invoice accuracy. Electronic data interchange (EDI) measures the percent of orders placed electronically, which increases efficiencies for MHS and the supplier. The target is mutually agreed upon by MHS and Cardinal and is reviewed at the time of contract negotiations.

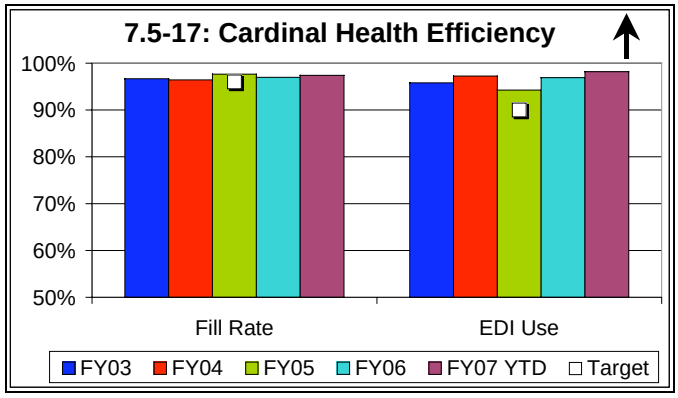


Figure 7.5-18, Alliant Annual Savings: Facilities staff learn of new technology and potential cost savings from journals, site visits, professional organizations, and suppliers. MHS works with Alliant to identify equipment for replacement based on estimated payback and available capital.

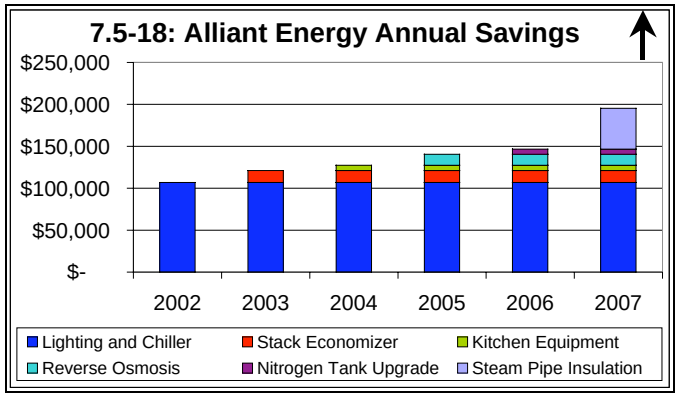


Figure 7.5-19, Pharmacy Purchasing: MHS contracts with McKesson Pharmaceuticals to obtain wholesale drugs for its pharmacies. Service level is a measure of timely delivery and completion of orders. Contract compliance measures MHS's ability to order drugs on contract, decreasing costs and increasing efficiencies. In 2004, the vendor launched a new

ordering system. Staff education was provided and compliance monitored for sustained improvement. A high level of staff competency, quarterly vendor business reviews, and partner feedback on compliance measures has allowed for a sustained level of performance.

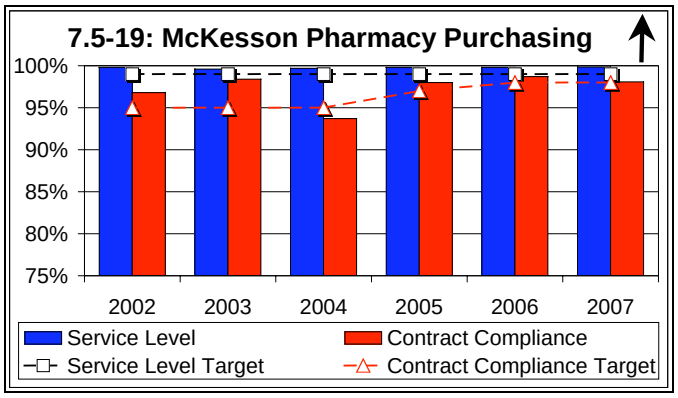
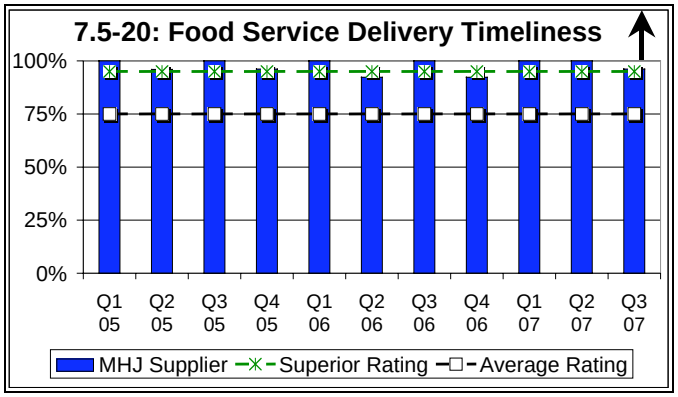


