

St David's HEALTHCARE

2014



Malcolm Baldrige National Quality Award Application

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Glossary of Acronyms

Acronym	Definition
A/R	Accounts Receivable
AA	Adjusted Admission
ABX	Abbreviation for antibiotics
ACC	American College of Cardiology
ACE	Academy for Clinical Excellence
ACEI	Angiotensin Converting Enzyme Inhibitor
AD	Active Directory
ADA	American with Disabilities Act
AFIB	Atrial Fibrillation
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research and Quality
AIDET	Acknowledge, Introduce, Duration, Explanation and Thanks
AMA	Abbreviation for leaving against medical advice
AMI	Acute Myocardial Infarction
AP	Action Plan
APD	Adjusted Patient Day
ARB	Angiotensin Receptor Blocker
ASC	Ambulatory Surgery Center
ASTD	American Society for Training and Development
AVG	Abbreviation for average
AVP	Associate Vice President
BM	Abbreviation for benchmark
BMT	Bone Marrow Transplant
BOG	Board of Governors
BOTS	Board of Trustees
BSN	Bachelor of Science in Nursing
BW	Bi-weekly
C.N.A.	Certified Nursing Assistant
CAGR	Compound Annual Growth Rate
CAPHMPC	Capital Area Public Health and Medical Preparedness Coalition
CARTO 3	Sophisticated system of electroanatomical mapping used to reconstruct the cardiac chambers and to ablate some of the most common arrhythmias
CATRAC	Capital Area Trauma Regional Advisory Committee
CC	Core Competencies
CE	Clinical Excellence
CEO	Chief Executive Officer
CEOC	CEO Council

Acronym	Definition
CEU	Continuing Education Unit
CFET	Customer Focus and Engagement Team
CFO	Chief Financial Officer
CHF	Congestive Heart Failure
CHOIS	Comprehensive Health Outcomes Information System
CIO	Chief Information Officer
CLABSI	Central Line Associated Blood Stream Infection
CME	Continuing Medical Education
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid
CNA	Community Needs Assessment
CNO	Chief Nursing Officer
CO2	Carbon Dioxide
COMET	Database used to capture and manage CMS clinical process measures
COO	Chief Operating Officer
CPR	Cardiopulmonary Resuscitation
CRD	Clinical Resource Director
CV	Cardiovascular
DVT PE	Deep Vein Thrombosis Pulmonary Embolism
EA	Environmental Assessment
EAG	Employee Advisory Group
EBITDA	Earnings Before Interest, Taxes, Debt and Amortization
ECG	Electrocardiogram
ECO	Ethics & Compliance Officer
ED	Emergency Department
EEOB	Equivalent Employees per Occupied Bed
EEOC	Equal Employment Opportunity Commission
EKG	Electrocardiogram
EMR	Electronic Medical Record
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EP	Electrophysiology
ER	Emergency Room
ESSC	Employee Safety and Security Committees
F	Frequency
FDA	U.S. Food and Drug Administration
FECC	Facility Ethics and Compliance Committee
FMEA	Failure Mode Effect Analysis
FSED	Free-Standing Emergency Department

Acronym	Definition
FTE	Full-Time Equivalent
GHF	Georgetown Health Foundation
GI	Gastrointestinal
GN	Graduate Nurse
HAC	Hospital Acquired Condition
HCA	Hospital Corporation of America
HCAHPS	Hospital Consumer Assessment of Providers and Health Systems
HCAPS	HCA Physician Services
hCARE	A software integration tool to link a physician practice EMR to a HCA facility
HCMG	Healthcare Market Guide, authored by PRC
HF	Heart Failure
HHA	Heart Hospital of Austin
HIE	Health Information Exchange
HIM	Health Information Management
HIPAA	Health Insurance Portability and Accountability Act
HITECH	Government program for Meaningful Use
HMM	Harvard Manager Mentor - series of online management courses
HPG	HealthTrust Purchasing Group
HR	Human Resources
HRA	Health Risk Assessment
HROne	Name of HCA Centralized Human Resource model
HVAC	Heater, Ventilation, Air Conditioning
ICARE	SDH's Values: Integrity, Compassion, Accountability, Respect and Excellence
ICC	Integrated Care Collaborative
IFL	St. David's Institute for Learning
INF	Infection
IOM	Institute of Medicine
IP	Inpatient
IS	Information Systems
IT	Information Technology
IT&S	Information Technology and Support
LAQ	Leadership Academy Quarterly
LDQ	Leadership Development Quarterly
LEAN	Methodology for reducing waste and rework
LEM	Leadership Evaluation Manager
LMS	Learning Management System
LOS	Length of Stay

Acronym	Definition
LPT	Left Prior to Triage in the Emergency Department
LPTMSE	Left Prior to Medical Screening Exam by an ED Physician
LT	Long Term
LVS	Left Ventricular Systolic - measurement of the function of the left side of the heart
LVSD	Left Ventricular Systolic Dysfunction
M	Month
M3	Physician Practice Satisfaction Tool offered through a website
MAN	Metropolitan Area Network
MD	Medical Doctor
MEC	Medical Executive Committee
Med Axiom	Database for Cardiology
MFM	Maternal Fetal Medicine
MGPS	Medical GPS - software vendor for M3 physician practice patient satisfaction tool
MOR	Monthly Operating Reviews
MVVG	Mission, Vision, Values and Goals
NEO	New Employee Orientation
NEURO	Abbreviation for Neuroscience
NICU	Neonatal Intensive Care Unit
NIMS	National Incident Management System
NR	Net Revenue
NRC	National Research Corporation
OB	Obstetrics
OD	Organizational Development
OP	Outpatient
OPPE	Ongoing Physician Performance Evaluation
OPTT	Outpatient Tests and Treatments
OR	Operating Room
ORTHO	Orthopedics
PACS	Picture Archival and Communication System
PCI	Percutaneous Coronary Intervention
PCM	Patient Call Manager
PCP	Primary Care Physician
PCT	Patient Care Technician
PCTI	Patient Care Technician Intensive
PDCA	Plan, Do, Check, Act
PDS	Patient Data System
PI	Performance Improvement
PLUS	Productivity Labor Utilization System

Acronym	Definition
PN	Pneumonia
POA	Present On Admission
pRBC	Packed Red Blood Cells
PRC	Survey Vendor
PRN	As needed staff
PSA	Primary Service Area
PSR	Physician Sales Representative
PTO	Paid Time Off
Q	Quarterly
QRS	Quality Review System
RN	Registered Nurse
ROA	Return on Assets
ROI	Return on Investment
RVU	Relative Value Unit
S	System
SA	Strategic Advantage
SANE	Sexual Assault Nurse Examiner
SAPortal	Website for IT&S Security Officer to manage security risks
SBAR	Situation, Background, Assessment, Recommendation – acronym for successful handoff of patient information
SC	Strategic Challenge
SCD	Supply Chain Director
SCIP	Surgical Care Improvement Processes
SDF	St. David's Foundation
SDGH	St. David's Georgetown
SDH	St. David's HealthCare
SDHMG	St. David's HealthCare Medical Group
SDMC	St. David's Medical Center
SDNAMC	St. David's North Austin Medical Center
SDRRMC	St. David's Round Rock Medical Center
SDS	Same Day Surgery
SDSAMC	St. David's South Austin Medical Center
SL	Abbreviation for service line
SLA	Security Level Assessment
SMART	Supply Management and Resource Tracking System
SMAT	Supply Management Action Team
SNAP	Specialty Nurse Accelerated Program offered through the Institute for Learning
SO	Strategic Objective
SPP	Strategic Planning Process
SQI	ASC database for tracking metrics
SSA	Secondary Service Area

Acronym	Definition
STaR	Successful Transition and Retention program
STEMI	ST Elevation Myocardial Infarction
STK	Abbreviation for Stroke
SVP	Senior Vice President
SVPCI	Senior Vice President of Clinical Innovation
SWAP	System-wide Action Plan
SWB	Salaries, Wages and Benefits
SWOT	Strength, Weakness, Opportunity, Threat
SWT	System-wide Tactic
TAT	Turnaround Time
TCAI	Texas Cardiac Arrhythmia Institute
TDH	Texas Department of Health
THA	Texas Hospital Association
THCIC	Texas Health Care Information Council
TJC	The Joint Commission
TMS	Talent Management System
TNS	Taylor Nelson Sofres – vendor for employee engagement survey
TTY	Teletype – text telephone
TX	Texas
U.S.A.	United States of America
UCC	Urgent Care Center
UDS	Uniform Data System
UT	University of Texas
VM	Virtual Machine
VM ware	Software to manage virtual machines
VOC	Voice of the Customer
VP	Vice President
VTE	Venous Thromboembolism
W	Weekly
YTD	Year To Date

Preface: Organizational Profile

P.1 Organizational Description

P.1a Organizational Environment

With a vision of being “the finest care and service organization in the world,” St. David’s HealthCare (SDH) provides exceptional care to every patient, every day as it serves the residents of Central Texas. The Austin-based organization dates back to 1924, when St. David’s Hospital opened its doors as a small, not-for-profit community hospital. In 1996, St. David’s Foundation (SDF) recognized the need to strategically position St. David’s Hospital for the rapidly changing health care environment and entered into an innovative joint venture with for-profit Hospital Corporation of America (HCA) to form SDH, bringing together the business acumen of HCA and the conscience of the community through SDF. In 2006, Georgetown Health Foundation (GHF) entered the joint venture, adding its individual hospital, and longtime local commitment to the system. Since then, SDH has acquired additional facilities and expanded beyond the hospital setting to offer a full continuum of care and establish itself as a regional medical hub, touching more than 1,000,000 lives each year. Together, “sponsors” SDF, HCA and GHF own the assets of SDH, and balance the needs of the diverse SDH stakeholders.

To support its mission of providing exceptional care, SDH adopted the Baldrige Criteria for Performance Excellence and continues to use the Criteria to drive improvement across the organization. SDH earned the Texas Award for Performance Excellence in 2008, and in 2012 Truven Health Analytics (formerly Thomson Reuters) recognized SDH as one of the nation’s top 15 health systems based on its performance in key measures of clinical quality, patient satisfaction and operational efficiency. These milestones mark SDH’s progress toward becoming the finest care and service organization in the world.

P.1a (1) Healthcare Service Offerings. SDH provides exceptional care and service to every patient, every day through a full continuum of care. The organization’s main health care service offerings are: Inpatient services, Emergency services, Outpatient services and Physician practices.

SDH earns roughly two-thirds of its margin from its inpatient services. The remaining third comes from the combined operations of its emergency services, outpatient services and physician practices.

SDH delivers its services primarily through the hospitals described in P.1a(4). Emergency care is provided through hospital-based emergency departments, 4 free-standing EDs (FSED) and 4 urgent care clinics. While outpatient services are primarily hospital-based, SDH offers outpatient surgical services through 6 ambulatory surgery centers (ASC). The SDH Medical Group (SDHMG), comprised of 13 physician practices, provides care in 29 primary locations throughout Central Texas in the areas of Primary Care, Cardiology, Neurosciences, and a wide array of Specialty Care.

P.1a (2) Vision & Mission. The Vision, Mission and ICARE Values (Figure P.1-1) establish the foundation for the

FIGURE P.1-1: VISION, MISSION & VALUES

Vision
To be the finest care and service organization in the world.
Mission
To provide exceptional care to every patient, every day with a spirit of warmth, friendliness and personal pride.
Goals
Exceptional Care • Customer Loyalty • Financial Strength
ICARE Values
Integrity • Compassion • Accountability • Respect • Excellence

SDH culture and focus the organization on providing exceptional care to every patient, every day. SDH’s Vision to be the finest care and service organization in the world is intended to inspire its workforce toward ever-improving performance. In addition, SDH uses three overarching Goals to provide the framework for accomplishing its Mission and Vision. The three Goals – Exceptional Care, Customer Loyalty and Financial Strength – are the key areas of strategic focus for SDH and provide the structure for the organization’s cascading measurement system. The values of Integrity, Compassion, Accountability, Respect and Excellence form the foundation of the SDH culture and are referred to as the ICARE Values. To reinforce the Values across the organization, SDH established the ICARE Commitment to Values that details specific behavioral standards aligned with each Value. Figure P.1-2 presents a sample of these Commitments.

To accomplish the Mission, SDH leverages its core competencies:

- Providing clinical expertise
- Ensuring a culture of excellence
- Collaborating with physicians
- Strong operating discipline

P.1a (3) Workforce Profile. SDH’s workforce groups are employees and physicians (Figure P.1-3). As the area’s fourth largest employer, SDH has just over 7,400 employees in the groups and segments presented in Figure P.1-4. Educational

FIGURE P.1-2: SAMPLE ICARE COMMITMENT TO VALUES

INTEGRITY – <i>Be Honest and Do What You Say</i>
<ul style="list-style-type: none"> • I am trusted by my patients and coworkers • I can be counted on to do the right thing
COMPASSION – <i>Be Sympathetic to the Needs of Others</i>
<ul style="list-style-type: none"> • I show warmth, friendliness and personal pride in all of my interactions • I respond to customer requests and concerns in a timely manner
ACCOUNTABILITY – <i>Take Ownership for How Actions Impact Outcomes</i>
<ul style="list-style-type: none"> • I introduce myself to others and wear my badge at all times • I explain procedures and sequence of events to customers in clear and understandable terms
RESPECT – <i>Value Others and Embrace Diversity</i>
<ul style="list-style-type: none"> • I treat everyone with dignity, valuing each person individually • I give my full attention, listen carefully and ask clarifying questions to understand others’ perspectives
EXCELLENCE – <i>Take Personal Pride in Exceeding Expectations</i>
<ul style="list-style-type: none"> • I seek new and better ways to improve my performance • I take initiative to improve service and care

and certification requirements for each position are detailed in individual job descriptions. Over 1,600 physicians are credentialed on the medical staffs of its hospitals, including over 150 physicians employed through the SDHMG. SDH also contracts with independent physician groups to provide hospital-based services, including hospitalists, emergency care, anesthesia and radiology. The remaining physicians on SDH’s medical staffs are independently employed but have privileges to see patients at various SDH facilities. **Figure P.1-3** summarizes key engagement factors for each workforce group.

Workforce health and safety requirements mirror most health care organizations and are addressed through the organization’s Healthy Work Environment program [5.1b(1)]. The benefits offered to the SDH employees are highlighted in 5.1b(2). SDH facilities, which are union free, have been recognized as a “Best Place to Work” by state and regional organizations for several years.

P.1a (4) Assets. SDH’s major facilities are highlighted in **Figure P.1-5**. Since 2000, SDH has invested over \$1 billion in these facilities and their clinical capabilities without incurring any debt. Remaining debt free gives SDH a strategic advantage that allows the organization to continue to invest in the latest technology. Major technology is strategically deployed within SDH, including the Carto 3RMT 3-dimensional mapping system for cardiac arrhythmias, robotic-assisted MAKO Surgical Technology for partial knee replacements, navigation-assisted anterior total hip replacement, digital radiology and several DaVinci Surgical Robots, including the first DaVinci Xi system in the world. In addition, SDH invests in ongoing information technology upgrades that support its mission of

FIGURE P.1-3: SDH WORKFORCE	
Workforce Groups	Key Engagement Factors
Employees	<ul style="list-style-type: none"> • Culture • Leadership • Staffing • Quality
Physicians • <i>Employed/Contract</i> • <i>Independent</i>	<ul style="list-style-type: none"> • Efficient processes • Communication • Staff competence

providing exceptional care to every patient, every day and position the organization for optimal performance under health care reform. The Meditech platform for clinical documentation is standardized at all SDH facilities, enabling patient care providers to communicate seamlessly from one facility to another. The platform is the same one used by 160+ HCA hospitals across the country, with standardized fields and data definitions to support robust and meaningful data mining opportunities.

P.1a (5) Regulatory Requirements. SDH operates in a highly regulated health care environment and has mechanisms in place to meet or exceed relevant laws, regulations and standards. To support delivery of exceptional care, SDH also strategically pursues voluntary accreditations through organizations such as The Joint Commission (Stroke Center of Excellence), Commission on Cancer, American Society for Metabolic and Bariatric Surgery (Center of Excellence), Centers for Medicare and Medicaid Services (Transplant Center), American College of Surgeons (Trauma Centers), Texas Nurses Association, National Commission on Quality Assurance and Accreditation Association for Ambulatory Health Care.

P.1b Organizational Relationships

P.1b (1) Organizational Structure. SDH’s governance system (**Figure P.1-6**) consists of the SDH Board of Governors (BOG), hospital-specific Boards of Trustees (BOTs), facility Medical Executive Committees (MECs) and SDHMG Boards. Each of the ASC’s has individual Boards that oversee the operations of each surgery center. The SDH CEO Council

FIGURE P.1-4: EMPLOYEE PROFILE		
Role	Nursing direct care	40%
	Patient care support	23%
	Allied health practitioners	24%
	Management/supervisory	9%
	Clerical/administrative	4%
Gender	Female	79%
	Male	21%
Classification	Full-Time	77%
	Part-Time	9%
	PRN	14%
Tenure	Employed less than 1 year	22%
	Employed 1-4 years	39%
	Employed 5-9 years	20%
	Employed 10-14 years	10%
	Employed 15-19 years	5%
	Employed 20+ years	4%
	Ethnicity	White
Hispanic		18%
Black		9%
Asian		7%
Other		2%

FIGURE P.1-5: MAJOR SDH FACILITIES	
Six acute-care hospital campuses and associated services	Licensed Beds
St. David’s South Austin Medical Center (SDSAMC)	304
St. David’s Medical Center (SDMC)	414
Heart Hospital of Austin* (HHA)	58
St. David’s Georgetown Hospital* (SDGH)	98
St. David’s North Austin Medical Center (SDNAMC)	332
St. David’s Round Rock Medical Center (SDRRMC)	169
Total Acute Care licensed beds	1,375
SDHMG	Locations
Managed Physician practices – 13 total	29
Outpatient Surgery	# OR’s
Ambulatory Surgery Centers – 6 total	35
*SDGH and HHA are licensed under SDMC, so they are combined with SDMC for some deployment and reporting purposes.	

is the primary management structure supported by executive leadership teams at each hospital, the medical group and the ambulatory surgery division.

Governance - The SDH BOG has 13 members, including clearly defined representation from sponsor organizations SDF, HCA and GHF, as well as physicians and community members. The SDH Chief Executive Officer and Chief Financial Officer serve as ex officio members and provide regular operational updates to the BOG. The BOG meets bimonthly to provide direction and oversight to SDH and has delegated limited responsibilities for quality assessment and improvement to the hospital-based BOTs. The BOTs are populated to reflect the communities served by their respective hospitals.

In addition to the SDH BOG and hospital-based BOTs, SDHMG has four boards organized by Primary Care, Cardiology, Specialty Providers and Neurosurgeons. Each board has at least three practicing physicians and representation from SDH administration. Also, each ASC has a separate board. These boards have responsibility for all credentialing, quality assurance, utilization review and peer review policies.

Management - CEO Council. The SDH CEO leads the CEO Council, comprised of the CEOs from each hospital with the SDH CFO, Chief Information Officer, Chief Legal Officer, Chief Medical Officer, and Vice Presidents of Strategic Planning, Clinical Innovation, Human Resources, Quality, Physician Services, Sales, Business Development, Facilities and Performance Improvement. The CEO Council meets biweekly to direct and manage operations of the organization. Each hospital also has a facility-specific executive team, including a Hospital CEO, COO, CNO, CMO, CFO and an HR representative. The SDHMG leadership team led by the VP of Physician Services is comprised of the Director of Operations, CEO of Austin Heart, Area Practice Managers and a controller. The ASC Leadership Team is led by the VP of Operations

FIGURE P.1-7: SDH PATIENT & OTHER CUSTOMER GROUPS

Key Patient & Other Customer Groups	Key Requirements
Patients <ul style="list-style-type: none"> • Inpatient • Emergency • Outpatient • Physician Practice 	<ul style="list-style-type: none"> • Consistent quality and service • Communications • Responsiveness • Smooth transitions of care
Community	<ul style="list-style-type: none"> • Physician affiliations • Convenient locations • Previous experience

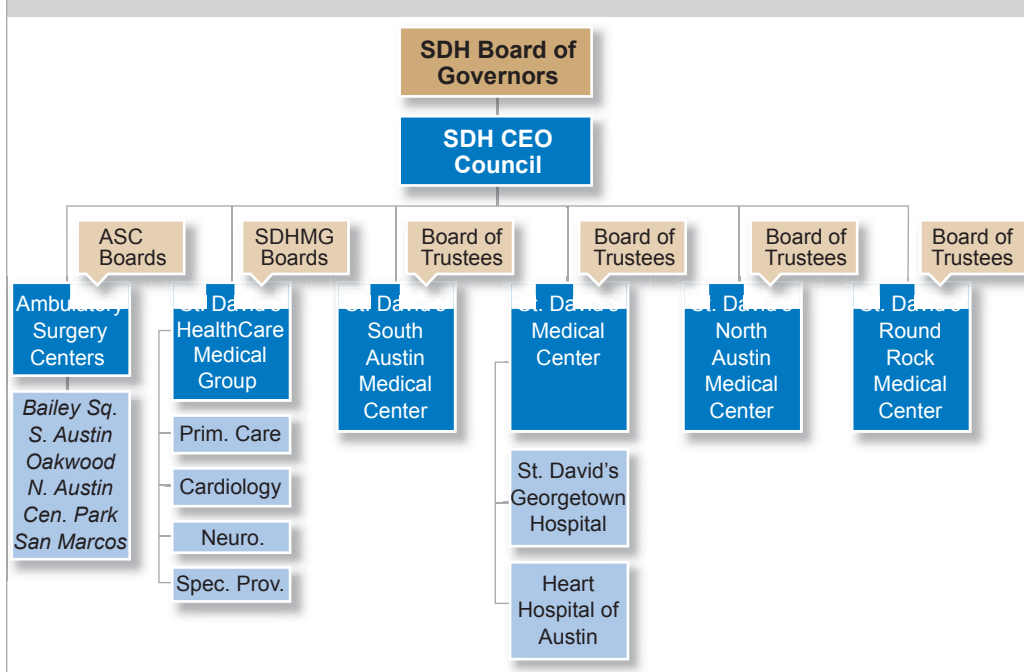
and includes the ASC Center Administrators, Clinical Director and Business Director. SDH outsources the management of the ASCs to HCA's Ambulatory Surgery Division through a management services agreement. Both the VP of Physician Services and VP of Operations have dual reporting relationships to the SDH CEO and HCA.

Medical Staff - Each licensed acute-care hospital has a medical executive committee (MEC) comprised of the Chief of Staff, Vice Chief of Staff and the Chairs of each medical staff department. These leaders are elected by their physician peers. The MECs provide oversight for the credentialed medical staff, including quality and credentialing. One MEC serves SDMC, SDGH and HHA, which are all under one Medicare provider number. The Capital Area Primary Care, Capital Area Cardiology, Capital Area Specialty Providers and Capital Area Neurosurgeon Boards, comprised of physician leaders, provide oversight for the clinical care provided in the physician practices.

P.1b (2) Patients, Other Customers and Stakeholders. SDH's key healthcare market segments are cardiac, neurosciences, women's/NICU, general surgery and orthopedics. [Figure P.1-7](#) highlights the organization's key patient and stakeholder groups and their key requirements of SDH.