Figure 7.5-20, Food Service Delivery: Timely delivery for food service supplies is essential to maintain efficiency and safety. The International Food Service Distributors Association sets a Superior Rating as on-time delivery greater than 95% of the time. Deliveries at MHS are scheduled during time when food can be stored quickly, maintaining proper temperatures and safety. With the vendor, MHS determined that fill-in drivers were not familiar with MHS delivery expectations. A new process was implemented where new drivers meet with MHS personnel to discuss expectations. The vendor is accountable for these expectations on the vendor report card.



7.6 Leadership Outcomes

EC objectives are included on the system dashboard as shown in Figure 4.1-2. Governance and leadership responsibility measures shown in 7.6 demonstrate success of organizational strategies and commitment to MHS's mission.

7.6a(1) Organizational Strategy and Action Plans:

Figure 7.6-1, Dashboard Goals Achieved: Since FY 03, EC has used a color-coded, system dashboard, balanced by the Four Pillars, to drive performance excellence. Consistent with MHS's value "strive for excellence", the dashboard goals are made more difficult as additional top box benchmarks are incorporated into the visionary strategy. This inspires MHS to reach world-class performance and helps assure MHS's sustainability. Figure 7.6-1 shows the number of system dashboard goals achieved over a five-year period.

7.6-1: System Dashboard Goal Achievement

Visionary Strategy	FY 03	FY 04	FY 05	FY 06	FY 07
Quality	2	2	3	5	6
Excellence in	0	0	1	0	0
Patient Care	0	0	1	0	0
Service	4	6	5	3	7
Exceptional Patient	2	0	1	0	0
and Customer Svc	0	0	0	2	2
Partnering	4	4	5	5	5
Best Place to Work	0	1	0	0	0
	0	0	0	0	0
Cost	3	2	4	3	4
Long-Term	0	2	0	1	0
Financial Success	1	0	0	0	0

Figure 7.6-2, Integrated Comparison, Top Competitors: Verispan publishes annual ratings of integrated healthcare networks (IHNs). MHS has placed in the top quartile of the top 100 IHNs nationwide for the past five years. Ten categories comprise 33 weighted attributes determined to be the key success indicators, and the Integration Composite is the heaviest weighted in the survey. MHS's high level of performance demonstrates commitment to sustaining a strong, quality-focused, integrated healthcare system, partnering with physicians to serve community need.

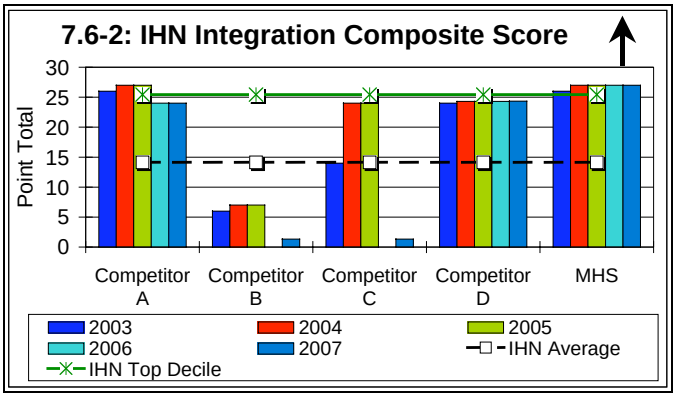


Figure 7.6-3–4, Key Growth Statistics, Referrals: MHS continues to expand services to meet customer needs, remain competitive, and construct a diversified financial base. Steady growth in employed physician partners and MCIC enrollment increases in-system referrals. Employed physicians currently comprise 78% of MHS's medical staffs, compared to 20% for a regional health system competitor. BOD/EC objectives support the strategy to expand services in Walworth and McHenry Counties. As the result of service expansion in Walworth (freestanding ED in 7/01, critical access hospital in 12/05), MWH admissions and MHJ specialty service referrals have increased.

7.6-3: Key Growth Statistics					
Year	Clinics	Employed MDs	Staff Partners	MCIC Enrollees	Net Rev (Millions)
2002	27	212	2,520	29,228	$287.7
2003	29	227	2,680	29,570	$325.7
2004	32	247	2,906	31,930	$380.6
2005	38	261	3,081	30,951	$421.1
2006	39	275	3,324	31,350	$458.5
2007	39	280	3,449	30,032	$490.6
5-Yr Inc	44.4%	32.1%	36.9%	2.8%	70.5%
Best Practice Net Revenue Growth					54.6%

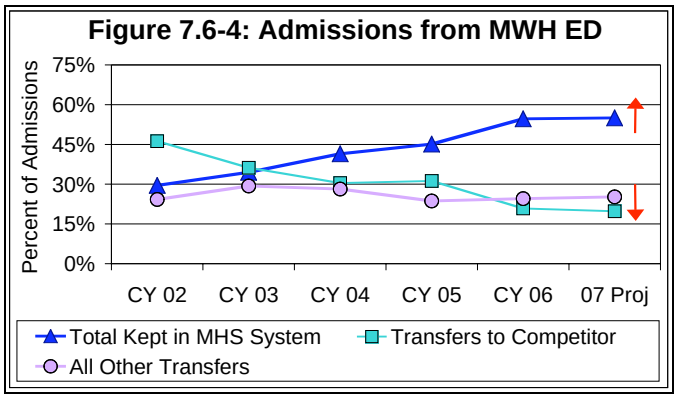


Figure 7.6-5, Physician Board Certification: A key MHS partnering vision goal is to recruit board-certified physicians to ensure high quality MHS physician partners.

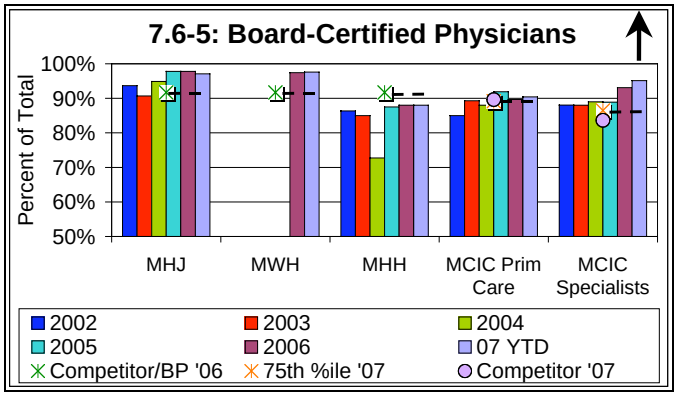


Figure 7.6-6, Average Charge per Discharge: MHS strives to maintain charges at a level that ensures profitability yet maintains affordability to customers. As a result, MHS remains competitive in the marketplace.

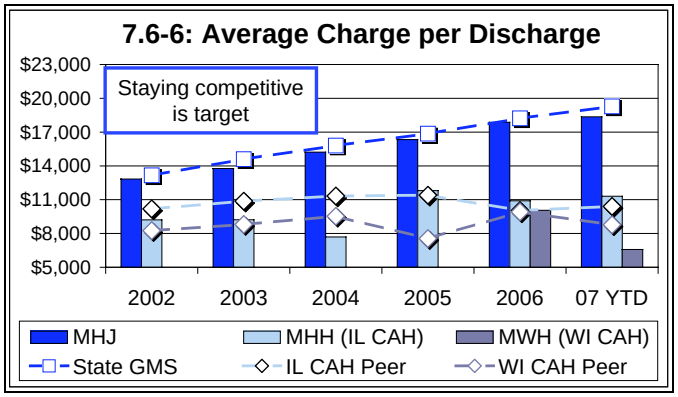
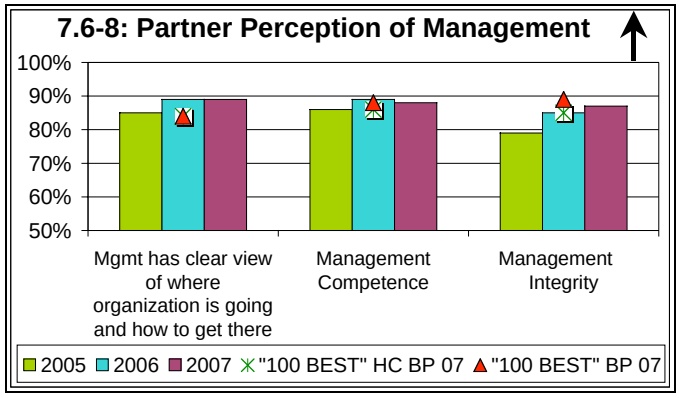