P.1b (3) Suppliers and Partners. SDH outsources the supply chain management, as a part of the management services agreement with HCA, to Parallon. Parallon is an HCA subsidiary that manages the SDH supply chain and provides staffing for key support departments. As a group purchasing organization, Parallon negotiates nationwide contracts but maintains a local supply distribution center in Central Texas to serve SDH facilities. A local HCA-employed supply chain director and facility-specific supply chain staff ensure that Parallon meets SDH requirements related to quality, delivery and cost of supplies. Multidisciplinary Supply Management Action Teams (SMAT) at each facility provide input into sup-

FIGURE P.1-6: SDH LEADERSHIP & GOVERNANCE STRUCTURE



ply, equipment and technology selection and standardization. A database called SMART supports electronic ordering and quarterly reports to track supply chain performance relative to service agreements. The supply chain director participates in all SDH leadership events.

Parallon also provides staffing for patient accounting, information technology and revenue cycle. A management services agreement between SDH and HCA details SDH requirements, with primary oversight responsibility assigned to the SDH CFO. Employees provided through Parallon are fully integrated into SDH operations, programs and communications.

SDH considers its key partners to be its three sponsor organizations — SDF, HCA and GHF, which jointly own the assets SDH uses to deliver health care services. The sponsors provide oversight and direction to SDH through the BOG, which receives updates from SDH CEO and CFO at its bimonthly meetings. Also, as part of the formal joint venture agreement, a percentage of SDH earnings go to SDF to support community organizations in the SDH service area.

Key collaborators for SDH include affiliate hospitals and regional emergency medical service providers.

- SDH has affiliation agreements with three hospitals in its rural service area [3.2b(1)]. SDH collaborates with these hospitals on procedures and protocols to improve care for patients transferring to SDH facilities, and in some cases, provides physicians to staff key departments. An SDH executive serves on the affiliate Boards, and the affiliates attend the Board Retreat to provide input into the Strategic Planning Process (SPP).
- SDH has a formal collaboration with a regional EMS provider that includes data sharing, integrated resource planning and efficient transport services to SDH patients. SDH outreach coordinators also regularly visit other EMS stations and participate with them on a regional advisory council [3.2b(1)].

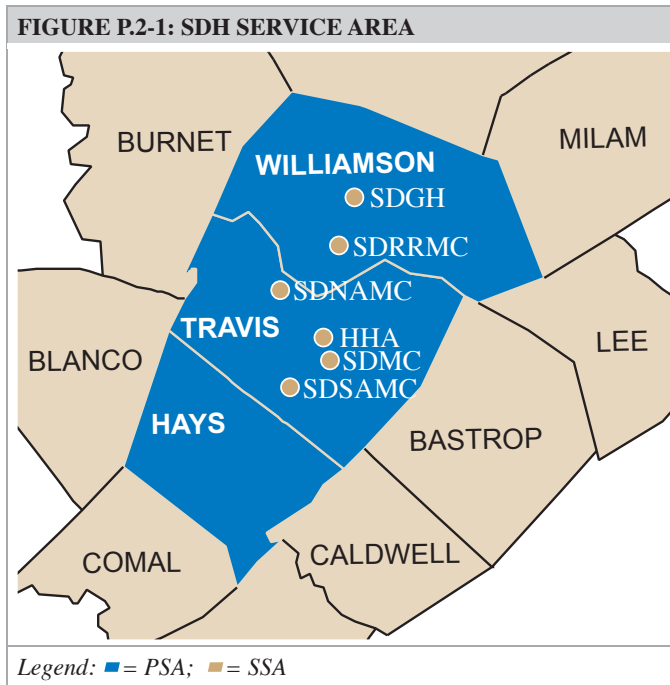


FIGURE P.2-2: KEY COMPARATIVE DATA SOURCES

National Database	Purpose
Comprehensive Health Outcomes Information System (CHOIS)	National database of risk-adjusted clinical indicators
CMS Hospital Compare website	Publicly reported indicators
HCA	Operational & financial metrics
HCA Physician Services (HCAPS)	Operational metrics from HCA physician practices
Texas Hospital Association (THA)	Market share
TNS International	Employee engagement
PRC	Physician engagement
Gallup	Patient satisfaction (inpatient, emergency, outpatient)
Medical GPS (MGPS)	Patient satisfaction (SDHMG)
National Research Corp. (NRC)	Community perception
Moody's	Financial performance

P.2 Organizational Situation

P.2a Competitive Environment

P.2a (1) Competitive Position. SDH’s primary service area (PSA) encompasses Hays, Travis and Williamson counties in central Texas. Its secondary service area (SSA) encompasses seven surrounding counties. The entire service area, representing a population of more than 1.8 million, is one of the fastest growing geographies in the nation (Figure P.2-1).

SDH is the leading health care provider in its PSA. Despite the presence of 20 hospitals in the PSA and five more in the SSA, SDH competes almost entirely with the Seton Family of Hospitals, which has seven facilities in the PSA. Together, SDH and Seton comprise 87% of the total market share in the region. In recent years, the Austin acute care market has been growing by 3 percent per year.

P.2a (2) Competitiveness Changes. Key changes that affect SDH’s competitive situation include changes in:

- Revenue deterioration related to declining government reimbursement and changes in acuity and payor mix
- Intensifying physician employment/alignment across the region
- Increasing physician investment opportunities
- Hospital capacity constraints

P.2a (3) Comparative Data. To achieve the vision of being “the finest care and service organization in the world,” SDH has defined “exceptional care” as being in the top 5-10% of available national comparative databases. Goals are typically set at the 90th percentile and then raised to the 95th percentile to drive ever-improving performance. For measures where exceptional benchmarks are not available, SDH uses the best available comparison and historical data to set stretch goals.

Key sources of comparative data for SDH are highlighted in Figure P.2-2. CHOIS is HCA’s database of clinical indicators that uses the Truven (formerly Thomson Reuters) risk-adjustment methodology and contains a comparative dataset of 38 million cases a year. As a joint venture with HCA, SDH also has

access to comparative data from the 160+ HCA hospitals, which collectively have more than 18 million patient encounters a year and account for 5% of all emergency department visits in the United States. In addition, SDH benchmarks against role model organizations including US News and World Report top hospitals, Truven Top 100 hospitals and Baldrige award recipients.

The primary limitation for SDH in obtaining comparative data relates to constraints in obtaining competitive data. SDH is limited to obtaining data on Seton from publicly available sites and databases. Also, obtaining comparative data for outpatient and physician practices is challenging due to a lack of reporting requirements and measure standardization.

P.2b Strategic Context

As part of the annual Strategic Planning Process (SPP), SDH identifies strategic challenges and advantages over a three-year horizon.

SDH Challenges (SC)

- SC-1 Patient expectations for service and quality
- SC-2 Physician investment opportunities
- SC-3 Changing reimbursement environment
- SC-4 New and maturing competition (incl. hospitals, UCCs, and FSEDs)

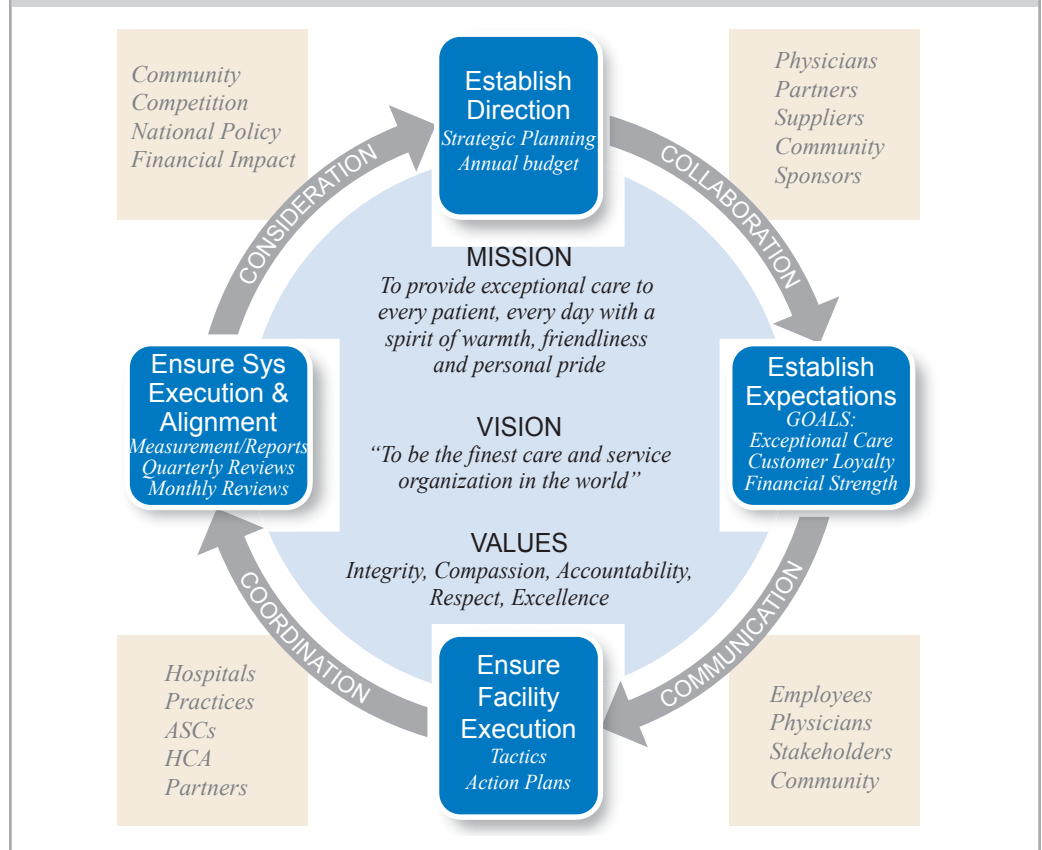
SDH Advantages (SA)

- SA-1 Organizational culture
- SA-2 Clinical expertise
- SA-3 Physician collaboration/engagement
- SA-4 Operating discipline
- SA-5 Mgmt. services & cost control systems provided by HCA
- SA-6 Community benefit provided by partnership with SDF and HCA

P.2c Performance Improvement System

With a value of excellence and a vision to be the finest care and service organization in the world, SDH has embedded a focus on performance improvement in its culture and in its processes. As depicted in the leadership system (Figure P.2-3), senior leaders establish direction for the organization through the Vision and Mission and use the goals of Exceptional Care, Customer Loyalty and Financial Strength to create a strategic framework. Through the strategic planning process [2.1a(1)], senior leaders establish organizational expectations, including exceptional performance goals. Senior leaders then allocate resources to ensure execution of the strategic plan. To ensure strategy deployment,

FIGURE P.2-3: SDH LEADERSHIP SYSTEM



senior leaders communicate the strategic direction across the organization and align workforce incentives to support accomplishment of performance goals. The performance measurement system [4.1a(1)] establishes and holds leaders accountable for exceptional performance on key organizational metrics.

SDH uses the Baldrige Criteria for Performance Excellence to provide a framework for organizational learning, and benchmark world-class organizations. Since 2007, the organization has performed a criteria-based self-assessment each year and used feedback reports from state and national examiner teams to drive performance improvement. SDH earned the Texas Award for Performance Excellence in 2008 and continues to use the Baldrige Performance Excellence Program to benchmark world-class organizations.

SDH has selected Plan, Do, Check, Act (PDCA) as its process improvement methodology, with formal and informal approaches driving continuous process improvement across the organization.

SDH's performance measurement system is used to systematically measure and evaluate key work and support processes and to prioritize improvement opportunities. SDH leaders review dashboard results and key indicators on a scheduled basis utilizing color-coded dashboards to reflect levels and trends of performance. In addition, leaders communicate results related to initiatives through staff and physician committees and task forces; SDH quality review processes; formal reviews; and leadership meetings at SDH, hospital, SDHMG and ASC levels. The communication of these results allows staff and physicians to provide additional input to drive even further improvement towards attaining the SDH vision.

Category 1: Leadership

1.1 Senior Leadership

1.1a Vision, Values and Mission

1.1a (1) Vision and Values. CEO Council, in collaboration with the Board of Governors (BOG), established the SDH Mission, ICARE Values, and Goals (Figure P.1-1) when SDH was formed in 1996. In 2010, as a cycle of learning for the historically mission-driven organization, the CEO Council went through a formal visioning exercise, considering the organization’s future state, input from key internal and external stakeholders, and vision statements from world-class organizations. As a result, SDH established its Vision “to be the finest care and service organization in the world.” The CEO Council and the BOG annually review the Vision, Mission, ICARE Values and Goals during the Strategic Planning Process (SPP) [2.1a(1)].

Senior leaders share the Mission, Vision, Values and Goals (MVVG) with the workforce, suppliers, partners, collaborators, patients and the community through numerous mechanisms (Figure 1.1-1), including a semi-annual communication from the SDH CEO to all key stakeholders.

Employees. Deployment of the MVVG begins during the hiring process, when applicants sign the Values Commitment, and it continues through orientation. Reward and recognition programs along with the annual performance review process [5.2a(3)] reinforce the MVVG, as do Leader Rounding [1.1b(1)], quarterly employee forums, the Leadership Advance Quarterly program and the Daily Round-Ups, which briefly gathers employees within their work areas to focus on one of the ICARE Values every day.

Physicians. Both employed and independent physicians receive the Values during the medical staff initial and recredentialing process, with reinforcement through orientation and regularly scheduled meetings (Figure 1.1-1). The MVVGs are deployed to the SDHMG through the hiring process, SDHMG strategic planning and standardized meeting agendas.

Suppliers & Partners. Supplier and partner contracts also reinforce the MVVG, with further deployment through the vendor certification process which is accomplished through Parallon Workforce Solutions. A senior leader also participates on the boards of affiliate hospitals and shares the SDH MVVG.

To demonstrate a personal commitment to the ICARE Values, and to reinforce the MVVG, senior leaders discuss the Values at least weekly during the facility executive team meetings, quarterly open employee forums, and present the peer-nominated ICARE employee of the month. Senior leaders also show a personal commitment to each of the specific Values. For instance, to reflect Accountability, the SDH CEO uses a standard meeting model with a must-haves matrix to guide monthly reviews with each hospital CEO. The hospital CEOs follow a similar approach with their direct reports at each facility. To reinforce Excellence, senior leaders set organizational performance goals at the national top 5-10%, and to show Respect, senior leaders send hand-written thank-you notes to employee and physician homes as well as model respectful

behavior with staff and physicians. The employee engagement survey enables senior leaders to monitor their effectiveness at deploying the Values of the organization (Figure 7.4-2).

1.1a (2) Promoting Legal and Ethical Behavior. In addition to establishing and overseeing the processes described in 1.2b, senior leaders personally promote an organizational environment that fosters, requires and results in legal and ethical behavior by:

- Personally acknowledging receipt of the SDH Code of Conduct, understanding the policies it describes and agreeing to abide by them;
- Completing annual ethics training and additional training related to physician relations;
- Annually disclosing conflicts of interest;

FIGURE 1.1-1: SENIOR LEADER COMMUNICATION

Method	Audience						
	Deploy MVVG	2-Way Communication	Employees	Physicians	Suppliers	Sponsors/Partners	Collaborators/Patients/Community
Hiring Process	•		•				
Orientation	•	•	•	•	•		
Daily Round-Up	•	•	•				
Leader Rounding	•	•	•	•	•		•
Employee Forums	•	•	•				
Employee Advisory Groups		•	•				
Leadership Academy Qrtly	•	•	•		•		
Performance Review	•	•	•				
SDHMG Practice Management Council	•	•	•	•			
SDHMG Annual Meeting	•	•	•	•			
Medical Staff Meetings	•	•		•			
Executive Breakfast/Lunch in Medical Staff Lounge		•		•			
Medical Staff Department & Section Meetings	•	•		•			
Strategic Growth Council	•	•		•			
Medical Director Meetings	•	•		•			
Meeting Agendas	•		•	•	•	•	•
BOG/BOT Meetings	•	•		•		•	•
Affiliate Board Meetings	•	•		•			•
Contracts	•			•	•		•
Parallon [6.2b]	•				•		
e-News Bulletins	•		•	•	•		
Website	•						•
Newsletters/Publications	•					•	•
Facility Postings	•						•

- Establishing and enforcing policies related to breaches in ethical behavior; and
- Actively participating in Facility Ethics and Compliance Committees (FECC).

In their FECC leadership role, senior leaders guide and participate in evaluation and improvement of the organization's legal and ethical processes. As a cycle of learning, senior leaders made the decision to hire a local, dedicated SDH legal counsel to promote compliance.

1.1a (3) Creating a Sustainable Organization. To create an environment for organizational performance improvement and performance leadership, senior leaders established the SDH Vision to be the finest care and service organization in the world. The Vision inspires the workforce, suppliers, partners and collaborators to strive for ever-improving performance. The annual process for striving for exceptional performance goals at the national 90th to 95th percentile [4.1a(2)] establishes the expectation toward achievement of this Vision, with reinforcement through the workforce performance management system [5.2a(3)].

The Leadership System (Figure P.2-3) aligns the organization and keeps a system wide focus on achieving the Mission and Vision of the organization. Senior leaders establish direction for the organization through the annual SPP taking into consideration inputs throughout the year from a variety of key stakeholders. Expectations of performance are reviewed and established in support of the Vision, Mission and ICare Values, and are aligned with the three Goals of Exceptional Care, Customer Loyalty and Financial Strength. The senior leaders cascade and align supporting strategies and tactics within each facility, medical group and ASC. [2.2a(2)]. To ensure execution, senior leaders allocate resources to support the strategic plan and communicate key aspects of the plan to key internal and external stakeholders. The leadership ensures system execution through the review of key performance measures in monthly or quarterly reviews that provide feedback on progress relative to the plan [4.1a(1)].

To support personal learning, senior leaders created and continue to support the SDH Institute for Learning [IFL, 5.2c(1)] and promote organizational learning through ongoing performance reviews that drive improvements (Figure 4.1-2).

To promote a Service Excellence culture, senior leaders — including the SDH CEO, hospital CEOs and CNOs — meet quarterly with Service Excellence Champions from each facility to review Service Excellence metrics and patient feedback at a system and facility level. The VP of Physician Services meets monthly with practice managers to review similar data. Senior leaders select some of these measures for the Performance Dashboard and quarterly reviews (Figure 4.1-2) and set stretch goals for each based upon benchmarking high performing organizations. These measures and goals cascade across the organization and drive leader and workforce performance expectations. An AVP of Service Excellence provides strategic direction and coaching to ensure competency in this key area of organizational performance across the system. As a cycle of improvement, in late 2013, SDH leaders chartered a Customer Focus and Engagement Team to further formalize the process

of understanding and validating patient, community and physician requirements [3.2a(1)].

Senior leaders create an environment for innovation and intelligent risk-taking through mechanisms including:

- Establishing stretch goals to promote breakthrough innovation [4.1a(1)];
- Appointing a Senior Vice President of Clinical Innovation [2.1a(2)];
- Supporting benchmarking of processes from world-class organizations [4.1a(2)];
- Providing access to robust data warehouses for identification of best practices [4.1a(2)];
- Establishing an Innovation Council to create systems and structure to support Innovation; and
- Judging and submitting facility nominations for HCA's Innovator Award.

To ensure organizational agility, senior leaders annually review and update the three-year strategic plan; and then conduct monthly and quarterly reviews of key performance measures which alert senior leaders to the need for ongoing adjustments. SDH's leadership structure with hospital, medical group and ASC executive teams further supports agility at the facility, practice and ASC level, while maintaining alignment and accountability established by SDH to achieve its mission and vision.

Senior leaders have established a formal succession plan and support development of future organizational leaders through both resource allocation and participation in leadership development programs. Senior leaders established the Leadership Advance Quarterlies (LAQs), Hospital Leadership Development Quarterlies (LDQs) for supervisory level leaders and they participate in development and delivery of IFL leadership curriculum. In addition, each hospital CEO can identify candidates with the potential to become senior leaders and can formally recommend them into HCA's COO, CNO or CFO development programs. The Medical Group identifies candidates for participation in the Center for Creative Leadership course. They also established a mid-year employee performance review process that designates employees as high-, solid- or low-performers [5.2a(3)], identifying a pool of high-performing candidates for growth opportunities. As a cycle of improvement, SDH implemented the use of a 9 box evaluation system to categorize current and potential leaders. To support succession planning for medical staff leaders, administrative and physician leaders at each facility identify and invite future leaders to participate in medical staff committees and take on department leadership.

Senior leaders at the system and facility level create and promote a culture of patient safety through mechanisms including:

- Creating Chief Medical Officer (CMO) positions at the facility and system level;
- Leading a Patient Safety Committee at each facility;
- Selecting, monitoring and responding to key patient safety measures across hospitals, SDHMG and ASCs during quarterly quality reviews; and
- Participating in the annual Leapfrog Patient Safety survey.

1.1b Communication and Organizational Performance

1.1b (1) Communication. Senior leaders create an open and transparent environment that facilitates communication at all levels of the organization. Some methods are system-wide, while others are tailored to meet facility-specific needs. Together, these methods, such as those highlighted in [Figure 1.1-1](#), enable senior leaders to communicate with and engage the entire workforce, patients and other key customers. Rounding remains a key element of senior leadership's approach to workforce communication and engagement. Senior leaders complete and document scheduled rounding using a template designed to connect senior leaders with frontline staff and provide opportunities for staff input and recognition. Facility leaders specifically visit Medical Staff lounges to connect with physicians. As a cycle of learning, SDHMG leaders expanded rounding to the physician practices. Senior leaders communicate with patients and the community as shown in [Figure 1.1-1](#).

Senior leaders use a cascading system to communicate key system decisions across the organization. Communication of key decisions begins with CEO Council, which shares decisions with direct reports, who cascade information to their respective facilities, practices or departments and, through them, to all employees. Senior leaders communicate key decisions to physicians through numerous meetings highlighted in [Figure 1.1-1](#). Senior leaders also distribute e-news bulletins at least monthly to communicate and emphasize key information and decisions to both employees and physicians.

Senior leaders resource, promote and personally participate in workforce reward and recognition opportunities [5.2a(3)]. Specifically, senior leaders review nominees for local and national, annual and monthly awards and select recipients in collaboration with reward and recognition teams. They also personally present many awards, including those that reinforce the Values and service excellence.

1.1b (2) Focus on Action. To create a focus on action to encourage innovation and intelligent risk-taking, accomplish the organization's objectives, improve performance and attain its' Vision, senior leaders use the SDH Leadership System ([Figure P.2-3](#)). Specifically, senior leaders use the SPP and performance management system [5.2a(3)] to identify organizational priorities, set exceptional goals that drive innovation, and reward leaders and the workforce for achieving those goals. Key performance measures populate the Performance Dashboard [4.1a(1)] and other facility- and discipline-specific reports and provide the framework for biweekly, monthly or quarterly review at all levels of the organization from the BOG to individual departments. Measures not performing to target prompt corrective action and more frequent performance review. By selecting measures that support each of the Goals of Exceptional Care, Customer Loyalty and Financial Strength, senior leaders ensure a focus on creating and balancing value for patients, the community, the workforce and the three SDH sponsors.

1.2 Governance and Societal Responsibilities

1.2a Organizational Governance

1.2a (1) Governance System. SDH achieves key aspects of its governance system as follows:

Accountability for Management's Actions. The SDH CEO reports to the BOG, which holds the CEO accountable for organizational operations and performance. Established BOG agendas incorporate key operational results and strategies. Annually, the BOG formally evaluates the CEO, and the CEO in turn evaluates facility CEOs and other key leaders [1.2a(2)]. The SDH CEO and CFO also give regular reports to the partners SDF and HCA.

Fiscal Accountability. In addition to the processes for overall management accountability, the BOG Finance Committee oversees SDH's financial reporting, reviews financial statements and monitors compliance and financial controls. The Finance Committee conducts a thorough review of financial metrics for SDH and individual facilities on a quarterly basis. On a daily basis, the CFO and senior leaders manage financial performance.

Transparency. The Partnership Agreements that created the joint venture in 1996 govern selection of BOG members to ensure: 1) representation of the three sponsors — SDF, HCA and GHF; and 2) needed financial and clinical acumen. Annually, all board members receive ethics and compliance training and sign a Conflict of Interest statement. To ensure transparency in operations, the BOG reviews dashboard measures and performance results on an ongoing basis.

Independence in Internal & External Audits. Independent external audits are conducted annually and results are reported to the BOG Audit Committee to follow the guidelines of Sarbanes-Oxley compliance. All internal audit results are reported to the Board's Finance and Audit Committees and findings are used to improve processes and controls.

Protection of Stakeholder Interests. BOG composition requirements outlined in the Partnership Agreements were established to protect the interests of the three sponsors, SDF, HCA and GHF, and other key stakeholders such as the workforce and the community. Facility-specific BOTs are systematically populated to reflect the communities they serve. The BOG Quality Committee is responsible for the oversight of clinical quality.

Succession Planning for Senior Leaders. In accordance with the Partnership Agreement, the BOG approves the organization's formal succession plan for senior leaders [1.1a(3)] and makes recommendations for succession of the SDH CEO.

1.2a (2) Performance Evaluation. The BOG Board Compensation Committee provides an evaluation of the SDH CEO annually based on review of performance measures linked to the strategic plan. The SDH CEO, in turn, annually reviews facility CEOs and other direct reports using a standardized tool, with input from facility BOTs on the evaluation of facility CEOs. As part of the annual process, the SDH CEO and other senior leaders complete self-evaluations outlining their strengths, development opportunities and performance on key

measures. Evaluation discussions focus on areas of strong performance and opportunities for improvement, as well as establishing annual goals directly linked to executive compensation, including bonuses. Executive evaluation is also ongoing based on monthly review of key measures. These discussions are standardized, documented and incorporated into the Authoria TMS tool. Results are aggregated and used to identify leadership development opportunities across the system.

In addition to a standard Medical Staff recredentialing process [5.2a(3)], members of the Medical Executive Committees (MECs) report to the independent Medical Staffs at each facility. Election by their physician peers holds these leaders accountable for their performance.

Individual board members annually evaluate the performance of the board as a whole. Results are aggregated and used to identify opportunities for improving board performance.

CEO Council reviews the leadership system (Figure P.2-3) as part of the organization’s Baldrige-based self assessment.

1.2b Legal and Ethical Behavior

1.2b (1) Legal Behavior, Regulatory Behavior and Accreditation. To address adverse impacts on society, SDH uses approaches including:

- Monitoring and responding to key clinical and patient safety measures at all levels of the organization (4.1);
- Establishing and annually updating an Environment of Care plan to identify areas of risk and detail proactive policies and procedures to address them [5.1b(1)];
- Leading and participating in regional emergency preparedness activities [6.2c(2)]; and
- Participating in a single stream waste initiative to minimize environmental impact.

SDH anticipates public concerns with current and future services through approaches including:

- Environmental assessment completed during the strategic planning process [2.1a(1)];
- Voice of the Customer listening methods (Figure 3.1-1);
- Diverse BOG and BOT representation [P.1b(1)];
- Leader involvement in local and national organizations; and
- Collaboration with local public agencies.

As a cycle of learning, SDH has begun to refine the data mining capabilities associated with its monitoring of social media [3.1a(1)] providing input into the Customer Focus and Engagement Team [3.2a(1)].

To proactively address public concerns with environmental impacts of operations or construction projects, SDH initiates project-specific communications, such as meetings with elected officials and stakeholders in communities targeted for service expansion.

SDH’s key processes, measures and goals for achieving and surpassing regulatory, legal and accreditation requirements and addressing risk are highlighted in Figure 1.2-1.

1.2b (2) Ethical Behavior. SDH promotes and ensures ethical behavior in all interactions through its Ethics and Compliance Program. The SDH Ethics and Compliance Officer (ECO)

is responsible for leading overall program implementation; where as hospital, SDHMG and ASC ECOs are responsible for implementation at each hospital, physician practice and ASC, supported by comprehensive policies and procedures. The SDH Code of Conduct forms the foundation of the Ethics and Compliance Program. Employees receive training on the Code of Conduct during orientation and annually thereafter, and acknowledge via signature or electronically that they have received the Code, understand it represents mandatory policies of the organization and agree to abide by them. Employees also sign a Confidentiality and Security Agreement prior to having access to any patient information. Annual ethics training on the Code of Conduct is required of all employees. Any employee, including leaders, who does not meet the annual requirement for ethics training is suspended until successful completion or released from the organization by policy. Physicians receive the Code of Conduct with their initial credentialing application and every two years as part of recredentialing; the Code of Conduct is incorporated into the certification process for vendors and into contract language with partners.

Adherence to the Code of Conduct is monitored at every level and location of the organization through Facility Ethics and Compliance Committees (FECC). To foster an open reporting environment and proactively address ethical questions and concerns, the Code of Conduct encourages reporting to supervisors and facility CEOs or to the confidential Ethics Hot Line. The hot line number is published so patients and community members can access it as well. All concerns are fully investigated, and the SDH CEO and facility CEOs review ethics reports by facility to identify and address common or recurring issues. Indicators SDH uses to monitor ethical behavior include completion rate for Code of Conduct training and calls to the ethics line (Figure 7.4-10).

Ethical breaches are managed by policy and may include counseling, suspension, or termination, depending on the nature and severity of the infraction. Lessons learned are shared across the system through quarterly meetings of the Ethics Compliance Officers (ECOs). Code of Conduct training is modified each year based on these lessons learned, as well as environmental changes. Facility and corporate internal audits monitor compliance with regulatory requirements, as well as ethics and compliance policies and procedures. Audit results are reported to the FECCs for review and corrective action as necessary. The ECOs present a report to their respective BOTs annually, including the results of audits and investigations.

Key Processes	Measures (Goals)	Results
Accreditation	Joint Commission Accreditation (Full)	7.4-9
Regulatory Compliance	Violations with CMS & Texas Department of Health (0)	7.4-9
Patient Safety	Falls (0)	7.1-17
Patient Privacy	HIPAA violations (0)	7.4-9
Audits	Audit completion findings (100% of scheduled audits, no significant findings)	7.4-7

1.2c Societal Responsibilities and Support of Key Communities

1.2c (1) Societal Well-Being. The innovative joint venture agreement that established SDH in 1996 forms the foundation of the organization’s approach for considering societal well-being and benefit. First, the agreement specifies that composition of the BOG, which provides oversight for SDH strategy and operations, must represent SDH’s sponsors and diverse community interests. Also, to continue St. David’s longtime commitment to its local community, the agreement requires distribution of a portion of SDH earnings to partner SDF (Figure 7.4-5). The local, independent SDF Board of Directors and staff then use a formal grant application process to determine how best to use those funds to support the community [1.2c(2)].

SDH also considers societal well-being, including social and economic systems, during its strategic planning process [2.1a(1)]. An environmental assessment (Step 3 of SPP) provides information regarding service gaps, demographic trends, regulatory changes and community health needs, and serves as the basis for long-term and short-term strategies and tactics balanced across the Goals of Exceptional Care, Customer Loyalty and Financial Strength (Figure 2.1-3).

To address the community’s environmental well-being, SDH partnered with the City of Austin to purchase wind and solar power and selected a common recycling vendor to support the single waste stream initiative program (Figure 7.4-13) across the system. SDH also made a strategic decision to adopt green building practices. The organization invests more than \$50 million a year in making existing facilities more sustainable, and the newest medical office building was certified through the U.S. Green Building Council.

1.2c (2) Community Support. SDH defines its key communities as the communities in its primary service area, which is validated each year during the strategic planning process. In addition to providing significant charity care (Figure 7.4-12), the primary way SDH supports these communities is through its partnership with sponsor SDF. To protect local interests, the joint venture agreement specifically separates SDH operations

and the SDF process for annually determining what community benefits to offer. By leveraging its strategic advantage of a strong operating discipline, SDH was able to fund SDF’s 2013 distribution of more than **\$46 million** to 55+ community service organizations and local safety net health clinics, as well as SDF’s Dental Program and scholarship fund for health care students (Figure 7.4-14).

In addition, CEO Council, in conjunction with the annual marketing plan, selected University of Texas (UT), a prominent and far-reaching organization in the Austin area, as a partner in community health improvement. Leveraging its core competency of providing clinical expertise, SDH now performs heart screenings on all UT athletes and thousands of other young recreational athletes, provides/coordinates medical coverage during all UT home athletic events, and uses stadium scoreboards to provide health education on topics such as stroke and CPR. SDH also places a nurse navigator at the UT athletic training center.

Senior leaders and staff also personally contribute to improving the health of communities served by SDH. Senior leaders serve on key community boards, as determined by matching individual passion with boards strategically targeted by SDH. In addition, senior leaders self-select boards for involvement based on current and future community needs, as well as organizational direction. To encourage workforce involvement, facility and SDHMG leadership teams use input from employees, physicians and community members to annually identify community organizations, such as local school districts, to target with volunteer hours. Also, senior leaders select members of the workforce for HCA’s Frist Humanitarian Award at the individual hospital level and then forward recommendations to HCA for national recognition. In 2010, a neonatologist and director of the neonatal intensive care unit at SDMC received the national honor for his efforts to found Mothers’ Milk Bank, which has served 94 hospitals in 21 states. In 2014, an innovative program called “Project Mary” designed to provide concierge services to surgical patients at SDSAMC earned this recognition. As a system, SDH also endorses United Way efforts to gain employee and physician contributions to support community health improvement.

Category 2: Strategic Planning

2.1 Strategy Development

2.1a Strategy Development Process

2.1a (1) Strategic Planning Process. SDH leverages a robust SPP that begins at the system level and encourages collaboration, coordination and innovation across the system. Initiated in 2001, the SPP was identified as a best practice by HCA, replicated in the Methodist HealthCare division by a team of consultants and then disseminated across the American Group of HCA in 2013.

The development of the system-wide action plan (SWAP) is highlighted in Steps 1-6 in Figure 2.1-3. The SWAP first specifies the system’s goals and performance targets and then the strategic objectives (SOs), system-wide tactics (SWTs) and

key system-level action plan items to achieve the three goals. As illustrated in Steps 6-10, the SWAP is then cascaded to and coordinated across all facilities and supporting services in order to support a consistent set of SOs and SWTs throughout the organization. The rolling 3-year plan is refreshed annually, thus SDH’s short-term planning horizon is one year and the longer-term planning horizon is three years. This ensures the system is responding to the current environment while positioning for projected changes in the marketplace.

Figure 2.1-3 illustrates the key process steps and participants in the SPP.

1 SDH engages year-round with stakeholders including partners, patients, physicians, employees, payors, suppliers and community members for input and context into the SPP (Figure 2.1-1). Depending on the complexity and scale of

FIGURE 2.1-1: SAMPLE SPP INPUTS	
Stakeholder	Input Approaches
Patients/ Community	VOC data and information (Figure 3.1-1), current and projected demographic and utilization trends (Sg2 analytics, THA PDS, THCIC, local surveillance data partnership); community preferences (NRC BrandArc and HCMG); and Community Health Needs Assessment
Employees	Employee engagement surveys [5.2b(1)], employee advisory groups, leader rounding, proposals for new health care services [3.2a(1)], workforce capability and capacity needs [5.1a(1)]
Physicians	Participation by CMOs, SDHMG leaders, and medical staff leaders in Governance Retreat; BOG/BOT representation; Membership of CMO, VP of Physician Operations, and VP of Physician Recruitment/Sales on CEO Council; Strategic Growth Council; physician engagement surveys [5.2b(1)]; physician liaisons/GrowthLink [3.2b(1)]
Suppliers	Parallon and Division CFO participation in Governance Retreat; HCA plans; Supply Management Action Teams (6.2b)
Partners	BOG representation; HCA plans, corporate initiatives, targets, and benchmarks
Collaborators	Affiliate hospital board meetings and participation in Governance Retreat; Regional EMS Advisory Council; physician liaisons/GrowthLink [3.2b(1)]; SVP of Affiliate Services on CEO Council
Payors/ Employers	VP Payor Engagement; Participation & Strategy Retreat; Two dedicated Broker Employer Relation Liasons; HCA Plans; External Expertise; (Hewitt, SG2)
Other	Texas legislative priorities, CMS regulations/mandates, competitor performance/plans, external intelligence, HCA intelligence

the feedback, it is addressed immediately, incorporated into current year action plans or integrated into the SPP. Prior to the system level strategy retreat (Step 4), each facility and support service submits a SWOT largely based on this input. For instance, SDHMG leaders extract information from physicians during quarterly reviews to drive SWOT development. As appropriate, stakeholders are surveyed in the first quarter of the year. This information is formally aggregated and analyzed each year to develop the Environmental Assessment (EA). The Customer Focus and Engagement Team (CFET) [3.2a(1)] synthesizes the requirements of patients, physicians and the community as an input to the SPP.

2 Next, SDH convenes the BOG with senior leaders, hospital executives, physician leaders from SDHMG, clinical affiliates, governance boards and the medical staffs, BOTs and other key stakeholders at an annual Governance Retreat. This day-long retreat features a state of the system presentation by the SDH CEO where participants have the opportunity to ask questions and give feedback on the system's performance and current strategic thinking. State and national thought leaders complement the discussions with perspectives on economic, regulatory and industry developments, allowing participants an

opportunity to gain a current understanding of the local, state and national health care environments and provide input to the system on key issues or strategies.

3 To support discussions at the Planning Retreat, the Planning Team produces the Environmental Assessment [EA, 2.1a(3)]. The EA incorporates input from the Governance Retreat, as appropriate. The EA may also include results from triennial Community Needs Assessments performed in collaboration with SDF. The EA helps CEO Council identify potential blind spots by analyzing and synthesizing extensive data and information, including customer requirements as determined by the CFET, competitive volumes, benchmarks, current and projected demand for services, demographic estimates and projections, technological innovations and economic and regulatory conditions. The EA also provides a first draft of baseline, benchmark and target performance for the Performance Dashboard. These goals drive SO and SWT development.

4 The Planning Team presents the results of the EA and Performance Dashboard recommendations to CEO Council at an off-site Planning Retreat. Goals and performance measures are established with one, two and three-year targets. Using the EA, CEO Council develops key assumptions for the planning horizon including the evaluation of potential risk areas. In considering modifications to the current plan, key questions are posed including:

- Do data indicate the SOs have been successful in meeting goals?
- If the SO has not been successful, is it lack of execution or the wrong tactics?
- If the SO has been successful, can we sustain success?
- Does the SWAP address new strategic challenges and opportunities?

Leveraging the EA and individual SWOTs submitted from each entity, CEO Council performs a system-level SWOT analysis, including identification of anticipated shifts in the competitive environment, technology, demographics, health care needs, patient/community preferences, the economy and the regulatory landscape. The system-wide SWOT is performed at the end of the planning retreat to prioritize efforts, identify or verify its strategic challenges, advantages and opportunities [2.1a(4)] and assess its core competencies. Finally, the CEO Council validates the MVVG. As an output of the retreat, the Planning Team encapsulates the team's key assumptions, drafts any modifications to the current SWAP and assigns accountability for due diligence on new strategic opportunities.

5 As a cycle of learning in 2013, SDH introduced an additional layer of accountability and innovation. Two months after the retreat and at least six weeks before the budget cycle commences, senior leaders reconvene to review and assess new strategic opportunities identified at the last planning retreat. Opportunities and associated action plans are prioritized based on impact on goals and incorporated into the system-wide plan, as appropriate.

6 Once the draft plan has been approved by the SDH CEO, it is distributed to CEO Council to cascade to each entity as appropriate. The SOs and SWTs provide the framework for

strategic plan development system-wide. Hospitals, SDHMG and supporting services maintain rolling three-year plans that support and coordinate with one another.

7 With a rolling three year plan that is routinely modified to respond to input and opportunity, the hospitals and support services generally do not have to modify plans much upon receiving the SWAP. They evaluate new opportunities and/or modify/re-prioritize existing plans. To foster innovation, the hospitals retain autonomy and flexibility to assess opportunities locally that support the SOs and SWTs. Individual hospitals refresh plans based on extensive input from stakeholders including employees, BOTs, suppliers and collaborators.

8 Next, annual budgets to support each hospital and supporting service’s short-term plans are developed. Each entity reviews its plans and budgets with system leadership to ensure accountability, alignment, feasibility and effective resource utilization. Upon confirmation of each hospital and supporting service plan and budget, the CFO and Controller consolidate the budgets.

9 The Planning Team combines budget highlights and assumptions with key details on the competitive environment, strategic challenges, SOs, key action plans and historical and projected performance measures for presentation to the sponsors for ultimate approval.

10 Based on partner feedback, the SWAP is modified and re-deployed as necessary.

Evaluation and improvement of the SPP is ongoing based on participant feedback and industry best practices. The results of recent cycles of learning are highlighted in [Figure 2.1-2](#).

Entity- and system-level operational reviews including the Monthly Operating Reviews (MOR), CEO Council and Quarterly Reviews [4.1a(1)] ensure the agility needed to respond to changing organizational, financial and capacity needs. If needed, SDH has a process outside the budget cycle to seek sponsor approval for additional resources [2.2a(3)].

2.1a (2) Innovation. SDH creates an environment that supports innovation through 1) setting and rewarding goals to promote breakthrough improvement [4.1a(1)] and 2) encouraging benchmarking of processes from within HCA and other world-class organizations [4.1a(2)].

In 2011, SDH appointed a Senior Vice President of Clinical Innovation (SVPCI), who reports directly to the SDH CEO. This physician executive analyzes data from SDH, HCA, other national databases and current literature to identify the greatest

opportunities for innovation. He then engages clinicians and administrators from across the organization in identifying and implementing data-driven best practices to achieve clinical excellence. Current focus areas include blood utilization, hip fractures, sepsis and heart failure. In each of these areas, individual physicians see their own data relative to their hospital, SDH and national benchmarks. The result is reduction of avoidable variation and improved performance ([Figure 7.1-12-13](#)).

Based on internal assessments and Baldrige feedback, in late 2013 SDH established an Innovation Council to identify opportunities for innovation, standardize a process for evaluating innovation pilots and define the process to communicate best practices across the system. Recent initiatives highlighted include a partnership with a post-acute care provider to reduce readmissions, expansion of the One Call Center [3.2b(1)] to include follow-up care, broadening of the High Alert Program to reduce frequent ED visits and the concierge approach for elective surgical patients at SDSAMC.

Performance reviews at the system- and facility-level identify sustained or significant performance gaps, and SDH dedicates resources for analysis, planning and collaboration to address these gaps. The cross-functional collaboration from these focused efforts often yields break-through performance. Sustained systematic gaps are highlighted during the EA, and a strategic opportunity is identified that could address this gap or one of the forward-looking assumptions (step 3 of SPP). Most often, opportunities for innovation support a current SO and are incorporated into the strategic plan. However, if the opportunity does not align with a current SO, and CEO Council believes the opportunity will drive fulfillment of the organization’s Goals, CEO Council may designate it as a new SO outside the normal planning cycle. The CEO Council identifies strategic opportunities and assesses intelligent risk based on impact on goals, ROI, and competitors positioning to determine which ones warrant further analysis and/or inclusion in the strategic plan.

The organization’s current key strategic opportunities under evaluation include:

- New staffing and compensation models that may improve turnover and/or patient satisfaction scores
- Expansion of the current geographic footprint

2.1a (3) Strategy Considerations. Through the SPP, SDH collects and analyzes data and develops information addressing key elements.

During Step 4 of SPP, CEO Council conducts a formal SWOT analysis based on the comprehensive EA, input from the Governance Retreat, individual entity SWOTs and the collective experience of CEO Council [2.1a(1)]. CEO Council uses these discussions as the basis for identifying the organization’s strategic challenges and advantages.

The SPP addresses potential blind spots and risks to organizational sustainability during Steps 1-3, which are designed to provide early indications of major shifts in technology, markets, health care services, patient and stakeholder preferences, competition, the economy and the regulatory environment. Annually, the Planning Team conducts a critical assessment of each of these variables through the EA, which includes

FIGURE 2.1-2: SPP IMPROVEMENTS

2013	Enhanced accountability and innovation
2012	Re-ordered retreats to better leverage learnings and input from Governance Retreat
2011	Enhanced linkage between Goals and Strategic Objectives
2010	Began using focus groups as SPP input
2009	Added SWOT analyses for competitors and collaborators; contracted with NRC to enhance community input into SPP
2008	Created new position for VP of Strategic Planning
2007	Established quarterly strategy reviews

inputs listed in Figure 2.1-1. The Planning Team highlights key trends and potential shifts during the Planning Retreat so CEO Council can make assumptions about their future impact and test those assumptions through scenario planning. CEO Council also considers them during the SWOT analyses and addresses them through the SOs and strategic plan.

The SWAP, with defined timelines and accountability for key system-wide action items, cascades through the organization, driving action plans at the facilities and the supporting services. To ensure execution of the strategic plan, SDH coordinates its planning and budgeting processes so that the organization allocates the workforce, capital and financial resources needed to accomplish the plan [2.2a(3,4)]. CEO Council, Monthly Operating Reviews (MOR) and Quarterly Reviews [4.1a(1)] further support plan execution and ensure the agility needed to identify changing organizational, financial and capacity needs. If needed, SDH has a process outside the budget cycle to seek sponsor approval for additional resources [2.2a(3)].

2.1a (4) Work Systems & Core Competencies. In addition to the planning effort described in 6.1a(1), SDH has identified two key work systems: Clinical Care Delivery and Support Services referenced in Figure 6.1-1 and Figure 6.1-2. CEO Council provides oversight of the Clinical Care Delivery work system through system-level policies, procedures and performance reviews highlighted in Figure 4.1-2 but delegates operational management to the hospitals, SDHMG and ASC leaders. Decisions regarding the Support Services work system reside with SDH executives, who interface with SDH and HCA to ensure that the work system meets the needs of both organizations.

To determine whether a key process within the work systems will be accomplished by external suppliers and partners:

- The process owner asks a series of screening questions:
 - Is SDH able to provide the service?;
 - Has the service traditionally been provided by SDH?; and
 - Is it more efficient and cost effective to use an external resource?
- For services that pass the initial screening, SDH performs a detailed cost/benefit analysis, including consideration of regulatory requirements, organizational capacity, availability of expertise and alignment with SDH Goals

and core competencies.

- The process owner develops an action plan for implementation, including performance requirements and seeks approval from CEO Council.
- The process owner monitors supplier/partner performance to ensure that performance requirements are met (6.2b).