Figure 7.6-7, MBA Scores: MHS has enhanced many of its systems/processes as a result of Baldrige feedback. MHS achieved the WFA Governor's Award in 2003, has received three MBA site visits, and has steadily progressed in meeting the Health Care Criteria for Performance Excellence.

7.6-7: MBA Scores				
	2003	2004	2005	2006
MBA Band Scores	Band 3	Band 4	Band 5	Band 5; 14/19 item scores increased

Figure 7.6-8, Partner Perception of Management: In 2004, MHS began participating in the 100 BEST employee survey. Results demonstrate MHS leaders' ability to convey organizational strategy and commitment into attaining established goals. Question responses about management's integrity and competence indicate a high level of trust.



7.6a(2) Ethical Behaviors and Governance: The MHSC BOD has completed annual self-evaluations for the past nine years. In 2003, MHH BOD completed its first self-evaluation.

Figure 7.6-9, Governance Principles: In 2003, the MHS BODs adopted applicable 21st Century Governance Principles as published by Kennesaw State University in Georgia and approved by the Institute of Internal Auditors. MHS's BODs meet and exceed 100% of these principles.

7.6-9: Governance Principles	BOD Assessment Results
Interaction: Effective interaction among board, management, internal/external auditors	MAI BOD meets qtly. MHSC, MHH, MAC BODs meet bimthly. MHSC's BOD committees meet bimthly, with EC & involved physicians and reviews various reports. Internal/external audits shared at MAI,MHSC BODs reg. basis.
Independence: Majority of directors independent in both fact and appearance	75% MAI BOD members independ 78% MHSC BOD members independ 80% MHH BOD members indepen 42% MAC BOD members independ
Leadership: Separate roles of CEO, BOD Chairs	All MAI Board of Director Chairs are separate and independent from the CEO.
Internal Audit: Internal audit function reports directly to BOD	MHS's effective, full-time internal audit function reports directly to MHSC BOD Finance and Audit Committee and serves all entities.

Figure 7.6-10, Ethical Behavior Measures: MHS has a zero tolerance policy for unethical behavior, and has implemented proactive processes such as training and coding audits. In 2006, MHS implemented a key supplier ethics policy "sign-off" process. The Corporate Compliance Committee monitors processes to assure ethical behavior and addresses concerns.

7.6-10: Ethical Behavior Measures

Key Measures	2003	2004	2005	2006	07 YTD
LG CCP sign off on business practice pol.	NA	NA	100%	100%	Due 10/07
Partner CCP sign off	100%	100%	100%	100%	100%
Hot-line follow up within 48 hours	100%	100%	100%	100%	100%
Ethical policy violation terminations	7	9	7	6	9
Provider coding audit	60	58	110	224	245

7.6a(3) Fiscal Accountability: MHS governance and senior leadership believe regular external audits contribute to fiscal accountability and conduct them for all entities. MHS's auditing firm, hired by the Finance Committee of the BOD, annually reviews accounts receivable, investments, liabilities, and long-term debt. MHS external auditors have never found audit differences, material errors, illegal acts, or material weaknesses in internal controls. MHS has maintained an A2-rating since 1996, a key measure of its commitment to financial stability and long-term viability. Maintaining a consistent rating contributes to bondholder confidence, providing access to capital needed to achieve growth strategies.

7.6a(4) Accreditation/Compliance Results:

Figure 7.6-11-12, Accreditation, Licensure, Compliance: MHS elects to seek accreditation with various bodies to further drive program and service quality. MHS had Joint Commission site visits during 2005 and received full accreditation for all sites. MHS maintains Joint Commission readiness teams to monitor changing criteria and create processes to continuously address compliance. MHS has met standards set by numerous other accreditation bodies and results for licensure and compliance are identified below.