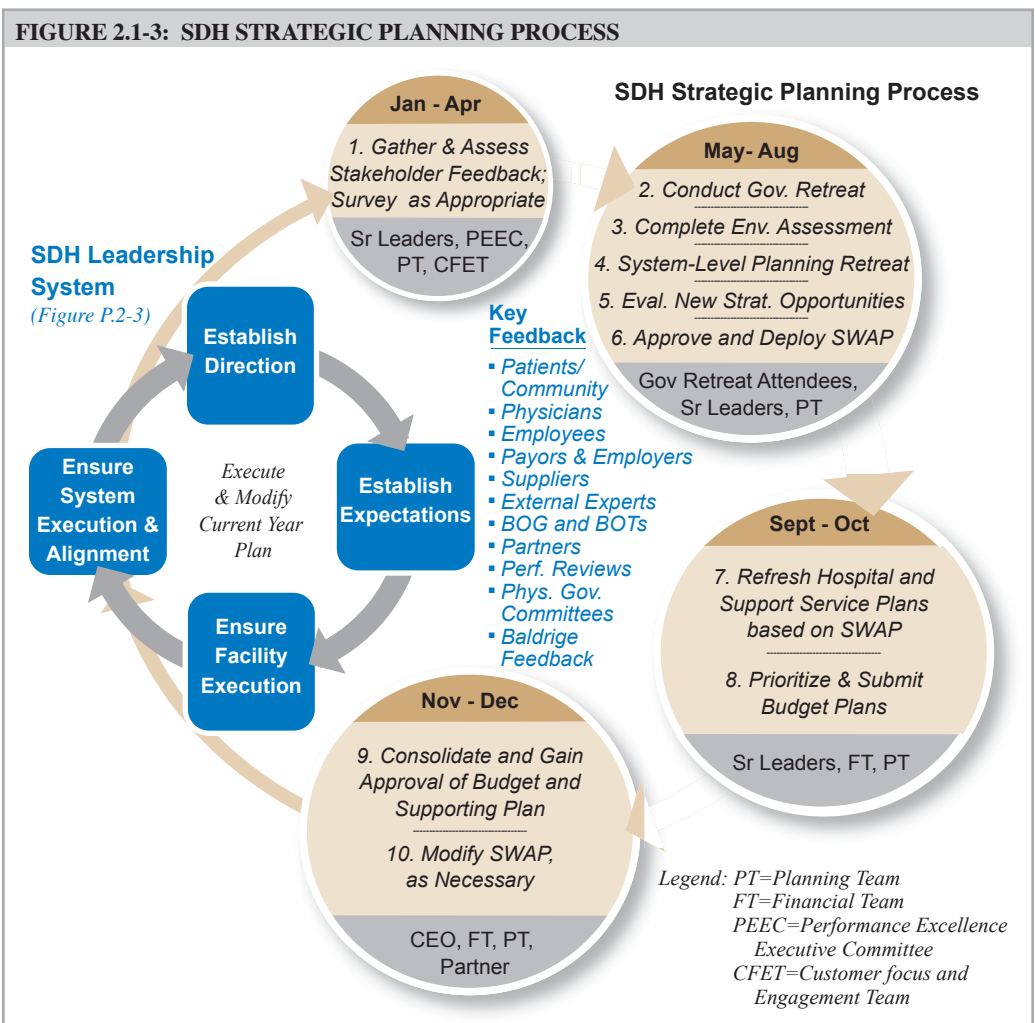
As part of the Planning Retreat (Step 4), CEO Council tests the organization's abilities and competencies against each SO. If the organization needs to develop a future competency, CEO Council incorporates that into the strategic plan.

2.1b Strategic Objectives

2.1b (1) Key Strategic Objectives. SDH's SOs that support the Goals of Exceptional Care, Customer Loyalty and Financial Strength, along key SWTs, are highlighted in Figure 2.1-4. Short-term (annual) and longer-term (three-year) action plans support their accomplishment. CEO Council evaluates and, when appropriate, updates the SOs each year during SPP. For instance, the 2013 plan introduced a SO related to growing oncology services. Key planned changes for SDH include:

- Expanded service line offering particularly in pediatrics and oncology;
- Centralization of additional HR services; and

2.1b (2) Strategic Objective Considerations. SDH's SOs address strategic challenges, leverage strategic advan-



tages, and consider strategic opportunities as highlighted in [Figure 2.1-3](#) and described in Step 5 of the SPP.

The three over-arching Goals — Exceptional Care, Customer Loyalty and Financial Strength — provide a framework for SOs that balances the needs of all stakeholders. CEO Council validates this during the SPP by evaluating stakeholder needs against the collective SOs.

To balance short- and longer-term time horizons, SDH aligns each SO with one of its three Goals and establishes annual performance expectations extending out three years and reflected in the Performance Dashboard. Through the SPP, CEO Council defines SWTs needed to achieve those performance expectations. Once cascaded each facility has the autonomy to prioritize opportunities that support the SDH plan and submit them as a part of the budget process (Step 8). Monthly Operating Reviews (MOR) and Quarterly Reviews [4.1a(1)] provide a forum to alert the organization when market conditions require a shift in plans.

2.2 Strategy Implementation

2.2a Action Plan Development and Deployment

2.2a (1) Action Plan Development. The SWAP contains detailed accountability and timelines for key system-level action plan items – notably strategic opportunities discussed in Step 5. Once the SWAP is distributed, facilities and support services are responsible for assessing each SO, SWT and key action plan item. For relevant SO and SWTs, the facilities and support services will operationalize the SO with a specific list of items, owners and due dates. The strategic action plans of the facilities and supporting services establish accountability amongst senior (hospital/service) leaders for key action items. Where necessary, detailed project plans are developed outside of the strategic action plans. As with the SWAP, year-round input from stakeholders, including employees, physicians, BOTs, suppliers and collaborators, as appropriate, sets the context for the development and modification of these plans. Entity-specific opportunities are analyzed based on market need, alignment with the SOs and impact on the SDH goals. The Planning Team integrates relevant tactics from hospital and entity plans into the system-wide plan to ensure coordination. [Figure 2.1-4](#) summarizes the strategic plan and highlights key short- and longer-term action plans associated with each SO.

2.2a (2) Action Plan Implementation. SDH deploys and sustains action plans through the Leadership System ([Figure P.2-3](#)), supported by the budgeting process, key communication mechanisms ([Figure 1.1-1](#)) and the performance measurement reviews ([Figure 4.1-2](#)). Once action plans are resourced as described in 2.2a(3), assigned leaders communicate SOs, tactics and action plans to employees and physicians as described in [Figure 1.1-1](#). For action plans that require participation by suppliers, partners, or collaborators, the assigned leader is also responsible for that communication and coordination of execution.

Quarterly strategy reviews with SDH, hospital and SDHMG leadership ensure accountability for action plans across the organization. During these reviews, leaders report on the implementation status of each action plan as well as key

performance metrics. Status and results of strategies are also presented at CEO Council meetings on a scheduled basis.

2.2a (3) Resource Allocation. Steps 8 and 9 of the SPP ensure that financial and other resources are available to support accomplishment of the strategic plan while meeting current obligations. As entity plans are finalized, hospital, SDHMG and senior SDH leaders develop the following year’s budget. Financial review of the plans begins with presentations of short-term opportunities, infrastructure needs, anticipated growth of core services, supply chain needs and other costs. As a component of the budgeting process, SDH’s CEO, CFO and Controller assess the opportunities, integrate anticipated reimbursement trends, and allocate funding and capital. The system Director of Labor Management also participates to weigh productivity and staffing implications [2.2a(4)]. Plans and budgets are consolidated and presented to sponsors for approval and input.

The budget is set and managed through rolling three-year projections. Cash flow is largely predicated on the assumption that 95 percent of projected earnings will result in cash. Distributions for routine capital, payables and accruals also are factored in. Precise control of cash flow allows SDH to meet current obligations, support strategic initiatives and fund the work of SDF. To ensure agility and help manage risks, MORs provide an ongoing forum for entities to voice additional resource needs and share innovations in financial or operational management. Formal updates with sponsors are scheduled throughout the year for approval of additional funds outside the budget cycle, if needed, and under the innovative Partnership Agreements, SDH can draw on its sponsors’ financial reserves to address opportunities that require significant capital resources.

2.2a (4) Workforce Plans. SDH’s approach to human resource and workforce planning has several key components:

- As part of the SPP ([Figure 2.1-3](#)), SDH establishes tactics and action plans in support of the SOs focused on driving greater employee engagement, enhancing the physician service experience and growing/promoting SDH-aligned physicians. These SOs, SWTs and key action items shape the rolling three-year HR and SDHMG strategic plans.
- To consider and address the workforce capability and capacity needed to accomplish action plans across all the SOs, the system Director of Labor Management works with the appropriate directors or CFOs to determine productivity targets, staffing levels and skill mixes based on benchmarks, historical performance and a workload forecast tool. The tool is linked to SDH’s electronic productivity management system (PLUS), which has undergone multiple cycles of learning [5.1a(1,2)]. To address physician capability and capacity needs, the VP of Physician Recruitment and Sales works with hospital and SDHMG leadership, the Planning Team and the VP of Physician Services to update plans focused on medical staff succession and physician recruitment [5.1a(1,2)].

2.2a (5) Performance Measures. The key performance measures SDH uses to track achievement and effectiveness of its Goals and SOs populate the Performance Dashboard and are highlighted in [Figure 2.1-4](#). Expectations established for entities and leaders cascade from the Performance Dashboard to ensure organizational alignment across key deployment

FIGURE 2.1-4: STRATEGIC PLAN SUMMARY

STRATEGIC PLAN ALIGNMENT										
Goals	Performance Dashboard Measures	Performance Targets (%)			Strategic Objectives (SO)	Key System-Wide Tactics (SWTs)	Action Plan Items (Sample)	Key Performance Review Measures	SC SA	Key Performance Review Measures
		'14	'15	'16						
EXCEPTIONAL CARE	Risk Adjusted Mortality Index	0.64	0.64	0.64	US Top 5%	SA1-5 SC3	<ul style="list-style-type: none"> - Adhere to Best Medical Evidence - Implement Clinical Excellence (CE) Initiatives - Reduce HACs & Eliminate Never Events - Better Manage Care Across the Continuum - Identify & Deploy Innovative Practices - Expand Performance Measurement System 	<ul style="list-style-type: none"> - Redesign med rec process (LT) - Implement Cath PCI system-wide - Increase compliance with catheter removal - Implement standardized screening for of sepsis 	<ul style="list-style-type: none"> - Core Measures - HACs & Never Events - CE Measures - Readmissions 	
	Risk Adjusted Complication Index	0.55	0.55	0.35	Scaling from US Top 10% to US Top 5%					
CUSTOMER LOYALTY	HCAHPS Grand Composite	79	82	82	Scaling from US Top 10% to US Top 5%	SA1,3, SA4 SC1,3	<ul style="list-style-type: none"> - Hardwire Expectations & Processes - Monitor & Respond to Patient Feedback - Improve Process Efficiency 	<ul style="list-style-type: none"> - Implement No Pass Zone - Evaluate PCT Staffing (LT) - Improve ED operations 	<ul style="list-style-type: none"> - Responsiveness - Pain Mgmt - Communication 	
	Employee Engagement	80%	80%	80%	HCA Top 5%	SA1-5 SC4	<ul style="list-style-type: none"> - Refine & Execute Recruitment & Retention Plans - Implement Union Avoidance Strategy - Implement OneHR 	<ul style="list-style-type: none"> - Improve preceptor program - Implement nursing specialization program 	<ul style="list-style-type: none"> - Rounding - Exit Interviews 	
	Voluntary Employee Turnover Rate	12	12	12	Lowest rate in HCA TX					
FINANCIAL STRENGTH	Physician Satisfaction (Place to Practice Medicine)	66	66	70	Scaling from PRC Top 5% to Top 3%	SA1-3 SC2-4	<ul style="list-style-type: none"> - Improve the Ease, Efficiency & Value of Practicing at SDH - Develop & Grow Primary Care Network - Design & Execute Physician Alignment & Recruitment Plan* 	<ul style="list-style-type: none"> - Track performance of hospitalists - Evaluate alternative comp. models 	<ul style="list-style-type: none"> - Growth Link Reports - Vol/Share Trends per MD 	
	Tier 1 Market Share (inc. Dell)	49	50	51	Market Leader	SA2-3 SC1-4	<ul style="list-style-type: none"> - Develop/Expand CV Service Offerings - Develop & Promote System-Wide High-Risk MFM Expertise - Expand & Promote Comp. Stroke Network Program - Develop & Promote Blood Cancer/BMT Program - Grow Texas Institute for Robotic Surgery - Execute System-wide OR Improvement Plan - Control Rehab Leakage & Access Mgmt - Drive ED Process Improvement - Execute Targeted Marketing & Comm. Outreach - Expand Access in High-Growth Areas 	<ul style="list-style-type: none"> - Implement system-wide CHF program - Develop HHA at SDRRMC - Extend SDNAMC MFM model - Implement BMT program - Expand nurse navigator program - Expand "Project Mary" - Migrate rehab to Transfer Ctr - Implement ED Playbook 	<ul style="list-style-type: none"> - Vol/Share by SL 	
	EBITDA \$M (excl. Waiver & HITECH)	Proprietary			Budget + 6% CAGR	SA3-5 SC1-4	<ul style="list-style-type: none"> - Identify & Execute PI Initiatives - Ensure Effective Contracting & Revenue Realization - Position for Changing Reimbursement Environment 	<ul style="list-style-type: none"> - Establish Sch. Exc. Vol. Forecasting (VF) - Implement telepsych project - Appoint Employer/Broker Relations Liaison - Open Pediatrics Program 	<ul style="list-style-type: none"> - NR by Payor - Expenses 	

Note: * Referenced in the SO of each SL; detailed in Hospital and Physician Services' Plans

areas. By balancing measures across the Goals of Exceptional Care, Customer Loyalty and Financial Strength, SDH ensures that its measurement system addresses stakeholder interests.

2.2a (6) Action Plan Modification. Unfavorable trends in performance metrics, feedback from key stakeholders and/or changes in operating or regulatory environment serve as triggers to evaluate the modification of established action plans both at a facility and system level. Facility meetings, MORs, Quarterly strategy reviews, CEO Council and one-on-one meetings with hospital CEOs and the SDH CEO provide forums for assessing and modifying action plans, as appropriate. When these reviews indicate a need for action plan modification, responsibility is assigned to the appropriate hospital or supporting service leader. The leader develops a new/revised action plan that includes an evaluation of resource needs. The proposed plan is refined

through input from the entity leadership team and other stakeholders as appropriate. Depending on urgency and scale, the plan is presented for approval either to facility or SDH leadership during performance review. Implementation occurs as described in 2.2a(2).

2.2b Performance Projections

Figure 2.1-4 presents one-year and three-year projections for Performance Dashboard measures, with performance relative to benchmarks, key competitor Seton and past performance presented in Figure 7.4-16. SDH expects its projected performance to compare favorably with Seton, benchmarks and goals. Any projected performance gaps are addressed through tactics and action items defined in the strategic plan. If additional performance gaps are identified during monthly and quarterly performance reviews, leaders are assigned to take corrective action.

Category 3: Customer Focus

3.1 Voice of the Customer

3.1a Listening to Patients and Other Customers

3.1a (1) Listening to Current Patients and Other Customers. SDH uses an integrated approach to listen to, interact with, and observe patients, physicians and the community leveraging many formal and informal mechanisms. Some of these mechanisms vary across different patient groups, market segments and relationship stages as highlighted in Figure 3.1-1. Data and information obtained through the listening mechanisms are used as described in 3.2a and 4.1a(3).

Over the past several years, SDH has increased its integration of social media and web-based technologies into its listening mechanisms. SDH websites include a contact form, and the organization has used web-based focus groups through NRC to gather input on specific topics. SDH also has an official presence on Facebook, Twitter, YouTube, Flickr, Google Places and Yelp at both a facility and system level. The SDH interactive media consultant monitors these channels and generates monthly reports that aggregate and trend interest and engagement to guide future marketing efforts [4.1a(3)]. SDH has begun to mine social media for customer requirements as an input to the CFET [3.2a(1)].

In the physician practice setting, SDHMG utilizes a tool called Promote My Practice, which includes feedback from key social media outlets like Facebook, Twitter, Yelp, Google+Local, Four Square, Vitals and Healthgrades. This service includes monitoring negative responses and providing feedback on appropriate counter response and service recovery.

Key mechanisms SDH uses to follow up with patients and community members and receive immediate and actionable feedback include:

- **Patient Rounding.** SDH engages in two different types of rounding on patients: Leader Rounding and Hourly Rounding. In Leader Rounding on patients, leaders round daily to listen to, interact with, and observe patients who are in the hospital, emergency department, outpatient areas, and physi-

cian practices, with a specific focus on patient experience factors such as staff responsiveness, pain control, communication and cleanliness. Caregivers on hospital inpatient units also complete hourly rounding on patients using eight specific components of a successful round. Hourly rounding is a staff competency tracked through the SDH talent management system (TMS) [5.2c(1)]. If a patient raises an issue during hourly rounding, staff take immediate action to address the issue and follow up to let the patient know how the issue is being handled. If there is not a resolution, issues are escalated as complaints and are logged into a Meditech module as a component of the feedback system and tracked for resolution by each facility [3.2b(2)]. Within SDHMG, all practices participate in Leadership Rounding. Rounding logs from Practice Managers are submitted monthly to Share-Point and available for Senior Leadership Review.

- **Post-discharge calls.** After discharge, caregivers call patients to follow up on their care, review discharge instructions and assess their current condition as a last patient safety round. The calls also offer an opportunity to obtain feedback on the patient's visit. Depending on the nature of the feedback, it may be forwarded to the appropriate individual for follow-up or shared with a leader for reward and recognition. As a cycle of learning, SDH implemented the Patient Call Manager (PCM) database to aggregate information by facility from discharge phone calls for use in driving process improvement.
- **Surveys.** SDH uses nationally administered surveys to receive timely and actionable feedback from each patient group [3.1b(1)]. Data and verbatim comments are available weekly for the hospitals. In the practice setting, the M3 survey tool flags patients who rate their care.

The AVP of Service Excellence evaluates listening mechanisms on an ongoing basis relative to organizational needs and industry best practices and incorporates improvements as part of the strategic objective for superior service experience (Figure 2.1-4).

3.1a (2) Listening to Potential Patients and Other Customers. SDH listens to former, potential and competitors' patients through mechanisms highlighted in Figure 3.1-1.

Key mechanisms include:

- Evaluation of competitor and benchmark CMS data, which are publicly available online [3.1b(1)];
- Leverage National Research Corporation (NRC) survey to households across SDH’s primary and secondary service areas on an ongoing basis;
- Physician Relations Directors who capture key information from daily interactions with physicians both inside SDH facilities and in physician offices. All activity is entered into GrowthLink.
- One Call, which provides data about patient transfers into, out of and within SDH [3.2b(1)];
- Participation on affiliate hospital boards and regional advisory councils; and
- Analysis of service utilization data, including out-migration.

3.1b Determination of Patient and Other Customer Satisfaction and Engagement

3.1b (1) Satisfaction and Engagement. The primary listening mechanisms SDH uses to determine patient satisfaction and engagement are nationally administered patient surveys.

FIGURE 3.1-1: KEY CUSTOMER LISTENING MECHANISMS

Listening Mechanism	Pt. Groups				Stage			Community*	Physicians
	IP	OP	ED	Phys. Practice	Before Care	During Care	After Care		
Gallup survey	•	•	•				•		
HCAHPS survey	•						•		
PRC Med Staff Survey								•	
M3 survey				•			•		
NRC survey	•	•	•	•	•		•	•	
Focus groups	•	•	•	•			•		
Social media	•	•	•	•	•		•	•	
Rounding	•	•	•			•		•	
AIDET	•	•	•	•		•			
Pre-admit calls	•	•			•				
Post-discharge calls	•	•	•				•		
Patient Call Manager	•	•	•				•		
GrowthLink [3.2b(1)]	•	•	•	•	•		•	•	
Feedback system [3.2b(2)]	•	•	•	•	•	•	•	•	
BOG/BOTs [P.1b(1)]	•	•	•	•	•		•	•	
Community ed. events	•	•	•	•	•		•	•	
Community involvement by SDH leaders [1.2c(2)]	•	•	•	•	•		•	•	
Affiliate hospital boards					•			•	
Regional advisory councils					•			•	
Service utilization	•	•	•	•	•		•	•	
Demographics								•	

*Includes former, potential, and competitors’ patients

The Gallup Organization administers the phone survey for most SDH inpatients, outpatients and emergency patients, with questions tailored to each patient group. Preliminary survey data and verbatim comments are distributed to each hospital department weekly and made available through the Service Excellence SharePoint site, with comprehensive, formal reports provided on a quarterly basis. SDH can analyze results at the system level or segment by facility and department, viewing percentile ranking, a loyalty hierarchy and performance for the previous five quarters. While specific questions may vary between inpatient, ED, Same Day Surgery and Outpatient setting, the survey vendor does not. For inpatients, SDH also closely monitors performance on the CMS nationally standardized, publicly reported, HCAHPS survey. SDHMG uses the M3 survey tool, which allows benchmarking nationally, inside and outside of HCA. Results from all these surveys are used as described in 3.2 and 4.1a(3). The AVP of Service Excellence, Facility Service Excellence Champions and SDHMG leaders evaluate survey vendors and questions on an ongoing basis relative to organizational needs and industry best practices.

To assess the perceptions of the physician community as a customer, Medical Staff Perception Interviews are conducted annually by a national vendor called PRC. Physicians on the medical staff of each hospital, whether independent, contracted, employed or referring, are encouraged to participate each year. For the past three years the participation has been above 80% at all facilities. Physician Satisfaction Teams at each facility then review results, communicate findings out to physicians and formulate action plans to address key opportunities to improve physician engagement and care delivery.

The primary listening mechanism SDH uses to determine community satisfaction and engagement is the NRC survey, which polls households across the region on an ongoing basis to capture their perceptions of SDH facilities and services and identify key factors in their health care provider selection. The Marketing Department evaluates survey selection and adds custom questions or adjusts the geographic boundaries to support SDH needs.

3.1b (2) Satisfaction Relative to Competitors. SDH selected its current patient satisfaction vendors largely because of their ability to provide comparative data. Gallup and NRC allow SDH to compare its patient satisfaction directly to the satisfaction of Seton patients, as well as to state and national benchmarks. PRC data is benchmarked against the PRC database of 400+ hospitals. Gallup and M3 do not provide data specifically for SDH’s key competitor, but they support SDH’s vision of becoming the finest care and service organization in the world by enabling SDH to benchmark organizations across the country including Baldrige recipient organizations and highly reputable organizations reflected in the U.S. News & World Report best hospitals ranking.

3.1b (3) Dissatisfaction. SDH determines patient dissatisfaction through nationally administered surveys [3.1b(1)], rounding, post-discharge phone calls and the Feedback complaint management system [3.2a(2)]. The M3 survey tool specifically flags physician practice patients who rate their care as unfavorable. Survey data allow area-specific, drill-down

analysis to understand and address the causes of dissatisfaction. In addition, a prominent form on the SDH website allows anyone to submit feedback, whether positive or negative. This feedback is then distributed to responsible parties within the organization who either a) resolve the issue with direct follow-up with the individual completing the form or b) recognize individuals for care or service provided. SDH aggregates and trends dissatisfaction information from feedback and the various satisfaction surveys to identify opportunities for improving patient satisfaction with care or service at the facility and system level. The CFET also reviews this information in evaluating changing customer requirements.

3.2 Customer Engagement

3.2 Service Offerings and Patient and Other Customer Support

3.2a (1) Service Offerings. To identify new service offerings that help SDH meet and exceed customer requirements, enter new markets, attract new patients and expand relationships with existing patients, SDH, as a cycle of learning, has implemented a permanent Customer Focus and Engagement Team (CFET) to analyze input from the various listening mechanisms defined in [Figure 3.1-1](#) and translate those into patient and other customer requirements. The process for this work is to assign a sub-group of CFET to each key customer group including patients, community and physicians. Each sub-group is responsible for interpreting data and sharing with the larger team in monthly meetings. For instance, to verify key patient requirements ([Figure P.1-7](#)), SDH annually convenes a series of patient focus groups with representation from across SDH’s facilities, patient groups and market segments. Key community requirements come from analysis of NRC survey results.

The Customer Focus and Engagement Team (CFET) discusses and confirms this interpretation, then translates the data into customer requirements using an affinity diagram process. These requirements are then shared in CEO Council and used as inputs into the SPP, operations management, process improvement, Innovation Council and physician relations.

Innovative ideas for adapting and improving services are vetted at the facility or system level and evaluated in collaboration with impacted departments. Ideas for new services which impact SDH as a system are brought to the Planning Department, which assesses factors such as resource requirements, return on investment, workforce impact, payor mix and the competitive environment. A standard template guides evaluation of the proposed service relative to factors such as strategic fit, patient impacts and ROI benchmarks. The sponsoring executive then makes a case to the SDH or facility CEO. Approved new services roll into the strategic planning and budgeting processes. Follow-up evaluation against established measures of success is required at scheduled post-implementation intervals. For services not performing to goal, the sponsoring executive is responsible for improvements so that the service will meet and exceed patient or community requirements.

3.2a (2) Patient and Other Customer Support. SDH has established support mechanisms enabling patients and the community to seek information and obtain health care services.

Some mechanisms vary across patient groups and market segments, as indicated in [Figure 3.2-1](#). Patients and community members provide feedback as described in 3.1a(1).

SDH has several mechanisms in place to determine key patient and community support requirements:

- Through scheduled reviews of customer listening data and information [4.1a(3)], teams at the system, facility and physician practice levels verify support requirements and identify opportunities to more fully address them.
- During design of new facilities and services, multi-disciplinary teams review national best practices and customer requirements as determined by the CFET to identify specific support requirements and opportunities for innovation.
- During strategic planning, CEO Council may identify the need for new services or service locations based on the Environmental Assessment [2.1a(1)].
- The Marketing and Communications Department evaluates key communication tools relative to patient and community feedback and industry best practices to identify new ways customers like to receive information.

To reinforce universal support requirements across the organization, SDH has deployed the Values Commitment ([Figure P.1-2](#)) and the service excellence initiative, which includes Key Words at Key Times, the use of AIDET (which is an acronym for Acknowledge, Introduce, Duration, Explanation and Thank) and patient rounding. These key elements of the SDH culture are reinforced through the hiring and orientation process [5.1a(2)], workforce performance management [5.2a(3)], the learning and development system [5.2c(1)] and supply chain management [6.2b].

3.2a (3) Patient and Other Customer Segmentation. Annually during the SPP [2.1a(1)], SDH identifies/verifies current patient, stakeholder and market segments while anticipating future ones. With the Environmental Assessment providing context, CEO Council evaluates the current patient and

FIGURE 3.2-1: KEY SUPPORT MECHANISMS

	Patients	Community
Obtain information	Leader rounding, hourly rounding, AIDET, bedside shift report, in-room white boards, patient education materials, post-discharge phone calls, patient portal	Website, social media [3.1a(1)], health fairs, Consult-a-Nurse, physician referral service, targeted mailings
Obtain services	One Call (IP), valet parking (IP, OP), free parking (SDHMG), patient navigators (cardiac), room service (IP), urgent care centers (ED), free-standing emergency departments (ED), Triage Tickets for transferring high-acuity ED patients, physician practices with extended hours and walk-in appointments (SDHMG), pre-admission process (IP, OP), interpretive services, ID card for UT athletes (ED)	Health screenings, Executive Wellness, hospital affiliate agreements, medical coverage at UT games (ED), nurse navigator at UT athletic training center

stakeholder groups and determines whether any changes need to be made. For instance, as SDHMG continues to grow, SDH added physician practice patients as a patient group. Also during SPP, CEO Council, service line leaders and key physicians evaluate current and anticipate future service lines (market segments), considering factors such as market share, utilization, demographics, revenue, key clinical indicators, competitive environment and the strategic challenge of health care payment reform. SDH considers potential and competitors' patients in these discussions through analysis of market share, utilization, demographics, intelligence on competitor service offerings and data described in 3.1a(2). Based on this analysis, CEO Council identifies service lines that will best support the organization's strategic objectives and achieve its goals of Exceptional Care, Customer Loyalty and Financial Strength. As a result, SDH began development of oncology as a new service line in the 2013 SPP. Additionally, SDH has increased focus on Emergency Department process improvement initiatives which is being led by the VP Performance Improvement, and utilizes multi-disciplinary teams across the system to track metrics and implement improvement tactics

3.2b Building Relationships with Patients and Other Customers

3.2b (1) Relationship Management. SDH has numerous mechanisms to market, build and manage relationships with patients and the community.

SDH uses marketing channels to engage with patients and other customers. Selected campaigns utilize direct mail advertising to engage consumers and cross market service lines. Consumers are encouraged to engage via tools such as the online Health Risk Assessments (HRAs). This offering meets a growing consumer need and allows SDH to interact on an on-going basis. Additionally, metrics are tracked across the system through CPM monthly reporting.

To acquire patients and build market share:

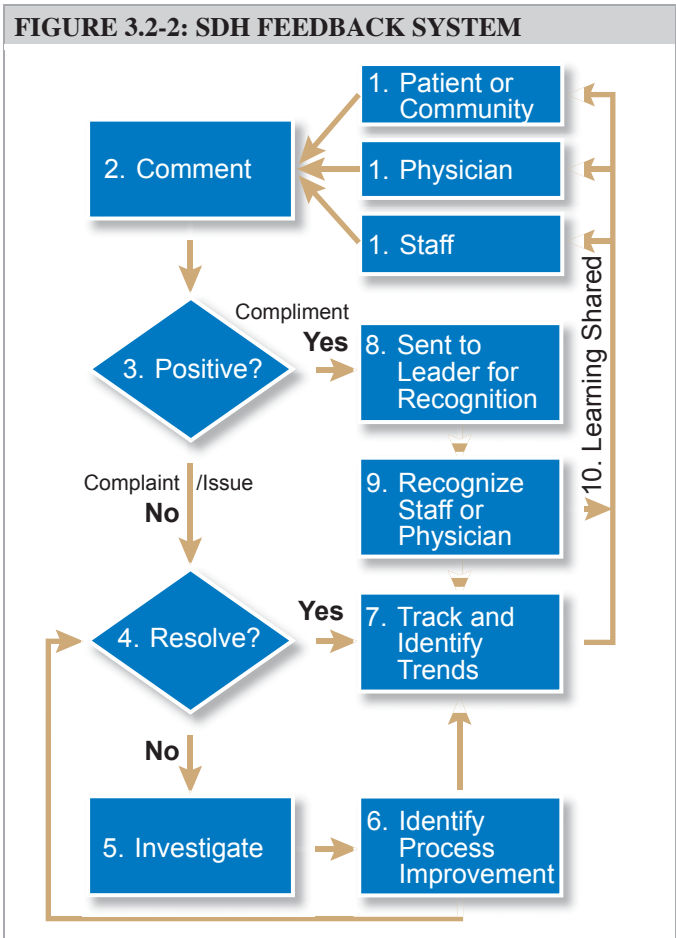
- SDH invests significant resources in building relationships with referring physicians across the region. Physician Sales Representatives (PSRs) maintain regular communication with physicians and work to make physician interactions with SDH both efficient and effective. PSRs log activities and findings in GrowthLink to ensure resolution of any identified issues and to allow aggregation and trending for improvement and planning purposes.
- SDH established its One Call Center to streamline patient transfers into, out of and within the system based on physician and affiliate hospital input on wanting just "one number to call".
- SDH establishes formal agreements with affiliate hospitals in its secondary service area. Through these agreements, SDH provides a variety of services, including nursing education; outreach specialty clinics; assistance with clinical protocols; physician staffing in specialty areas such as emergency medicine and neonatal intensive care; and general support from a designated SDH outreach coordinator. SDH partners with affiliate hospitals on protocols, such as heart attack or stroke, that prepare patients for transfer into SDH and asks for feedback on all transfers. A SDH execu-

tive serves on the boards of directors for affiliate hospitals and affiliate hospitals participate in the SDH BOG retreat to provide input and clarify requirements.

- Two members of the SDH outreach team focus on regional EMS providers. They regularly visit EMS stations, serve with EMS providers on regional trauma and emergency preparedness advisory councils and annually survey them. They then log activities and findings into GrowthLink for aggregation and trending. SDH has entered into a formal affiliation agreement with one EMS provider to share data, place a staff person in SDH's One Call center and shift resources to meet SDH needs.
- SDH partners and collaborates with community organization, such as the University of Texas (UT) [1.2c(2)]. SDH also sponsors numerous non-profit organizations such as American Heart Association, American Cancer Society and the Leukemia and Lymphoma Society, to name just a few. Additionally, SDH has a presence at many community events and health fairs throughout the region.

3.2b (2) Complaint Management. To retain and increase engagement of patients in each stage of their relationship with SDH, SDH leverages several processes highlighted in Figure 3.2-2.

- SDH has a formal marketing, communications, physician relations and outreach plan. This plan is formulated annually at a system-wide level in support of the updated SWAP and is centered around engaging new patients and physicians and retaining current ones through strategic messaging and



- building relationships.
- SDH has implemented numerous mechanisms to support patients in obtaining care (Figure 3.2-1). For instance, high-acuity ED patients transferring to SDH EDs from urgent care centers and other EDs inside and outside the system receive Triage Tickets to streamline their care and prevent duplication of services.
- SDH's service excellence initiative focuses the workforce on engaging patients during their care. Key elements of this initiative include the Values Commitment (Figure P.1-2), leader and hourly rounding [3.1a(1)], AIDET and Key Words at Key Times.

- Also during care, caregivers use bedside shift report to engage patients and their families in setting care goals and developing care plans. Care goals are documented and updated on prominently displayed white boards in each patient's room.
- Environmental services workers use clean teams and distribute business cards to improve accountability for room cleanliness.
- SDH has implemented a "No Pass Zone" requiring all staff members to respond to patient call lights.
- To engage patients after their care, SDH uses post-discharge phone calls [3.1a(1)] and staff thank you notes.

Category 4: Measurement, Analysis and Knowledge Management

4.1 Measurement, Analysis and Improvement of Organizational Performance

4.1a Performance Measurement

4.1a (1) Performance Measures. SDH uses the Performance Dashboard to align the organization's focus on the three Goals of Exceptional Care, Customer Loyalty and Financial Strength. These three goals and the measurement and review process support the organization's ability to deliver its' mission on a day-to-day basis and ultimately achieve its vision. The process for selection of key performance measures expressed in the dashboard begins with the SPP.

- During the SPP [2.1a(1)], CEO Council evaluates the results and trends for the Performance Dashboard measures and considers new ones based on selection criteria. These criteria include relevance to system goals, alignment with sponsor HCA reporting, and recommendations from key stakeholders and leaders throughout SDH.
- CEO Council establishes targets for the measures to drive continuous improvement and innovation [4.1a(2)].
- The measures cascade to supporting system, facility, SDHMG and department dashboards to drive strategic plan execution and enable both analysis and comparisons between facilities.
- Key Reports are formatted using colors to indicate at a glance which measures are at or below goal.
- The measures are used to inform individual goal setting for leaders [5.2a(3)].
- SDH senior leaders re-evaluate the Performance Dashboard process during the organization's Baldrige-based self-assessment.

As a cycle of improvement, in late 2013 SDH chartered a Measurement Team to evaluate current and potential measures and ensure alignment and deployment throughout the organization.

Clinical and operational information systems collect and store data using standardized data definitions that reduce measurement variability across the system [4.2b(2)]. Data and information for tracking daily operations and overall organizational performance are captured and retained in several databases for

FIGURE 4.1-1: SDH PERFORMANCE DASHBOARD

Goal	Measure	Source	Freq	Reviewed
EC	Risk-adj mortality index	CHOIS	Q	Quality Rev.
EC	Risk-adj compl. index	CHOIS	Q	Quality Rev.
CL	HCAHPS Grand Comp.	Gallup	W	Srvc Exc Rev.
CL	Employee Engagement	TNS	A	HR Rev.
CL	Voluntary Turnover rate	HR	Q	HR Rev.
CL	Physician satisfaction	PRC	A	CEOCFac.
FS	Tier 1 market share	TDH	M	CEOCFac.
FS	EBITDA	Vista	W	MOR

*Legend: EC=Exc. Care; CL=Customer Loyalty; FS=Fin. Strength
Frequency: W=Weekly; M=Monthly; Q=Quarterly and A=Annual*

aggregation, trending and easy access.

Performance Dashboard measures are highlighted in Figure 4.1-1, and include a risk-adjusted mortality index, risk-adjusted complication index, HCAHPS Grand Composite, Overall Employee Engagement, Employee voluntary turnover rate, Physician satisfaction, Tier 1 market share and EBITDA.

Standard reports support scheduled organizational and operational performance reviews (Figure 4.1-2), which identify and prioritize areas in need of improvement and innovation.

A sample of the SDH reporting systems for tracking operations include:

- Daily admissions and key statistics (Admin Tracker),
- Length of stay and census (Daily Census Report),
- ED process measures (ED dashboard),
- OR process measures (OR dashboard),
- Bed availability (Teletracker),
- Cardiac clinical process measures (MedAxiom),
- Daily reports on volumes, revenue, cash collections and staffing (Vista),
- IT&S metrics (IT&S),
- Hospital clinical measures (COMET/CHOIS),
- Turnover and HR measures (HR analytics), and
- Productivity (PLUS).

IT&S collaborates with hospital, ASC and practice leadership to evaluate clinical and operational information systems on an ongoing basis to identify new technology for capturing and presenting actionable data and information.

FIGURE 4.1-2: KEY ORGANIZATIONAL MEETINGS AND REVIEWS

Meeting	Participants	Freq*	Level*	Focus
BOG	BOG	BM	S	Performance Dashboard, key operational indicators including financial and quality
Board Quality Committee	BOG members, physicians, SDH CEO, CMO, VP Quality	Q	S,F	Clinical outcomes, patient safety, patient satisfaction
Facility BOT's	BOTs	M	F	Facility dashboards, key financial indicators
Facility MEC's	MECs	M	F	Clinical quality, patient satisfaction
CEO Council	CEO Council	BW	S	Performance Dashboard, key operational indicators including financial, clinical quality, patient satisfaction, HR, productivity
Facility Admin Team	Facility CEO, COO, CNO, CMO, CFO, HR director	W	F	Facility dashboard, key operational indicators including financial, clinical quality, patient satisfaction, HR, productivity
Monthly Operating Reviews (MORs)	SDH CEO & CFO with each facility admin team and SDHMG admin team	M	F	Financial results & volumes relative to budget
Practice Management Meeting	VP Physician Operations, SDHMG practice managers	M	F	Patient satisfaction, productivity, financial & HR indicators
ASC Leadership Meeting	VP Operations, ASC administrators	M	F	Patient satisfaction, productivity, financial & HR indicators, ASC metrics
Productivity Review	SDH CEO, CFO, Director Management Engineering, Facility Admin Teams	W	S,F	Productivity, contract labor, position control
Quality Review	SDH CEO, CMO, VP Quality, Facility Admin Teams, Facility Quality Directors	Q	S,F	Clinical outcomes, patient safety, patient satisfaction
HR Review	SDH CEO, CMO, VP HR, Facility Admin Teams, Facility/SDHMG HR Directors	Q	S,F	Turnover, vacancies, staffing, culture
Service Review	SDH CEO, AVP Service Excellence, facility CEOs, CNOs & service excellence champions	Q	S,F	Patient satisfaction
Strategy Review	SDH CEO, CMO, VP Planning, Facility Admin Teams	Q	S,F	Action plan progress
Patient Safety Councils	SDH & facility CMOs, CEOs, COOs, CNOs, quality staff	M	S,F	Patient safety metrics

Legend: S = system, F = facility, BM = bi-monthly, BW = bi-weekly, M = monthly, Q = quarterly and W = weekly

4.1a (2) Comparative Data. Selection of comparative data is done through an approach that includes: 1) researching benchmarks (which includes data and processes) for key performance indicators inside and outside the health care industry; 2) evaluating high-performing organizations, both inside and outside healthcare, and organizations providing similar services based on complexity and scope of operations; 3) ensuring consistency of measurement definition; and 4) evaluating the availability and frequency of the data. Targets set relative to identified comparative data cascade to supporting reports across the organization and are incorporated into MORs and other reviews, at various levels throughout the organization. Organizational performance is evaluated relative to established and appropriate measures to drive operational improvements and provide exceptional care.

The recommended key comparative data and the targets are approved by CEO Council, which annually establishes targets for Performance Dashboard measures. To achieve the vision of being the “finest care and service organization in the world,” SDH aspires to reach the top 5-10% on all of the established goals. However, realizing that all organizational units are not at that level, incremental goals are set in collaboration with individual hospital leadership teams. For measures, where exceptional

benchmarks are not available, CEO Council uses historical data and the best-available comparison to set goals.

4.1a (3) Patient and Other Customer Data. SDH selects voice-of-the-customer (VOC) data and information (Figure 3.1-1) based on national best practices, availability, actionability and alignment with sponsor HCA. The most visible VOC data at all levels of the organization are patient satisfaction results [3.1b(1)], which is one of the key measures on the Performance Dashboard, as well as facility specific dashboards. For inpatient areas, department performance dashboards display patient satisfaction data to the question level detail. To support a focus on this key measure and drive innovation, CEO Council uses weekly patient satisfaction reports to understand progress towards goals and identify areas of improvement.

To build a more patient-focused culture, SDH leaders engage employees and physicians in reviewing and responding to patient satisfaction results through the use of dashboards populated weekly with the latest results. As an improvement, results are posted on SharePoint so all employees can access them. Formal performance reviews relative to SDH targets, national benchmarks and other HCA entities display relative performance and drive development of action plans by facil-

ity service excellence champions. Quarterly service excellence planning meetings bring together CEOs, CNOs and service excellence champions from each facility to review survey results, report progress on action plans and share best practices related to patient satisfaction results.

To engage physicians, hospital results are presented at the hospital medical staff section meetings, SDHMG leaders review physician practice results at their monthly operations meetings, and ASC leaders review relevant data at ASC board meetings. Accomplishment of patient satisfaction goals is a component of leader incentive pay [1.2a(2)] and is addressed in medical director contracts.

The establishment of a formal CFET [3.2a(1)] enables SDH to better understand the VOC data relating to patients, the community and physicians. As a component of this team, the SDH interactive media consultant monitors social media outlets such as Facebook, Twitter, YouTube, Flickr, Google Places and Yelp and generates monthly reports that aggregate and trend interest and engagement and presents this information to the CFET.

4.1a (4) Measurement Agility. Annual evaluation of the performance measurement system and frequent, scheduled reviews of organizational performance ensure that SDH and its performance measurement system are able to respond to rapid or unexpected organizational or external changes. Each year during SPP, CEO Council evaluates Performance Dashboard measures and goals and makes any changes necessary to support the SOs and address the competitive and regulatory landscape. Frequent, scheduled performance reviews (Figure 4.1-2) alert senior leaders at the system and facility level when the organization is not performing to goal and enable rapid corrective action. The performance measurement system also allows the addition of new measures throughout the year.

4.1b Performance Analysis and Review

SDH monitors organizational performance and capabilities through frequent, scheduled reviews. Scheduled CEO Council meetings follow a standard structured agenda with updates addressing performance in areas including clinical outcomes, patient satisfaction, productivity, human resources, finances and strategic plan tactics. Each hospital executive team, SDHMG leadership team and ASC leadership team meets weekly and follows a similar process. These reviews and others highlighted in Figure 4.1-2 evaluate current performance, trends, variability between facilities and performance against established goals as well as competitor and benchmark performance. As appropriate, the organization is integrating performance measures from the SDHMG into the scheduled reviews. With all reviews, additional analysis, such as regression analysis or root-cause analysis, support valid conclusions and help effectively target corrective action. Since the measurement selection process sets goals for performance needed to achieve SOs and ensure organizational sustainability, review of performance relative to these goals enables senior leaders to assess organizational success, financial health, strategic progress and organization-

al agility. The BOG also reviews organizational performance through established agendas that incorporate key operational results and action plan updates. The BOG Finance Committee and BOG Quality Committee review key financial and clinical metrics respectively for the system and individual facilities on a quarterly basis. The individual hospital Boards of Trustees, the Boards of the SDHMG and the ASC Boards all review pertinent clinical and operational measures of performance.

4.1c Performance Improvement

4.1c (1) Best Practices. SDH intentionally designed its performance review structure to facilitate best-practice sharing across the organization. Standard dashboards and reports present data from multiple facilities side-by-side for easy comparison, and review meetings, such as those highlighted in Figure 4.1-2, bring together leaders from across facilities, departments and disciplines. Additional meetings at all levels of the organization bring together “like” positions to facilitate sharing between facilities. For instance, facility CMOs, CFOs, CNOs and COOs, each meet on a regular basis with their system-level counterpart, as do facility- and SDHMG-based quality directors and HR directors. In each case, the goal is to identify high performers and disseminate their best practices across SDH.

4.1c (2) Future Performance. SDH annually projects future performance during SPP (2.2b) based on performance review findings and key comparative and competitive data. The Planning Department looks at historical trends and considers the impact of key planned or anticipated internal and external changes. The SDH Measurement team [4.1a(1)] supports the Planning Department by reviewing all measures and making recommendations on relevant benchmarks. The organization performs a similar analysis for its key competitor and for benchmark organizations. Projected performance gaps in key areas help the organization identify and prioritize action plans and resource allocation.

4.1c (3) Continuous Improvement and Innovation.

The Performance Dashboard establishes the framework for translating organizational performance review findings into priorities for improvement and opportunities for innovation. During review of the Performance Dashboard and supporting measures, measures not performing to goal prompt corrective action, including innovation when possible. These improvement opportunities are assigned to an “owner” responsible for further evaluation and action plan development. The owner is also responsible for engaging impacted employees, physicians, suppliers, partners, or collaborators, as appropriate. Depending on the scope of the action plan, deployment mechanisms may involve communication mechanisms highlighted in Figure 1.1-1 or regularly scheduled meetings with Parallon [6.2b]. At the system level, status reports from the owner become a standing agenda item at CEO Council meetings until performance reaches or returns to goal.

4.2 Knowledge Management, Information and Information Technology

4.2a Organizational Knowledge

4.2a (1) Knowledge Management. SDH collects and transfers employee and physician knowledge through: 1) integrated information systems, including the EHR, AdminTracker and Teletracker; 2) an intentionally designed meeting structure (4.1b), including organizational performance reviews; 3) documented policies and procedures; 4) training curriculum; 5) SharePoint; 6) bedside shift reports; 7) SBAR (Situation, Background, Assessment and Recommendation) hand-off communications; 8) GrowthLink and One Call [3.2b(1)]; and 9) communication mechanisms highlighted in Figure 1.1-1.

Transfer of knowledge from and to patients and the community happens primarily through the listening mechanisms (Figure 3.1-1), key support mechanisms (Figure 3.2-1) and the EHR system [4.2b(2)]. Knowledge transfer with key supplier Parallon is described in 6.2b and with collaborators (affiliate hospitals and EMS providers) in 3.2b(1). SDH has numerous mechanisms for transferring knowledge to and from partner HCA, including an integrated information system that gives SDH access to HCA data for comparison and data-mining purposes; standard reports from SDH to HCA, standard HCA reports that compare the performance of SDH to HCA facilities and divisions across the country and regular executive visits between SDH and HCA headquarters in Nashville. Knowledge transfer with partners SDF and GHF happens primarily through bimonthly BOG meetings.

SDH has structured the organization to support organizational learning and information transfer to improve service and operational performance. In addition to mechanisms highlighted in 4.1c(1), CEO Council, support services, key organizational performance reviews (Figure 4.1-2) and Leadership Advance Quarterlies bring together employees and physicians from across SDH to share best practices. The organization also supports the workforce in seeking national best practices through participation in conferences and professional associations, as well as benchmarking trips to high-performing organizations. Lastly, SDH leverages best practices identified by HCA across its 160+ hospitals. HCA details these best practices in “Playbooks” and pushes them out to all HCA facilities for implementation. When SDH leaders identify a best practice or receive an HCA Playbook, an assigned responsible party develops an implementation plan that includes targeted communications, workforce training, new equipment, and/or revisions to policies, procedures, protocols, forms, IS fields and workflow process. Following implementation, the responsible party evaluates results and makes any needed adjustments.