7.6-11: Accreditation Measures

Key Measures	Current Results
Accreditations and Certifications:	
Joint Commission	
MHSC/MMTC/MHH/MHCC	Full 2005-2008
MHSC/MHH Lab	Full 2006-2008
MCIC–NCQA	Full 2007-2010
Radiology–MQSA; ACR	Full 2004-2007
MHJ Intersocietal Comm. Vasc. Labs	Full 2005-2007
National Assoc. of Sleep Programs	
Janesville	Full 2005-2010
Harvard	Full 2007-2012
American College of Surgeons	Full 2006-2010
Commission on Cancer	with Commendations
American Association of Blood Banks	Full 2006-2008
Wisconsin Medical Society of CME	Full 2003-2009
Council for Graduate Medical Educ.	Full 2007-2012
MHSC American Diabetes Assoc.	Full 2005-2008

7.6-12: Licensure and Compliance Measures

Key Measures	Current Results
Licensure for Fiscal Year 2007:	
Staff Licensure	100%
Facility Licensure	100%
Compliance for Fiscal Year 2007:	
Nuclear Regulatory Violations	0 Violations
HIPAA Violations	0 Violations
IRS Violations	0 Violations
FDA Violations	0 Violations
CMS Conditions of Participation	100%

7.6a(5) Organizational Citizenship Results:

Figure 7.6-13, Commitment to Healthy Environment: MHS demonstrates its commitment to the environment and community through initiatives such as infectious waste reduction and mercury elimination. The Waste and Environmental Management Committee conducts education through video audits and waste awareness campaigns. MHJ was one of 14 hospitals in the country awarded the 2006 H2E Environmental Leadership Award for implementing innovative waste reduction programs. MHH and MWH also received awards for launching new programs. Partner and community mercury thermometer exchanges have been conducted since 2003. MHS has contributed almost 20% of the total WI thermometers collected through a WI DNR grant program.

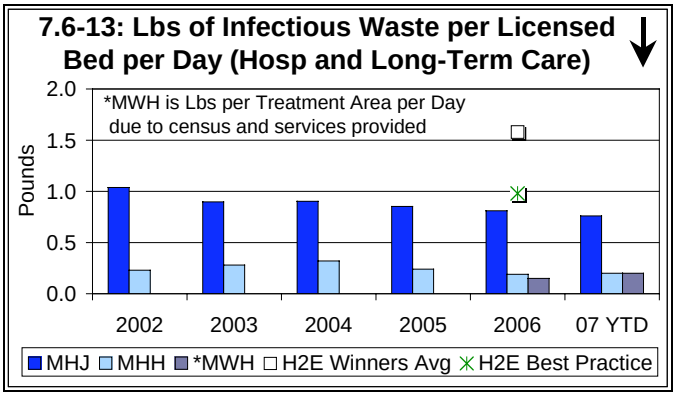
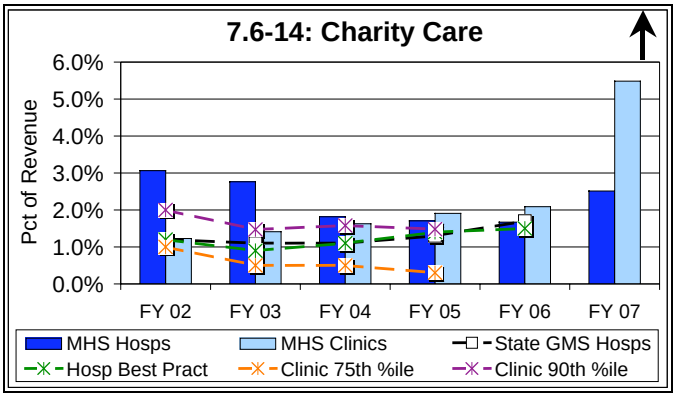


Figure 7.6-14-15, Charity Care, Community Sponsorship: MHS provides charitable care to benefit individuals unable to obtain healthcare services. Increases for FY 07 reflect a changing economy and more uninsured patients. MHS demonstrates its commitment to the community by contributing time and funds to support charitable and service organizations. MHS's support for communities through gifting compares favorably to a Baldrige recipient at $79/FTE.