Assembly and transfer of knowledge for use in strategic planning, including identification of areas to target for innovation, are the focus of the annual environmental assessment [2.1a(1)].

4.2a (2) Organizational Learning. SDH uses knowledge and resources to embed learning in its operations through multiple mechanisms:

- SDH has established key organizational performance reviews (Figure 4.1-2) to monitor operational effectiveness

and identify opportunities for improvement.

- SDH promotes internal and external best-practice sharing [4.1c(1), 4.2a(1)].
- SDH provides access to robust data-mining capabilities by leveraging HCA’s national information platform [4.2b(2)] for drill-down analysis of process performance relative to national benchmarks.
- SDH supports leader participation in state and national Baldrige organizations and conducts an annual Baldrige-based self-assessment.

4.2b Data, Information and Information Technology

4.2b (1) Data and Information Properties. SDH manages organizational data, information, and knowledge to ensure accuracy, integrity, reliability, timeliness, security and confidentiality.

SDH ensures data accuracy and integrity through extensive workforce training and system checks and balances, including limited open-text fields, entry validation and standardized dictionaries and drop-down menus. As data are entered into SDH’s integrated systems [4.2b(2)], they are immediately available. The data flow from the primary Meditech system to other systems is virtually instantaneous for access at all facilities and remotely. To further ensure timely and reliable access to data, SDH establishes specific accountabilities with service level agreements to maintain a high level of systems availability [4.2b(2)]. All systems are backed up according to business continuity and disaster recovery plans to protect information assets [4.2b(4)].

To ensure security and confidentiality, employees receive initial HIPAA training at orientation, sign a confidentiality and security agreement, and complete annual mandatory training, which is tracked by SDH’s online education system. Physicians receive information on HIPAA during medical staff credentialing and sign a confidentiality and security agreement before IT&S physician support coordinators give them access to SDH systems. SDH uses a Consolidated Provisional Role-Based access methodology to limit and standardize data access across facilities through unique user sign-ons and strong passwords. Software and hardware systems provide audit trails that identify the user, time and operation to allow for monitoring and analysis of data integrity and security issues. Alerts are automatically generated for any instances of unauthorized access and disciplinary measures for any improper access or breach of confidentiality are taken as necessary. IT&S receives automated notification of departing employees through links to the HR system to support immediate removal of access to SDH IT systems. Physical security of the network and database servers is protected with physical controls. Additional security measures are described in 4.2b(3).

IT&S evaluates SDH systems on an ongoing basis relative to new technology, regulatory changes, industry best practices and internal audit findings and updates technology [4.2b(2)], processes and training as needed.

4.2b (2) Data and Information Availability. At SDH, IT&S is a centralized function that leverages the technology,

innovation and data-rich systems of the national HCA organization while balancing the needs of local stakeholders. An industry-leading redundant system-wide Metropolitan Area Network (MAN) with mirror images of all data in two data warehouses eliminates system downtime. This “redundant MAN” is being replicated by other HCA markets and provides connectivity for employees, physicians, suppliers, partners and collaborators from any SDH facility and remotely. Through a management services agreement, SDH’s primary clinical data repository is HCA’s nationwide Meditech platform. HCA sets national standards and core business applications for the platform, but the Austin-based CIO and IT&S departments manage the SDH system and make local changes to support unique SDH needs. The most significant advantage the HCA platform offers SDH is access to the world’s largest clinical data warehouse, which the SDH VP of Clinical Innovation is working to leverage for identification of new clinical decision support opportunities. Standardized data fields across the nationwide platform also allow unique drill-down analysis of operational performance [4.1a(1)].

To support the delivery of exceptional care and anticipate the need for more integrated care delivery, SDH devotes significant resources to data access for physicians. SDHMG and independent physicians have remote access to secure patient information with integrated clinical information systems such as Meditech, Picture Archival Communication System (PACS) and Airstrip OB for real-time fetal monitoring. SDHMG practices have direct access to Meditech, while independent practices can access Meditech through HCare Portal or established interfaces with their practice EHR.

Each facility has an intranet, in addition to the SDH intranet, that is accessible to all staff for sharing and communicating company information including policies and procedures, employee benefits, facility events, online education and much more. SDH also provides a system-wide internet site with the capability of customizing content at the facility level. The internet site provides a variety of information for patients and families including education, facility services, news and resources, interactive tools, online bill payment, price transparency and maps and directions, as well as an online application for candidates who want to apply for a job. All employment applications are processed online and kiosks are provided in each Human Resource Department for those without Internet access at home. Applications are also available in Spanish. Employees have email, leaders use mobile devices with wireless connectivity, and wireless access is available for employees, physicians, patients and community members at all facilities.

In addition to the internet site, SDH makes data and information available to patients and the community through key support mechanisms (Figure 3.2-1). Also, the CIO and partner SDF participate in an Integrated Care Collaborative (ICC) working to establish a health information exchange (HIE) reaching from New Orleans to North Texas. SDH received a Computer World award for its High Alert program, which leverages the Integrated Care Collaborative to identify and track drug-seeking and behavioral issue patients who frequent SDH EDs. This reduces inappropriate ED visits and ensures

that these patients are placed in the right care setting with appropriate treatment plans.

Key supplier Parallon has access to SDH and nationwide HCA information platforms for inventory monitoring and automated re-ordering of supplies.

4.2b (3) Hardware and Software Properties. The IT&S department ensures the reliability, security and user-friendliness of SDH computer systems through the use of Information Technology standards, policies and procedures.

The SDH Information Security Official leads SDH’s security program, backed by an outsourced agreement with HCA and the IT&S Security group and is supported by policies and a privacy and security official at every facility. All computers and mobile devices are encrypted, and an extensive set of security guidelines, standards, policies and procedures are in place to monitor activity on computer systems and non-electronic data and information.

In addition to approaches described in 4.2b(1), firewalls, anti-virus/anti-spam filtering, intrusion detection and other technologies provide further system protection. As a cycle of learning, IT&S centralized risk management and implemented tools such as SAPortal to perform monthly scans on all devices and assess risks and vulnerabilities. IT&S then pushes appropriate patches and updates to devices to ensure a safe networking environment.

SDH has multiple mechanisms in place to understand and address user requirements:

- The SDH Clinical Information Systems Council reviews new applications to ensure that they meet requirements for functionality and ease of use.
- IT&S engages end-users in hardware and software selection to ensure applications meet their needs.
- With deployment of new systems, IT&S performs pre- and post-flow analyses to validate ease of use or identify the need for vendor enhancement requests.
- Initially piloted at one facility, the SDH Service Desk has expanded across the entire system, allowing SDH to consolidate and centralize multiple help desks. The result has been higher service availability and more consistent customer services.
- An annual IT/HIM compliance survey of physicians, employees and key suppliers identifies opportunities to enhance usability of key systems and applications. For instance, based on survey results, SDH installed hCARE Portal to simplify Internet access to clinical data.

In addition to disaster recovery plans [4.2b(4)], SDH ensures hardware and software reliability through the Technology Refresh program, which keeps data and information availability mechanisms current. Annually, IT&S gathers input from SDH leaders, employees and physicians through analysis of resources needed to support the strategic plan, and an assessment of current software, hardware and infrastructure relative to established performance requirements. Based on these inputs, IT&S updates its project portfolio and develops an implementation schedule, including a plan to refresh hardware across the system. The SDH CIO submits the plan to the CEO Council for approval and integration with the strategic planning and

budgeting processes. The CIO meets monthly with the SDH CEO and CFO and facility CEOs for ongoing IT review.

Application software and operating systems are updated in accordance with vendor acceptance and undergo rigorous quality assurance testing to avoid any conflicts. SDH assesses and upgrades all network infrastructures, end user devices and the wireless infrastructure on a four-year rotation plan.

4.2b (4) Emergency Availability. As an integrated part of SDH emergency preparedness [6.2c(2)], IT&S develops and annually updates plans to ensure availability of hardware and software systems and data at all facilities. Redundancy is provided locally, regionally and nationally through HCA. Every corporate regional data center has redundant networking, hot sites, HVAC and power. Data for SDH is stored in a regional data center in Dallas/Ft. Worth, with redundancy provided in Orlando and in Nashville. Through the use of VMware, SDH

servers are “virtualized,” which allows data to be replicated and mirrored on multiple servers. During a downtime, virtual servers allow data restoration and provide access to users across the system within minutes. In a collaborative effort with Dell Computer, Meditech, VM and others, HCA virtualized more than 1,000 production servers in 2008. Since then, every new SDH server has also been virtualized.

To ensure continuity of care during planned or unplanned system downtimes, every department maintains consistent emergency downtime procedures. Employees are trained on these procedures, which include transition to a “paper system,” during orientation and through their departments. Scheduled and unscheduled downtimes, as well as extensive system tests, are documented to identify improvement opportunities. These opportunities are addressed through system changes or procedure updates.

Category 5: Workforce Focus

5.1 Workforce Environment

5.1a Workforce Capability and Capacity

5.1a (1) Capability and Capacity

Employees. To address workforce capacity, SDH uses an integrated labor productivity management process (Figure 5.1-1) to strategically and operationally assess staffing capacity needs. During the SPP [2.2a(4)], the system Director of Labor Management works with CFOs and operational leaders at each facility to determine staffing needs based on volume forecasts, historical trends, benchmark data and internally established workload and staffing standards. These aggregated staffing needs, along with projections from specific tactics and action plans from the strategic plan, comprise the master staffing schedule, department specific staffing grids, position control guidelines and the annual recruitment plan.

The system Director of Labor Management reviews and approves all facility personnel requisitions on a weekly basis, monitoring compliance to staffing plans and adjusts hiring targets in each department to compensate for changes in volume, attrition and recruiting patterns.

On a daily basis, within facilities, SDH’s web-based Productivity and Labor Utilization System (PLUS) helps managers monitor and adjust schedules to address fluctuating patient volumes. PLUS integrates with the electronic Facility Scheduler to provide shift-by-shift data to help managers evaluate their scheduling effectiveness relative to volume needs and productivity goals. Facility Scheduler is also used to generate a monthly Scheduling Excellence Dashboard which measures how often a manager’s staffing schedule is complete relative to both capability and capacity and how well schedules support healthy work-life balance (Figure 7.3-6). Facility leaders identify and address scheduling issues based on the dashboard. Cycles of learning in recent years have resulted in improvements to the reporting systems, addition of PLUS and Scheduling Excellence training to new director orientation, and plans to deploy Facility Scheduler to all departments where

benefit can be gained.

To address capability needs, SDH strives to ensure that all staff have the requisite knowledge and skills to provide exceptional care and service every day. SDH and its CNOs support the IOM recommendation to have 80% of the RN workforce be BSN prepared by 2020 and has implemented development programs to support the attainment of certifications and further training. Hiring managers and preceptors assess employees at 90 days and annually thereafter relative to defined, job-specific competencies. An electronic system tracks and aggregates current education, mandatory certifications and competencies to help SDH identify capability gaps, which are addressed through training [5.2c(1)] or the recruitment plan. Recent improvement efforts focused on standardizing competencies across all of the hospitals in the system.

Physicians. SDH has two key components of its approach to assess physician capability and capacity needs — the Medical Staff Succession Plan and the Physician Recruiting Plan:

1. SDH performs a comprehensive review of the medical staff at each facility to evaluate factors such as age and specialty and labels each physician as high-, medium-, or low-risk for leaving. Based on this review, as well as service utilization data, regional demographics and community need, SDH develops its Medical Staff Succession Plan.
2. Annually, during the SPP, the VP of Physician Recruitment and Sales works with action plan owners to identify physician recruitment needs in support of specific strategic plan tactics. The aggregated results form the basis for the Recruiting Plan, which addresses needs related to SDHMG, independent physician practices and practices under contract to provide hospital-based services.

5.1a. (2) New Workforce Members

Employees. The annual recruitment plan [5.1a(1)] drives SDH’s recruiting efforts, with direction from the Director of Recruitment. The recruiting process begins when the hiring managers submit electronic position requests based on either a vacancy or new positions based on position control guidelines established during SPP [5.1a(1)]. System recruiters receive

electronic notification of these requests and source applicants through a process that leverages community outreach, job fairs, employee referrals, online job boards, social media and trade journals to ensure that the workforce represents the diverse ideas, cultures and thinking of the hiring and patient communities. Through shared learning, a system-wide process was developed whereby requisitions are opened early to hire staff based on historical turnover. This process helps reduce time to fill and allows departments to maintain optimal staffing. Through Affirmative Action Plans and patient population data, SDH monitors the composition of its workforce to confirm that diverse populations are adequately represented, with targeted recruitment to address difficult-to-fill positions, SDH offers sign-on, relocation and referral bonuses, as outlined in specific policies. To address national nursing shortages, SDH established the innovative Specialty Nursing Accelerated Program (SNAP), which trains high-performing nurses to work in specialty areas such as intensive care, emergency, and medical surgical departments which adds staffing flexibility, helps the organization “grow its own” specialty nurses, and also increases nursing engagement and retention (Figure 7.3-4).

SDH received a \$5 million grant over four years for a nurse residency program – Successful Transition and Retention (STaR). All new graduate nurses attend the Immersion Residency and receive general and specialized education, support and training, which incorporate the latest evidence on transition to practice.

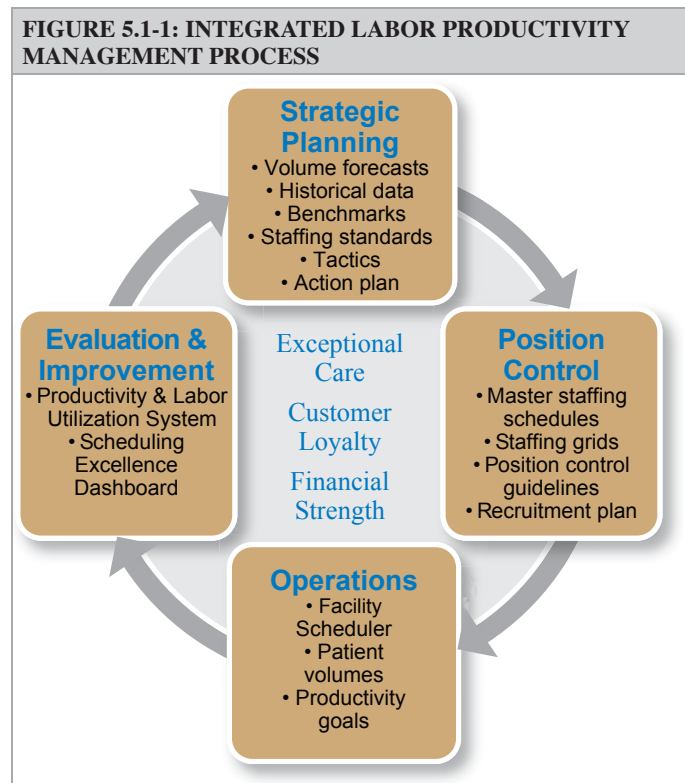
Also, in response to identified community needs, SDH partners with six area colleges and universities to support and expand health care training programs. Specifically, SDH established the St. David’s School of Nursing at Texas State University three years ago with contributions from partner SDF. SDH also co-chairs the Healthcare Workforce Alliance of Central Texas with its key competitor Seton to bring together educational institutions and private industry to plan for future training needs and develop community standards. Lastly, SDH partners with not-for-profit organizations Capital Idea, Goodwill and Skillpoint Alliance to recruit nurses and frontline workforce. These not-for-profit organizations also help SDH support its efforts to maintain a diverse workforce. This led to the establishment of the Patient Care Technician Intensive (PCTI) program for PCTs that provides the appropriate skills and clinical education with an annual retention rate of 85%.

Job candidates complete an on-line application form requiring them to accept the SDH Values Commitment (Figure P.1-2). Recruiters screen and forward qualified applicants to hiring managers, who coordinate a peer interview process using job-specific, behavior-based questions available from a centralized library. New hires participate in standardized New Employee Orientation (NEO), which emphasizes the MVVG, Code of Conduct and service excellence, including AIDET, rounding and Key Words [3.2b(1)]. To support retention, new hires have 30- and 90-day conversations with their supervisor and attend a welcome event hosted by senior leaders at their respective facilities. New hires also begin participating in the mid-year high/solid/low performer evaluations [5.2a(3)]. Based on ongoing evaluation of recruitment, placement and retention processes, SDH last year implemented a new job posting system and two

years ago retrained hiring managers on peer interviewing.

Physicians. A full-time physician recruiter works to address needs identified in the Physician Recruiting Plan [5.1a(1)]. The process begins with a recruitment readiness assessment of the practice the new physician will be joining. Recruitment methods include web postings and nationwide email blasts to the extensive HCA network. Facility-based physician relations directors orient new independent physicians, following a standard checklist, which is updated to reflect changing organizational needs. For instance, in 2012, a service excellence component was added. SDHMG provides orientation for employed physicians which includes key items such as MVVG, Code of Conduct and AIDET [3.2b(1)]. In 2012, SDHMG standardized the orientation process across all practices.

5.1a (3) Work Accomplishment. SDH organizes its workforce into functional departments and cross-functional teams to accomplish the work of the organization. At the system level SDH provides support function leadership in the areas of finance, human resources, information technology, planning, communications and quality, with staff located centrally and at each facility. At each hospital, clinical, ancillary, administrative and support departments are organized to support the clinical care provided. SDHMG has organized the workforce to support the physician practices while the ASCs manage patient care delivery and patient care support in alignment with system goals and strategies at the individual ambulatory surgery centers. The SDH CMO and hospital based CMOs and CNOs collaborate with physicians, a core competency, to evaluate, improve and execute clinical protocols based on evidence based medicine and the highest standards of care. All leaders within SDH have a focus on having a strong operating discipline as evidenced by balancing the attainment of the three goals of exceptional care, customer loyalty through the service excellence culture



and achieving strong financial results. System-wide oversight committees and regular reporting and reviews [4.1a(1)] are structured to reinforce system alignment, facilitate best practice sharing across the organization and to achieve established performance expectations.

5.1a (4) Workforce Change Management. Workforce change management begins during the SPP with identification of changing organizational capability and capacity needs [2.2a(4), 5.1a(1)]. With significant planned changes, the appropriate leaders develop and implement a plan to proactively prepare the workforce for the change. For instance, as health care reform has required sweeping changes in the way employees and physicians document care for meaningful use, clinical leaders, in collaboration with IT&S, have trained physicians and nursing staff in a staged implementation across the system. Also, as reimbursement changes have required higher staff certification levels in certain areas, the organization has updated job descriptions and provided the training necessary to help employees meet the new standards (Figure 7.3-17).

Due to the effectiveness of SDH workforce planning and management processes (Figure 5.1-1), the organization rarely faces workforce reductions. In these rare instances, leaders perform a system-wide analysis to identify areas where cuts will have the least impact on patient care and strives to place impacted employees in alternate positions throughout the system. If this is not possible, employees are offered a severance package.

SDH's most significant workforce growth occurs through acquisition of hospitals or physician practices. Employees from newly acquired facilities complete transition orientation, which emphasizes the MVVG, Values Commitment, Code of Conduct and key service excellence initiatives. These employees are systematically incorporated into system infrastructure, such as oversight committees, based on their functional role.

5.1b Workforce Climate

5.1b (1) Workplace Environment. SDH takes a proactive approach to ensure and improve workforce health and security and workplace accessibility through integrated programs and processes at all levels of the organization. At each facility, the Environment of Care Committee provides oversight for the Employee Safety and Security Committee (ESSC) sub-committee. This sub-committee develops and annually updates a comprehensive plan to address specific safety needs associated with different workplace environments. For instance, departments with a higher potential for violence receive de-escalation training. These departments also have panic alarms installed to alert security to threatening circumstances or may have security personnel stationed there. Night shift workers are allowed to park closer to the facility; direct care givers receive training on safe patient handling, including lifting techniques; and elec-

FIGURE 5.1-2: WORKFORCE HEALTH AND SAFETY

Measure	Goal	Result
Lost time rate	0.60	7.3-8
Body fluids	1.36	7.3-8
Patient management	0.94	7.3-8
Slips & falls	1.11	7.3-8

tronic badges limit access after-hours and to designated secure areas. To keep employees healthy and protect patients, employees are required to get flu shots (free) or wear a mask. Managers use Facility Scheduler [5.1a(1)] to monitor how well staffing schedules support a healthy work-life balance.

SDH ensures workplace accessibility by remaining compliant with ADA standards. ADA and ergonomic assessments are provided upon request. All facilities have wheelchair access, TTY phones and large-font computers. Handicap parking is available for the workforce and a courtesy van is provided at facilities with remote workforce parking.

The ESSC is responsible for conducting quarterly hazard surveillance rounds, developing and delivering focused training, conducting accident and near miss investigations, managing the transitional duty program for injured workers, and monitoring and responding to key performance measures (Figure 5.1-2). Facility and SDHMG leaders, as well as the SDH CEO and SVP of HR, receive regular updates on these measures and any safety concerns, including action plans for improvement.

SDH implemented the HCA Healthy Work Environment program to standardize workforce health, safety and security across the system. The program includes committee structure, performance measures, policy implementation, surveillance rounds and leader/workforce training. It also allows for data analysis and best practice sharing across the system and across HCA's 160+ hospitals.

5.1b (2) Workforce Benefits and Policies. SDH supports the workforce through consistent system HR policies and comprehensive benefits and services (Figure 5.1-3). The HR

FIGURE 5.1-3: SAMPLE WORKFORCE BENEFITS/SERVICES

Benefit/Service	Employees	Employed Physicians	Independent Physicians
Medical & dental benefits	•	•	
Life insurance	•	•	
Long-term/short-term disability	•	•	
Core Plus benefits	•	•	
PTO	•	•	
Free parking	•	•	
Cafeteria discounts	•	•	
Doctor's dining room/lounge		•	•
Free Institute for Learning courses	•	•	•
Free financial education	•	•	•
CME offerings & tracking		•	•
Recruitment support		•	•
Information technology support		•	
401k	•	•	
Employee Stock Purchase Plan	•	•	

leadership team regularly reviews and updates policies based on input such as regulatory changes, employee survey results, Employee Advisory Groups, leader rounding and employee forums. In addition, HR annually conducts employee meetings to review benefit offerings and recommends appropriate changes to CEO Council. Over the past several years SDH enhanced its 401k plan to include additional investment options as well as greater transparency in fees and plan management. SDH also expanded its financial education program to include free one-on-one sessions with a financial planner and to make financial classes available online. Last year, changes in benefits included providing non-smokers an annual credit to offset premiums, free health coaching to employees who are “at risk” for health issues. SDH offers lower income employees the ability to apply for the Employee Health Assistance Fund. Employees tailor their benefit selections through a cafeteria style selection process. To ensure that SDH is meeting the needs of its diverse workforce, annual benefit meetings are offered in both English and Spanish and phone support is offered in a variety of languages. Benefits and services that comply with federal regulations governing hospital-physician referral relationships are available to independent physicians who have SDH medical staff privileges (Figure 5.1-3). Employed physicians have access to both employee and medical staff benefits and services.

In the spring of 2014, SDH opened a medical clinic which provides an array of medical services free to employees and their dependents enrolled in our medical plan and a nominal cost to those employees and their dependents not enrolled in our medical plan.

5.2 Workforce Engagement

5.2a Workforce Performance

5.2a (1) Elements of Engagement. SDH uses the nationally administered Taylor Nelson Sofres (TNS) employee engagement survey to determine key elements that affect employee engagement. SDH adopted TNS’s engagement dimensions as its engagement factors, based on TNS’s extensive research in this area.

Likewise, key elements that affect physician engagement (Figure P.1-3) are identified through regression analysis of results for the medical staff engagement survey, administered by PRC to physicians. The survey is conducted annually through both web and phone interviews to physicians on the medical staff at SDH hospitals which include those who practice at an ASC or within SDHMG.

Results are reviewed with employees and physicians who then work to put action plans in place to continue the cycle of continued engagement.

5.2a (2) Organizational Culture. The MVVG lays the foundation for SDH’s approaches to fostering an organizational culture characterized by open communication, high-performance work and an engaged workforce. Job candidates agree to adhere to the Values and cultural fit during the selection process [5.1a(2)]. Orientation emphasizes the MVVG, and the Values make up 50% of the annual performance evaluation score

[5.2a(3)]. Specific approaches to reinforce the culture include:

Communication. In addition to mechanisms described in 1.1b(1), senior leaders have a formal open door policy, so that any member of the workforce can request a meeting to discuss a concern or share an idea. Employee Advisory Groups (EAG) are facility based committees, comprised of staff members, that provide a forum for employees to voice concerns or issues that affect them in their workplace and to advise management of their ideas and suggestions for improvement. The ICARE Commitment to Values (Figure P.1-2) emphasizes communication with customers (Compassion and Accountability) and listening to others’ perspectives (Respect). The organizational performance review structure is intentionally designed to facilitate communication across facilities, departments and disciplines [4.1c(1)]. And the Leadership Advance Quarterlies take 300 leaders offsite for organizational updates, communication and training across the system focused primarily on the service culture of the organization.

High-Performance. The Vision to be the finest care and service organization in the world and the Mission to provide exceptional care inspire employees and physicians to high performance. CEO Council annually sets goals for key performance measures at the national 90th to 95th percentile [4.1a(2)]. These goals cascade to all levels of the organization and are integrated into workforce performance management processes [5.2a(3)].

Engagement. Annually, leaders use results from the TNS employee engagement survey [5.2b(1)] to improve engagement across the system. With support from HR, directors share results with their employees and gather input for area-specific action plans. These action plans are logged electronically in the survey software and directors review action plan progress quarterly with their respective senior leader. Results are also shared at employee forums and reviewed by CEO Council. Physicians take the PRC survey annually. Facility leaders present the results to their medical staff departments and gather input for an action plan that drives improvement. This process has had multiple cycles of learning. In 2009, SDH switched from HealthStream to PRC to increase physician participation which has risen from 35% to over 80% across the system. Also, SDH has begun linking survey action plans to contracts for hospital-based physician groups, such as hospitalists.

Diversity. To reinforce the ICARE Value of Respect and ensure that the organization benefits from the diverse ideas, cultures and thinking of the workforce, SDH translates key communications and documents into Spanish, and celebrates Diversity Month by highlighting employees and physicians from diverse cultures. To capitalize on all types of diversity, leaders recruit members from across the organization to populate committees and teams. SDH is a member of the Texas Diversity Council, with board representation. In addition, the IFL provides a self-paced multi-language program free to all interested employees and online competencies include cultural inclusion.

5.2a (3) Performance Management. Every SDH employee is evaluated annually by their immediate supervisor. The employee performance evaluation process is aligned with and reinforces the MVVG by integrating the a) ICARE Commit-

ment to Values, b) job knowledge and execution, c) the patient experience, and d) employee and patient safety into each employee's evaluation. Rating criteria recognize and support creative problem solving and innovative work approaches. The electronic evaluation system is fully integrated with SDH's Learning Management System (LMS) and overall performance ratings can be used to determine performance-based pay increases. SDH leaders are evaluated against established leadership competencies, as well as goals and action plans linked to the strategic plan. Performance relative to leader competencies encourage innovation and intelligent risk taking and are a component of leader incentive pay [1.2a(2)].

In addition, at the mid-point of the annual performance review cycle, SDH uses a High-Solid-Low evaluation process with the objectives to: 1) re-recruit and retain high-performing employees; 2) discuss coaching and development opportunities with solid performers and with high potential employees; and 3) formally counsel low performers and put them on 90 day action plans. HR provides training and tools to support directors with these conversations.

SDH structures its reward and recognition programs to reward high performance, intelligent risk taking and innovation focused on patients and aligned with the organization's three goals of exceptional care, customer loyalty and financial strength. These programs include monthly ICARE awards, quarterly Hall of Fame Awards, Caregiver of the Year Awards and facility-specific awards. Leaders also send thank you notes to employee homes, submit nominations for the national HCA Innovator Award and Frist Humanitarian Award.

Independent and employed physicians on SDH medical staffs are evaluated through the credentialing and recredentialing process as well as on a concurrent basis. Ongoing Professional Practice Evaluation (OPPE) using specialty-specific criteria and national benchmarks occurs three times within a two-year credentialing period. Medical staff departments monitor aggregate and physician-specific performance on key indicators, such as core measures and HCAHPS and use the peer review process to address areas of concern. Physicians receive feedback during the evaluation process or more frequently if issues arise.

In addition, contracts with medical directors and hospital-based physician groups establish performance requirements that align with organizational goals and encourage innovation. SDHMG physicians also have an annual performance review using a standard form that integrates patient satisfaction, clinical measures and behaviors consistent with the ICARE Values Commitment (Figure P.1-2). In addition, SDHMG evaluates each physician monthly for productivity and quarterly for clinical performance. All physicians are eligible for recognition programs, such as the monthly ICARE award, Frist Humanitarian awards and the national HCA Innovator Award. They also receive thank you notes from leaders and staff.

5.2b Assessment of Workforce Engagement

5.2b (1) Assessment of Engagement. SDH uses the TNS engagement survey to annually assess employee engagement. The nationally benchmarked survey supports numerous data

segmentation options, but SDH most commonly reviews results at the system, facility and department levels. Results are used to improve employee engagement as described in 5.2a(2).

SDH uses a separate survey to assess engagement of independent and employed physicians on the facility medical staffs. Results of both surveys are shared and used to drive improvement as described in 5.2a(2).

To help ensure that workforce engagement is an ongoing process and not just an annual event, leaders at the system, facility, and department levels use additional indicators to assess and improve engagement throughout the year. Biannual HR reviews involving HR staff and senior leaders incorporate turnover, productivity, EEOC charges and health and safety measures. Additionally, SDH conducts exit interviews aligned with the annual engagement survey. SDH outsourced the process to allow anonymity and system-level data aggregation.

5.2b (2) Correlation with Organizational Results. The organizational performance review structure (4.1b) is intentionally designed to facilitate side-by-side review of workforce engagement assessment findings with key results for Exceptional Care, Customer Loyalty and Financial Strength. The Performance Dashboard (Figure 4.1-1) and other standard dashboards and reports provide a balanced view of organizational performance and allow analysis of workforce engagement trends (e.g. turnover, productivity) relative to other key indicators.

5.2c Workforce and Leader Development

5.2c (1) Learning and Development System. St. David's Institute for Learning (IFL) provides the framework for the organization's learning and development system. IFL staff evaluate delivery mechanisms each year relative to national trends and an educational needs assessment. Also, on an annual basis, IFL staff develop strategies that are incorporated into the HR Strategic Plan based on inputs including: 1) learning and development needs associated with core competencies, strategic challenges and accomplishment of the strategic plan

Organizational Factor	Sample Offering
Core competencies	Finances for non-financial managers, Scheduling Excellence [5.1a(1)]
Strategic challenges	Value-based purchasing; charge nurse training; ED crisis prevention (in response to increased employee safety incidents); SNAP [5.1a(2)]
Action plans	CME offerings on new technology/procedures; Meaningful Use training; Leadership Academy
Performance improvement & innovation	CME offerings on new technology/procedures; statistics for nurses; evidence-based practice; PDCA training
Ethics	Employee, physician & leader orientation; annual Code of Conduct training
Patient/stakeholder focus	Employee, physician & leader orientation; AIDET training; service excellence (Leadership Academy)

[2.2a(4)]; 2) annual educational needs assessment sent to all employees and managers; 3) annual employee and leader performance evaluations [5.2a(3)]; 4) review of key performance metrics; 5) biweekly meetings of HR directors from across the system; 6) changes in educational compliance requirements; and 7) competency gaps identified through an electronic tracking system. The electronic system assigns specific, defined competencies to each position across the system and tracks, on an individual employee basis, which competencies are met. These competencies include traditional clinical competencies as well as key elements of the SDH culture, such as AIDET, rounding and leadership competencies adapted from HCA. In 2011, SDH transitioned managers and above to a talent management system to better support individualized learning, development activities and succession planning [5.2c(3)].

Learning and development opportunities prioritized in the HR Strategic Plan (Figure 5.2-1) are made available to the workforce through the IFL. The IFL includes the Academy for Clinical Excellence (ACE) and the Leadership Academy. ACE provides a wide variety of clinical courses and simulation based programs aimed at enhancing clinical excellence as well as professional growth and development. The Leadership Academy, which previously designed and conducted a mandatory two-year, ten-course core curriculum for SDH leaders, recently designed and Implemented a new blended learning leader curriculum that combines online modules from the Harvard Manage Mentor (HMM) curriculum with targeted classroom offerings. This new curriculum uses three separate tracks - Charge Nurse, Supervisory/Lead and Director-Manager is mandatory and must be completed within one year. The development of individual leader action plans are also an integral component. SDH uses an online Learning Management System (LMS) to reinforce new knowledge and skills and track annual mandatory education. CE Direct, a web-based continuing education curriculum available to all clinical employees, has dramatically improved access to ongoing, discipline-specific educational programming. To further maximize course offerings and delivery systems, the IFL has implemented videoconferencing across SDH facilities, as well as Audience Participation technology to enable real-time feedback, testing and course evaluation.

SDH's continuing medical education (CME) program offers additional learning and development opportunities for physicians. The CME Committee, comprised of physicians and CME liaisons, prioritizes CME offerings based on physician requests, quality dashboards, new services and data from previous offerings. As the most recent cycle of learning, the committee extended CME offerings to nurses who need to earn CEUs.

SDH's departing worker process is managed at the facility and department level, with support from a comprehensive system of documented policies, procedures and protocols. Department leaders are responsible for ensuring a smooth transition without disruption to normal business operations. Departing workers meet with appropriate leadership to discuss and develop a transition plan. Whenever possible, the new incumbent works with the departing employee to assist with the transition of duties. Departing employees are asked to document and discuss

with other department staff, as appropriate, the current status of assignments and responsibilities.

Across the system, managers and supervisors reinforce employees' new knowledge and skills through system, facility and department orientation processes. Once oriented, employees are supported through processes including leader rounding, staff meetings, annual performance management and competency assessment processes. High-performing nurses are selected through an application/interview process to participate in the SDH nursing residency program, SNAP Fellowship [5.1a(2)]. After participating in training events, action planning by participants and the support of supervisors help reinforce the key concepts and best practices learned. Upon return to their departments, employees are encouraged to discuss their learning experiences with their leaders and coworkers, and leaders are asked to provide opportunities for employees to practice new skills. To help nurses move from novice to expert, unit preceptors provide ongoing coaching in clinical skills. Preceptors, selected from high and solid performers [5.2a(3)], attend an eight-hour IFL course, followed by a competency assessment and an annual refresher course.

5.2c (2) Effectiveness of Learning and Development.

SDH evaluates the effectiveness and efficiency of its learning and development system against established objectives through a multi-pronged approach. Learning and development staff analyze performance metrics associated with specific course offerings to assess the impact on organizational performance. A series of leader-specific questions on the annual employee survey are tracked and monitored to assess how well SDH cultural elements and broader leadership elements are being received by employees across the organization. Course evaluations completed by participants for each offering focus on the overall effectiveness and efficiency of the program as well as each course's ability to help employees maximize their performance and job satisfaction. The new curriculums online component provides module specific pre and post testing. This data is being tracked and will form the basis for additional analysis of program effectiveness as available data increases. New Audience Participation technology enables real-time feedback, testing and course evaluation. Overall ratings and individual comments are analyzed and used to improve the programs.

To assess the overall learning and development system, SDH performs an annual learning and development needs assessment. Also, IFL staff round on leaders and departments to get feedback on training needs and effectiveness, and they review learning and development costs relative to industry benchmarks.

5.2c (3) Career Progression. SDH uses a multi-pronged approach to manage career progression and succession planning. In addition to approaches highlighted in 1.1a(3):

- Each senior leader annually can identify candidates with potential to become senior leaders and formally recommends them into HCA's executive development programs.
- During the annual performance evaluation [5.2a(3)], employees and managers collaborate to write development goals and discuss career plans. High-/solid-/low-performer conversations include discussions with high performers about training and development needed to progress within

the organization. The electronic talent management system (TMS) tracks competencies of managers and above. Emerging leaders can fill competency gaps through IFL and the Leadership Academy [5.2c(1)].

- As vacancies occur, department leaders review existing staff to identify potential candidates qualified to fill the position. Employees are able to apply for any open position posted throughout the system.
- Front-line clinical workers can take competency-based skills courses required for promotion within their job families. The nursing residency program and SNAP [5.1a(1)] support

nurses in accelerating their transition from novice to expert and in obtaining specialty training and/or certification. The culture of certification is promoted through certification programs and reimbursement, which is shown to increase competencies and patient safety.

- Administrative and physician leaders at each facility identify and invite future physician leaders to participate in medical staff committees and take on departmental leadership. Additional development occurs as elected medical staff leaders transition from Department Chair to Vice-Chief of Staff to Chief of Staff.

Category 6: Operations Focus

6.1 Work Processes

6.1a Service and Process Design

6.1a (1) Design Concepts. SDH uses a systematic approach to design service offerings and work processes. When the need for a new process or service is identified through the SPP process [2.1a(1)], the facility CEO or other assigned executive launches a planning effort by assembling a team. The process for design follow six steps: **1** The idea for a team approach is identified either by a new service that is needed or an improvement based on performance gaps, **2** An executive is assigned to lead the effort, **3** the team is organized, **4** research is conducted including consideration of stakeholder input, **5** an ROI is completed to consider the cost/benefit considering intelligent risk of both completion and non-completion of the project and **6** an implementation plan is developed containing specific tasks for completion. Team composition is deliberate to capture organizational knowledge and ensure representation from impacted departments, facilities, and stakeholders such as physicians, suppliers, partners and collaborators. The team determines key service and process requirements as described in 6.1a(2) and works to identify best practices, including those from

high-performing organizations across the country. Depending on the scope of the project, the team may complete benchmarking trips to see these best practices in action and consider new technology that would optimize performance. To ensure service excellence and agility, a critical step in the design process is identification of measures, including in-process measures that indicate when the service or process

FIGURE 6.1-2: KEY SUPPORT PROCESSES

Support Processes	Requirements	Sample Process Measures (Results)
Human Resources (HR)	Competent, available	Turnover (7.3-1)
		Vacancy (7.3-2)
		Time to fill (7.1-27)
		Physician recruitment (7.3-3)
Financial Management	Accurate, timely	Days in AR (7.5-11)
		Cash collections (7.1-28)
		Financial audits (7.4-6)
Information Management	Reliable, timely	IT&S Call Ctr measures (7.1-29)
		IT security measures (7.1-31)
Supply Chain Management	Quality, timely, value	Supply cost savings (7.1-33)
		Fill rate (7.1-34)

FIGURE 6.1-1: KEY CLINICAL CARE DELIVERY PROCESSES

Work Processes	Requirements	Sample Process Measures (Results)	Associated Outcome Measures (Results)
Admission	Safe, effective, efficient	Admission core measures (7.1-7)	Overall mortality index (7.1-1)
		SDHMG patient wait time sat. (7.1-25)	SDHMG patient satisfaction (7.1-25)
		OR on-time 1 st case starts (7.1-24)	OR prime time utilization (7.1-24)
		One Call transfers (7.4-23)	Physician engagement (7.3-16)
		Pre-appointment calls (7.1-23)	EEOB (7.3-5)
		ED arrival to bed, to greet (7.1-20)	ED patient satisfaction (7.2-2)
Assess & Treat	Safe, effective, efficient SDHMG % productivity	SDHMG clinical measures (7.1-19)	SDHMG patient satisfaction (7.2-5)
		Assessment core measures (7.1-8)	Mortality/complication index (7.1-1,2)
		Medication scan rates (7.1-16)	OP satisfaction (7.2-2)
		ED LPT/LPTMSE (7.1-21)	ED patient satisfaction (7.2-2)
Discharge	Safe, effective, efficient	Discharge core measures (7.1-9)	30-day Readmissions (7.1-18)
		OP discharge phone calls (7.1-23)	OP satisfaction (7.2-2)
		ED length of stay (7.1-22)	ED patient satisfaction (7.2-2)
		SDHMG productivity (7.1-26)	SDHMG group volumes (7.4-21)

is not meeting requirements (Figure 6.1-1). Implementation proceeds as described in 6.1b(1).

6.1a (2) Service and Process Requirements. SDH determines key health care service requirements as described in 3.2a(1) through the CFET and uses them as the basis for design of new services and processes. As a key step in the service design process, a multidisciplinary design team identifies each of the component work processes and translates key health care service requirements from the CFET into process requirements based on Voice of the Customer data (Figure 3.1-1) and input from design team members [6.1a(1)]. Though key health care service requirements are determined at a system level, facilities and departments establish process requirements that address their unique needs. SDH's key clinical work processes and their key requirements are listed in Figure 6.1-1. A multi-disciplinary team reviews work process selection during SDH's Baldrige-based self-assessment.

6.1b Process Management

6.1b (1) Process Implementation. SDH's approach to ensuring that its work processes meet key process requirements begins with process implementation according to a plan developed by the responsible team [6.1a(1)]. Standardization across appropriate departments or facilities occurs primarily through development and deployment of new policies or procedures, new forms and workforce training. Major changes, such as computerized physician order entry, may incorporate phased implementation with "superusers" and additional technical support on hand. Implementation includes follow-up audits and performance monitoring to ensure workforce compliance and optimal performance.

After implementation, monitoring of in-process measures [4.1a(1)] ensures stable and capable process performance. Employees are trained and empowered to make real-time adjustments if a process is not performing at established thresholds. Leader and caregiver rounding, daily huddles and regular stoplight reports provide additional opportunities to improve process performance in real-time and based on trended performance.

Sample performance measures used to control and improve work processes are outlined in Figure 6.1-1. By monitoring these measures and making on-going improvements, process owners can impact associated outcomes and ensure that services meet key patient requirements.

6.1b (2) Patient Expectations and Preferences. SDH integrates multiple approaches to address and consider each patient's expectations and preferences, beginning at or prior to admission. Across care settings, EHR screens guide caregivers through an initial assessment that captures relevant patient preferences regarding issues such as religion, culture, language, support system, nutrition and visitation. These preferences are documented electronically and are accessible to the patient's care team for consideration throughout the patient's visit. Wow Cards documenting "what we can do to exceed your expectations" also accompany patient charts.

As a key component of the admission process, caregivers set realistic patient expectations and engage patients in develop-

ing their care plan. For inpatients, caregivers document patient goals on a visibly displayed white board in the patient's room and continue to engage the patient and their loved ones in care decisions. Individualized care plans are updated through collaboration with medical staff and nursing and are discussed during bedside shift report. Caregivers across all care settings conduct hourly rounding on patients to address patient care and safety needs. During these rounds, employees and physicians use AIDET (Acknowledge, Introduce, Duration, Explain and Thanks), which help ensure patient understanding of the care they are receiving. This key element of the SDH culture is reinforced through the hiring and orientation process [5.1a(2)], workforce performance management [5.2a(3)] and the learning and development system [5.2c(1)]. Across the organization, language interpreters and an interpretive service are available to support non-English speaking patients, and forms, consents, menus and patient education materials are available in Spanish. In surgical waiting rooms, surgical nurse liaisons and tracking boards keep family members informed of a patient's status, and nurse navigators are leveraged to support patients across the continuum of care. Communication from caregivers augmented by patient education materials help set expectations about care at home after being discharged from the hospital, with follow-up through post-discharge phone calls.

6.1b (3) Support Processes. SDH key support processes, depicted in Figure 6.1-2, include system-level functions necessary for clinical care delivery across all care settings. Through the management services agreement with HCA, HCA manages IT&S, supply chain and patient account services. The leaders of these key support services are fully integrated with SDH, and are able to leverage the scale and efficiency of resources and processes within HCA. To ensure that key support processes meet key organizational requirements, SDH implements, monitors and adjusts them as described for key work processes [6.1b(1)]. A director level position in each support area, (HR, IT&S, Supply Chain and Patient Accounts) are embedded in each hospital, SDHMG and ASC's to work with those entities to ensure operational requirements are being met. SDH also established an IT Governance Committee to review and prioritize the IT project portfolio in collaboration with key SDH leaders.

6.1b (4) Service and Process Improvement. SDH leaders understand innovation often occurs with those closest to the process. Valuing the ideas of all employees, staff are encouraged to discover new solutions to improve the care and services provided [1.1a(3)]. To help cultivate an environment of innovation, senior leaders have designated workforce development through the IFL[5.2c (1)].

Services provided to patients and other customers are facilitated through a bidirectional approach. Front-line staff engaged in "ground-up" performance improvement activities are trained to use the Plan, Do, Check, Act (PDCA) model. The PDCA model provides a simple approach to organizing performance improvement (PI) ideas and then deploying them into practice. This allows broader participation among employees, adding value to the organization through

increased idea generation and problem solving. Organizational knowledge is captured in two ways. First, through the broad inclusion of the employee base, both subject matter experts and novice learners are empowered to share ideas to improve performance. Second, ideas formally developed and evaluated are disseminated to other departments or facilities as appropriate. If new interventions demonstrate sustained performance throughout a facility, expansion to other facilities is considered.

For larger scale “cascading” projects, an assigned executive launches the effort by assembling a team and communicating the expectations. The team determines key service and process requirements as described in 6.1a(2) and works to identify best practices, including those from high performing organizations across the country. Depending on the scope of the project, the team may accomplish benchmarking either in person or through webinars to see these best practices in action and consider new technology that would optimize performance. The team maps out the process and develops an implementation plan, with a timeline, defined resources, desired outcomes, and, if possible, a pilot.

The bidirectional approach facilitates an optimum level of agility. The less formal, “ground-up” approach allows ideas for health care services and work processes to develop organically. Front-line staff engaged at this level is empowered to share ideas, adding value to the services provided. Ideas are tested at a unit level and positive outcomes result in expansion of the improved process or service as appropriate. The “cascading” approach can facilitate a resource rich, fully organized deployment of a targeted health care service or work processes. Execution of the initiative can occur quickly due to leadership support. Both approaches share the organizational culture as their core design.

6.2 Operational Effectiveness

6.2a Cost Control

SDH uses multiple approaches to control the overall costs of operations; minimize costs associated with inspections, tests and audits; and prevent errors, rework and waste:

- SDH uses its real-time Productivity and Labor Utilization System [PLUS, 5.1a(1)] and weekly productivity review meetings (Figure 4.1-2) to control and closely monitor labor costs (Figure 7.5-7).
- SDH leverages HCA’s nationwide buying power, as well as national and local supply chain improvement initiatives (6.2b) to reduce supply costs (Figure 7.1-33).
- SDH leaders at multiple levels of the organization monitor financial measures on a daily, weekly, and monthly basis and make rapid adjustments when measures are not performing to budget.
- Whenever possible, SDH works to standardize processes, policies, and procedures across the organization to integrate evidence-based practices, introduce automation and reduce variation.
- SDH’s EHR reinforces evidence-based practices and prevents errors through system checks and balances, including limited open-text fields, entry validation and standardized

dictionaries and drop-down menus [4.2b(1)].