7.6-15: Charitable Giving by MHS and Partners ($ Thousands)						
Fund	**2002**	**2003**	**2004**	**2005**	**2006**	**07 YTD**
House Mercy	Data removed					
Mercy Hospice						
Leave Sharing						
United Way						
Comm Funding						
MHH Found						
Am Heart Assc						
Total	386.2	341.0	367.7	449.1	497.5	243.7
Per FTE	193	166	161	190	184	90

Figure 7.6-16, Community Contacts: Annually, MHS sponsors thousands of screenings, classes, and wellness events such as health fairs to increase health awareness. Through community needs assessments, MHS maintains connection with its key communities to ensure health improvement and promotion needs are met. Data is segmented by contact type, county and by key communities.

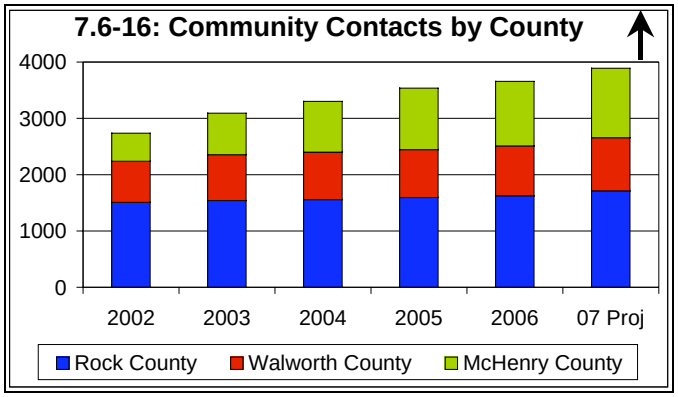


Figure 7.6-17, Corporate Image: Through feedback and use of benchmarks from the 100 BEST, MHS demonstrates that partners feel the organization positively affects the communities served.

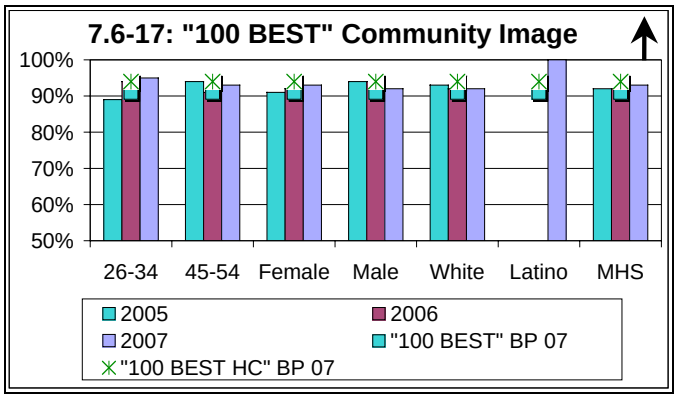


Figure 7.6-18, Recognitions and Awards: Recognition of MHS's community involvement, financial success and employer practices has led to many local, state, and national awards. MHS is proud to receive these awards recognizing its dedication to improving quality, service, partnering, and cost.

7.6-18: Recognition and Awards	
2007	Ranked #2 in nation on AARP's Best Employers for Workers Over 50; Nash Award for innovative programs
	Named to Working Mother magazine's 100 Best Companies for Working Mothers
	16th in Top 100 IHNs by Verispan/*Modern Healthcare*
	Received the Fred Graham Award for Innovation in Improving Community Health for the Janesville Community Health Center
	Outstanding Achievement Certificate for Excellence in Safety from the Wisconsin Council of Safety and the Department of Workforce Development
	H2E Awards: Environmental Leadership for MHJ; Partners in Change and Making Medicine Mercury Free for MHH and MWH
	Named a 100 BEST Adoption-Friendly Workplace by the Dave Thomas Foundation for Adoption
	Employee Services Mgmt. Assoc. Innovation Award
2006	Ranked #1 in the nation on AARP's Best Employers for Workers Over 50
	Working Mother magazine's 100 BEST Companies
	Top 100 IHNs by Verispan/*Modern Healthcare*
	Commission on Cancer, Outstanding Achievement Award for providing excellent care to cancer patients
	Spirit of Excellence Award from *Modern Healthcare* and Sodexho for House of Mercy Homeless Center
	H2E Awards: Environmental Leadership for MHJ, Partners in Change for MWH and MHH; Friend of the Environment Award from Wisconsin Working Group
2005	Top 100 IHNs by Verispan and *Modern Healthcare*
	Most Innovative Program Award by Employee Services Management Association for employee services
	WHA Global Excellence Award and Volunteer Excellence (WAVE) Community Service Program Award, both for the House of Mercy Homeless Center
	AARP Best Employers For Workers Over Age 50, ranked number 11 in the nation
2004	Top 100 IHNs by Verispan and *Modern Healthcare*
	Governor's Forward Award of Excellence for 2003 application, the highest honor bestowed by WFA
	Javon R. Bea named CEO/Employer of the Year by Employee Services Management Association
	American Hospital Association's NOVA Award finalist for effective, collaborative community health programs
	Calif. Pacific Excellence Award for Patient Satisfaction
	United Way Campaign Leadership Circle Award
	WI. Psychological Assoc. Healthy Workplace Award
2003	Mastery Level Wisconsin Forward Award 2002
	One of four finalists in the Foster G. McGaw award recognizing outstanding community service efforts
	Top 100 IHNs by SMG and *Modern Healthcare*
	Eastwood Award, Employee Services Management Association's highest honor
2002	Top 100 IHNs by SMG and *Modern Healthcare*
	McKesson Revenue Cycle Million Dollar Club
	H2E Making Medicine Mercury Free Award and the H2E Partners for Change Award
	Rock County YWCA's Women of Distinction Award

Glossary of Terms and Abbreviations

A

A2	Bond rating which indicates upper-medium-grade obligations
ABCD	Above and Beyond the Call of Duty (reward and recognition program)
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AICPA	American Institute of Certified Public Accountants
ALOS	Average Length of Stay
AMGA	American Medical Group Association
AMI	Acute Myocardial Infarction
AR	Accounts Receivable
AARP	American Association of Retired Persons
ASHHRA	American Society for Healthcare Human Resources Administration
AUR	Available Upon Request

B

BNA	Bureau of National Affairs
BOD	Board of Directors
BP	Best Practice
BSI	Blood Stream Infection

C

C&C	Cruise & Connect Committee
CAHPS	Consumer Assessment of Heath Plans Survey
CAP	Community-Acquired Pneumonia
CCC	Customer Comment Card; completed by a Mercy Partner at the time of a compliment or concern
CCP	Corporate Compliance Plan
CEO	Chief Executive Officer
CHC	Community Health Center, Inc.
CHF	Congestive Heart Failure
CME	Continuing Medical Education; formal education for medical professionals, including seminars, conferences, and courses
CMOS	Critical Moments of Service; formal training program to enhance customer service
CMS	Centers for Medicare and Medicaid Services
COE	Culture of Excellence; strategic initiative to achieve optimal customer satisfaction
COE-I	Culture of Excellence Institute; formal orientation program for new employees
COE-SC	Culture of Excellence Steering Committee
CRD	Customer Relations Department
CRM	Customer Relationship Management
CT	Computed Tomography, also known as CAT scan
CY	Calendar Year

D

DBV	Design, Build and Validate
DME	Durable Medical Equipment
DO	Doctor of Osteopathy

E

EAP	Employee Assistance Program
EC	Executive Council; comprised of the CEO, vice presidents, and Director of Medical Affairs
ED	Emergency Department
EMR	Electronic Medical Record
EOC	Environment of Care
EOP	Emergency Operations Plan

F

FDA	Food and Drug Administration
FMEA	Failure Modes and Effects Analysis; proactive method of identifying and preventing errors before they occur
FTE	Full Time Equivalent
FY	Fiscal Year; MHS fiscal year is July 1st to June 30th

H

H2E	Hospitals for a Healthy Environment
HCAHPS	Hospital Consumer Assessment of Health Plans Survey
HC BP	Healthcare Best Practice
HEDIS	Health Plan Employer Data and Information Set
HICS	Hospital Incident Command System
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
H&P	History & Physical
HPG	Healthtrust Purchasing Group

HQA Hospital Quality Alliance

HR Human Resources

I

ICU Intensive Care Unit

IHA Illinois Hospital Association

IHI Institute for Healthcare Improvement

IHN Integrated Health Networks

IM Internal Medicine (Physician Specialty)

IMAC Information Management Advisory Committee

IM Plan Information Management Plan

IMRT Intensity Modulated Radiation Therapy; a state-of-the-art technique used to treat tumors with minimal harm to healthy tissue

Ingenix National organization that provides comparative financial data for healthcare organizations

IRS Internal Revenue Service

IS Information Systems

J

JMC Janesville Medical Center; Mercy Health System Corporation subsidiary with unionized workforce

L

LDA Leadership Development Academy; internal management development program

LDR Leader

LEAD Listen, Empathize, Acknowledge, Apologize, Action, Direct, and Document; service recovery acronym used by partners

LG Leadership Group; comprised of the MHS CEO, vice presidents, directors, and managers

LMS Learning Management System

LOS Length of Stay

LTAP Long-Term Action Plan

LVF Left Ventricular Function

LVSD Left Ventricular Systolic Dysfunction

M

MAC Mercy Assisted Care, Inc.; assisted care support services, a subsidiary of Mercy Alliance, Inc.

MAI Mercy Alliance, Inc.; parent company and legal name of the organization

MBA Malcolm Baldrige Award

MCIC MercyCare Insurance Company; insurance company subsidiary of Mercy Health System Corporation

MGMA Medical Group Management Association

MHCC Mercy Harvard Care Center

MHH Mercy Harvard Hospital (Harvard, IL); subsidiary of Mercy Alliance, Inc.

MHJ Mercy Hospital (Janesville, WI); operating division of Mercy Health System Corporation

MHS Mercy Health System; commonly recognized name for Mercy Alliance, Inc.

MHSC Mercy Health System Corporation; subsidiary of Mercy Alliance, Inc. which includes MHJ and all clinics

MILE Mercy Institute for Leadership Excellence; provides resources for leadership development

MIP Maryland Indicator Project; national project that gathers and reports quality indicators

MLC Mercy Learning Center, brand name of learning system

MMTC Mercy Manor Transition Center, a sub-acute skilled nursing facility located in MHJ

Moody's Moody's Investors Service; national bond rating agency

MRI Magnetic Resonance Imaging; diagnostic imaging system

MUHL Madison United Healthcare Linen; joint venture of four Wisconsin healthcare organizations

MWH Mercy Walworth Hospital and Medical Center

N

NCC No Competitor Comparison

NCQA National Committee for Quality Assurance; voluntary accrediting agency for health plans

NNIS National Nosocomial Infection Surveillance; infection control database used for quality assurance

NPSG National Patient Safety Goals

NRC Nuclear Regulatory Commission

O

OASIS Outcomes Assessment Information Set; database of outcomes from Medicare-licensed home health agencies

OSHA Occupational Safety and Health Administration; federal agency committed to workplace injuries

P

P&T Pharmacy and Therapeutics (Committee)

PACS Picture Archiving Communications System; digital technology facilitating film-less diagnostics

PDA Personal Digital Assistant; technology facilitating remote and efficient access to information

PDCA Plan, Do, Check, Act (Quality Improvement Cycle)

PDP Personal Development Plan

PET Positron Emission Tomography

PI Performance Improvement

PIP Physician Incentive Program

PPA Partner Performance Appraisal

PG Press, Ganey Associates, Inc.

POS Point of Service

Q

Quality Council Coordinating body for clinical performance improvement activities

R

R&R Recruitment and Retention

RRT Rapid Response Team

S

SE Service Excellence

SO Strategic Objective

SPP Strategic Planning Process

SRP Service Recovery Program

SRS Service Recovery Score

STAP Short-Term Action Plan

STAR Someone to Admire and Respect; reward and recognition program

SWOT Strengths, Weaknesses, Opportunities, Threats Analysis

T

TACT Targeted Aggression Control Training

TAT Turnaround Time

U

UTI Urinary Tract Infection

V

VAP Ventilator-Associated Pneumonia

Verispan Formerly SMG Marketing Group Inc; rates integrated health networks on performance and integration

VP(s) Vice President(s)

VPO Vice President Operations Team

W

WFA Wisconsin Forward Award; state quality award modeled after the MBA

WHA Wisconsin Health and Hospital Association, State of Wisconsin

Y

YTD Year to Date