- The IT Strategic Portfolio and Technology Refresh program [4.2b(3)] address automation-based opportunities for error prevention and improved efficiency.
- Monitoring of established in-process measures [6.1b(1)] related to cycle time, productivity and other efficiency and effectiveness factors alert staff when processes are not performing to goal and support real-time adjustments for improvement.

In addition, the VP of PI, in collaboration with SDH and facility leaders has deployed specific PI projects aimed at improving efficiency and lowering costs of operations. The process for each of these nine-month PI engagements include 1 target setting, 2 opportunity assessment, 3 project kick-off, 4 weekly team meetings, 5 monthly steering committee meetings, 6 implementation of ideas and then 7 financial monitoring.

6.2b Supply-Chain Management

SDH manages its supply chain through Parallon, a group-purchasing organization and HCA subsidiary [P.1b(3)] that enables SDH to leverage HCA’s nationwide best practices and buying power while addressing unique local needs. To serve SDH, Parallon provides web-based electronic ordering, a local supply distribution center and a centralized point-of-use system that drives automatic restocking. Each facility has a supply chain director (SCD) and clinical resource director (CRD) who report to a system supply chain management director. The system and facility directors are Parallon employees but are based locally at SDH corporate offices or their assigned facility. CFOs lead facility Supply Management Action Teams (SMATs), with membership including that facility’s COO, CNO, CMO, SCD and CRD, as well as representatives from nursing, pharmacy, the operating room and other key disciplines. The SMATs meet monthly to: 1) identify and monitor ongoing supply chain improvement initiatives, and 2) provide input on product selection and supplier performance. The system supply chain management director, who participates in Parallon decision-making at the national level, aggregates input from the SMATs, feedback forms and facility rounding. The supply chain management director also works with SMATs to implement national Parallon improvement initiatives, such as standardizing medical devices to improve quality and reduce costs. Incentive plans encourage SDH facilities to use supplies and equipment managed through national Parallon contracts, but SMATs have the authority to opt for alternative products.

To ensure alignment and full integration of Parallon SCDs and CRDs into the SDH culture, they complete new employee orientation [5.1a(2)] and abide by the same standards and policies as any other member of the SDH workforce. The system SCD and CRD participate in all SDH leadership events and in the SDH strategic planning process to support alignment of local and national strategies. To ensure optimal supplier performance, SMATs monitor key performance measures (Figure 6.1-2), hold Parallon accountable to service agreements and use Parallon’s quality reporting process to elevate concerns. Parallon addresses consistent performance issues with specific vendors at the national level.

6.2c Safety and Emergency Preparedness

6.2c (1) Safety. SDH provides a safe operating environment through its Healthy Work Environment program and its Environment of Care infrastructure [5.1b(1)]. Healthy Work Environment focuses the organization on safety and accident prevention by providing financial incentives for facilities that implement specific components of an effective safety program. As a result, at each SDH facility, Employee Safety and Security Committees (ESSC) develop and annually update a comprehensive plan to address key workplace environmental factors that impact safety. Department Safety and Security Officers help the ESSC support the plan to address specific safety needs associated with different workplace environments. Prevention is also a key aspect of employee training during orientation and annually thereafter. On an ongoing basis, ESSCs monitor key safety indicators (Figure 7.3-8) and develop action plans for improvement. They also investigate accidents and near misses, including root cause analysis and manage the transitional duty program for recovering injured workers. Facility and SDHMG leaders, as well as the system CEO and VP of HR, receive regular updates on safety measures, safety concerns and action plan progress.

6.2c (2) Emergency Preparedness. SDH has a systematic approach to ensure disaster and emergency preparedness for the organization and takes the lead in coordinating the medical response for the region. Annually updated, facility-specific Emergency Operations and Business Continuity plans reside on the HCA Code Ready website that is accessible even if SDH systems are down. An annual system-wide hazard vulnerability analysis helps identify potential threats at each location and drives development of plans to address disaster and emergency prevention, mitigation and recovery. The SDH Emergency Management Committee, comprised of senior leaders and representatives from each facility, coordinates plan development to align with local, regional and state agencies. Employees receive training on checklists and mitigation grids that define responsibilities and response processes, including Hospital Incident Command System. To ensure continuity of operations, SDH has established plans for financial support, IT back-up/recovery [4.2b(4)] and evacuation to alternate SDH facilities or to regional locations formalized through memorandums of understanding. Supply contingency plans leverage HCA disaster stockpiles strategically placed across the county as well as vendor contracts for fuel, building materials, security and other critical resources. The Code Ready website also helps staff prepare for emergencies at home. In cooperation with city and county agencies, SDH conducts and evaluates annual drills for all hazards and uses results to improve processes. External evaluators grade each facility's ability to achieve drill goals and objectives (Figure 7.1-32).

Regionally, SDH has leadership positions in the Capital Area Trauma Regional Advisory Committee (CATRAC) and the Capital Area Public Health and Medical Preparedness Coalition (CAPHMPC), which is responsible for coordinating the medical response to natural disasters, terrorist attacks and other hazards in a 11-county area. Through the CATRAC/

CAPHMPC, SDH works with its competitors and collaborators, other health care organizations, emergency response agencies, school districts and the State of Texas to plan and execute drills that prepare the area for an all hazard response. As part of the CATRAC/CAPMPC drill committee, hospital plans, capabilities and threats are shared with community partners. These plans include maintaining adequate care in all types of emergency situations, as well as supporting communities with food, shelter and other resources. For instance, when the hottest summer on record threatened to overload the state's electrical capacity, SDH used its back-up generators to supplement the grid. SDH also provided power when almost half the state's power plants went off-line during the winter of 2012. Other specific areas of SDH regional leadership include:

- SDH serves as the storage site for regional pandemic supplies.
- SDH invested in equipment and training to establish new decontamination capabilities for the region.
- SDH coordinated development of a recall system to notify area physicians of specific medical assistance needs during a disaster.
- SDH is the first health system to participate in the national Urban Shield program aimed at integrating the emergency and disaster response infrastructure across the country.

6.2d Innovation Management

SDH's approach for managing innovation begins during the strategic planning process [2.1a(1)]. In SPP Step 4, CEO Council performs a SWOT analysis and uses the results to identify strategic opportunities, weigh the risks of pursuing or not pursuing them, and determine which ones warrant further analysis and/or inclusion in the strategic plan. For instance, in 2012, based on new partnering opportunities and demonstrated success in other markets, the CEO Council identified a system-wide oncology service line as a new strategic opportunity.

Once a strategic opportunity has been identified, SDH uses a standard proforma process to evaluate it and determine whether it represents an intelligent risk. Strategic opportunities are brought to the Planning Department, which assesses factors such as resource requirements, return on investment, workforce impact, payor mix and the competitive environment. A standard template guides evaluation of the proposed opportunity relative to factors such as strategic fit and ROI benchmarks. The sponsoring executive then makes a case to the system or facility CEO. Approved opportunities are resourced through the budgeting process. To address opportunities that require significant capital resources, SDH can draw on its partners' financial reserves, through an arrangement established in the original joint venture agreement. Follow-up evaluation against established measures of success is required at scheduled post-implementation intervals. Consistent performance below goal may prompt CEO Council to discontinue pursuing the opportunity.

Category 7: Results

The following items present SDH's performance on its journey to fulfilling its vision of becoming the finest care and service organization in the world. With many of the results, SDH leverages HCA's extensive national database for comparative data from 160+ hospitals and more than 18 million patient encounters. Many of the measures include segmentation but due to space constraints, in some cases results are shown for SDH as a whole.

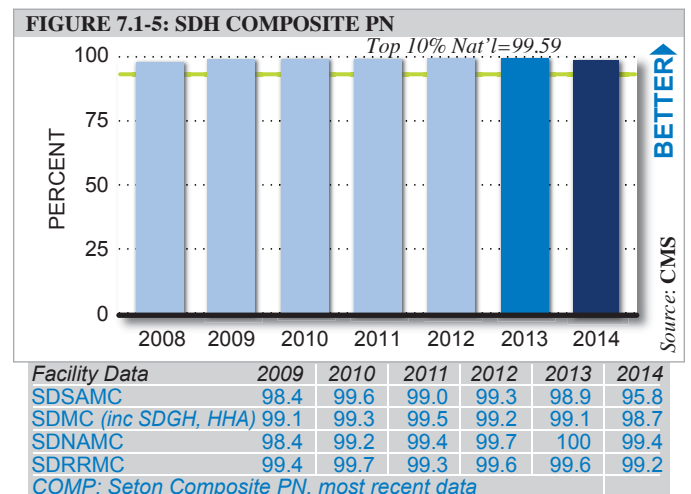
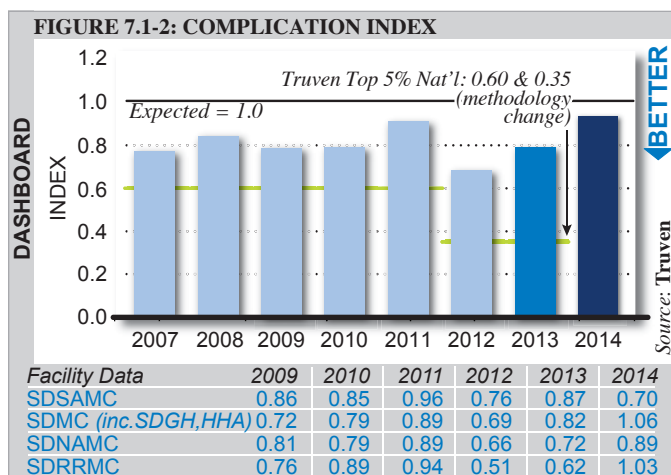
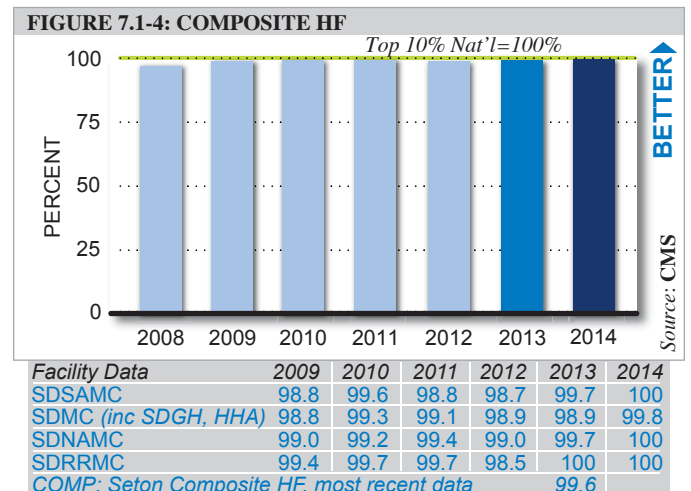
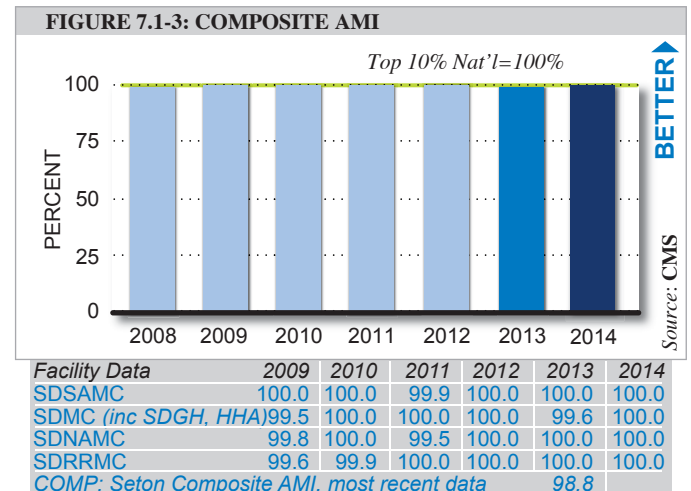
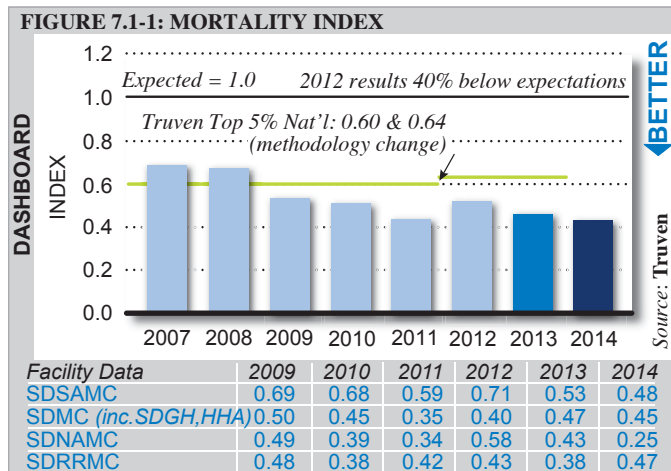
7.1 Health Care and Process Results

7.1a Health Care and Patient Focused Process Results

To address the key patient requirement of consistent quality and service and monitor performance on the Exceptional Care Goal, SDH measures health care and patient-focused results for its main service offerings of inpatient, outpatient, emergency and physician practice services; its service lines (market segments) of cardiac, neurosciences, women's, general surgery and orthopedics; its key patient groups of inpatient, outpatient, emergency and physician practice; and its facilities (Figure P.1-5), which represent its key service delivery mechanisms and locations.

Performance related to the SDH Goal of Exceptional Care are the mortality rate index and complication index. The mortality and complication indices are calculated by dividing the actual

mortalities/ complications by the expected mortalities/com- plications that are risk and severity adjusted by Truven Health Analytics, a national database of all U.S. hospitals. An index of 1.0 indicates that the actual number equals the expected number and a lower index represents fewer mortalities or complications than expected. In both measures, SDH has consistently had fewer than expected incidents for over a decade. SDH has achieved national benchmark performance in the mortality index by implementing several clinical improvements based on evidence-based best practices over the past four years (Figure



7.1-1). The complication index (Figure 7.1-2) performed at near top 10 percent performance levels with the past several years seeing an increase in the index, but still performing 20 percent below what would be expected for the patient population served. SDH conducts analysis through medical record reviews on complications through the hospital quality structure in collaboration with physicians. In 2012, the vendor Truven applied a methodology change in their calculation for risk adjusted mortality and complication by removing the Present On Admission (POA) indicator. This contributed to a more accurate depiction of complications and mortalities across their database. Truven is the same dataset that recognizes Top 100 Hospitals which St. David's Medical Center has attained for 5 consecutive years and St. David's North Austin for 3 consecutive years.

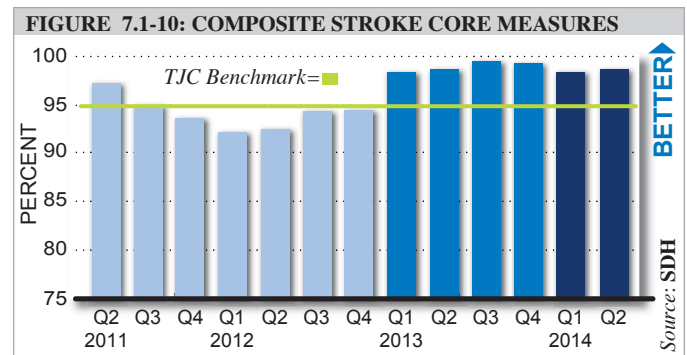
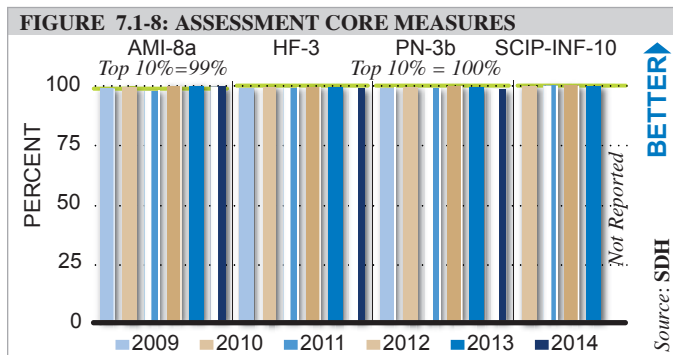
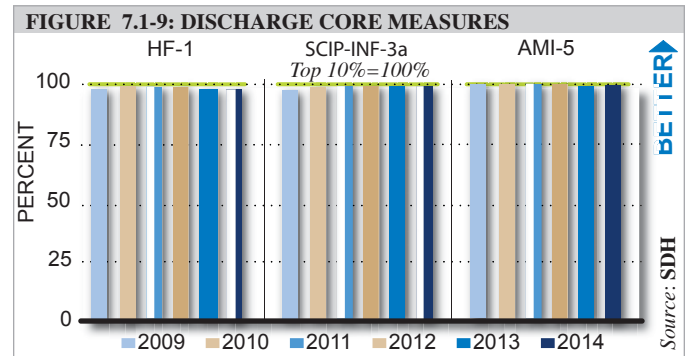
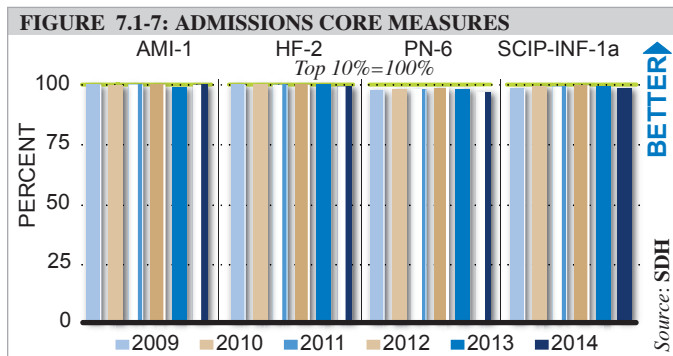
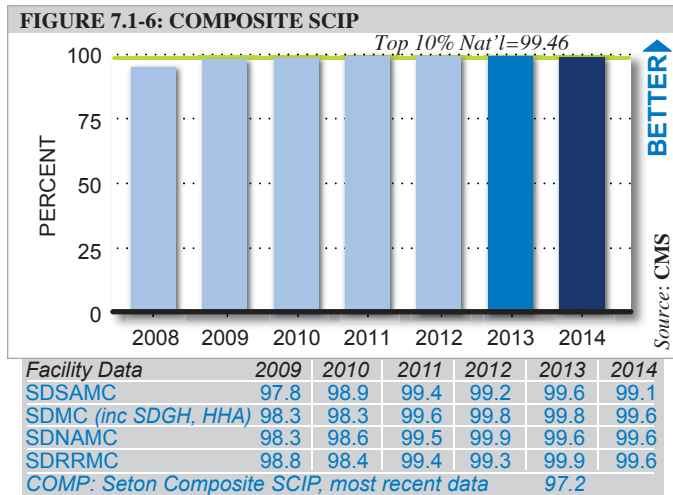
In 2005, the Centers for Medicare & Medicaid Service (CMS) and The Joint Commission (TJC) developed a national standard set of clinical process measures to help improve the quality of care for certain common conditions. These standardized measures evaluate the clinical care process for the conditions of

acute myocardial infarction (AMI), heart failure (HF), pneumonia (PN) and certain surgical care processes (SCIP). For each of these measures, SDH not only looks at the individual components of the clinical process, but reports and analyzes "composite" trends for each measure. These composites aggregate all the component measures under each of the four conditions. SDH is able to determine improvement and comparison to other leading organizations nationally by downloading the entire CMS database for comparison quarterly. SDH has performed at or better than the national top decile for the composite measures in each disease group since at least 2009 (Figures 7.1-3-6). SDH also outperforms competitor Seton in three of the four measures.

The measures related to the treatment for AMI Composite (Figure 7.1-3) include aspirin and beta-blocker within 24 hours of arrival, documentation of smoking cessation counseling or advice, and prescriptions at discharge for aspirin, beta blocker and ace inhibitor. SDH and each of its facilities achieved perfect performance in 2012 and near-perfect performance at each facility since 2008 for the AMI composite, which is a key measure for SDH's cardiac service line and addresses components of both inpatient and emergency care.

The measures related to the treatment of heart failure composite (Figure 7.1-4) address assessment and treatment, documentation and discharge instructions. SDH has significantly improved performance in this area and has achieved top 10% benchmark nationally for 3 years through the implementation of care bundles and improved instructions for heart failure patients. In 2012, due to some changes in medication reconciliation screens in Meditech, SDH saw a slight decline until the IT remedies were addressed. SDH demonstrated improved performance through 2013.

The measures related to the treatment of pneumonia (PN) include an oxygenation assessment and the administration of antibiotics. SDH continues to improve in this area each quarter



and has achieved and sustained top 10% performance nationally in every hospital within SDH (Figure 7.1-5).

The Surgical Care Improvement Project (SCIP) composite, a key measure for the general surgery service line, encompasses the timing of antibiotics before and after surgery as well as proven practices that systematically help reduce the likelihood of complications. Figure 7.1-6 indicates that SDH has improved its performance on SCIP process and outcome measures and has sustained top 10% performance on a national level. Each facility, in coordination with the other SDH facilities, works with clinical staff, both nurses and physicians, to improve the clinical processes related to these outcomes.

SDH also has the ability to track each of the clinical measures by the stage of patient care including admission, treatment and procedure or during the discharge process. This enables SDH to be able to focus its improvement efforts to individual facilities, nursing units or clinical processes, as appropriate.

Some of the individual core measures specifically address SDH's key work processes (Figure 6.1-1). To ensure that the Admission process is safe, effective and efficient, SDH monitors measures across the four disease groups (Figure 7.1-7). These measures include aspirin on arrival (AMI-1), left ventricle function assessment (HF-2), initial antibiotics for immunocompetent patients (PN-6), and appropriate antibiotic within one hour prior to surgical incision (SCIP-INF-1a). Results for each of these measures has improved each year since 2008 to achieve national top decile performance.

SDH has achieved similar exceptional performance for individual core measures related to its key work process of Assessment and Treatment (Figure 7.1-8). These measures include primary PCI received within 90 minutes of arrival (AMI-8a), administration of ACEI or ARB (HF-3), blood culture before first antibiotic (PN-3b) and appropriate perioperative temperature management (SCIP-INF-10).

Relative to its key work process of Discharge (Figure 7.1-9),

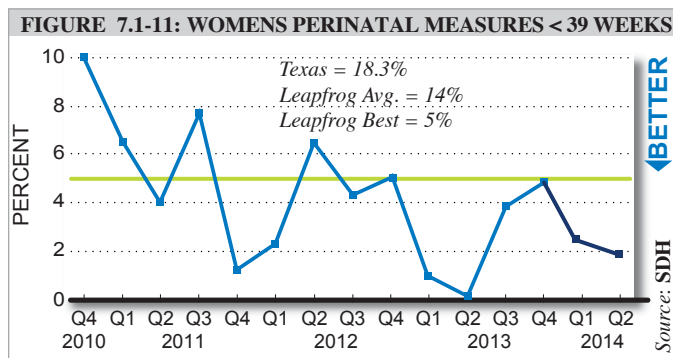


FIGURE 7.1-12: ANTIBIOTIC SPEND

	2010	2011	2012	2013	2014
ABX Spend/APD	12.14	10.49	9.54	7.40	6.24

FIGURE 7.1-13: PACKED RED BLOOD CELL TRANS.

	2010	2011	2012	2013	2014
Spend/APD	12.99	12.25	10.25	8.28	6.91

SDH monitors beta blocker prescribed at discharge (AMI-5), HF discharge instructions given (HF-1) and antibiotic discontinued within 24 hours of surgery end time (SCIP-INF-3a). Again, performance on these measures has improved over the past five years and SDH continues to approach national top decile performance. The only exception being in HF-1 due to the identified medication reconciliation process that has been corrected.

A set of eight component measures for Stroke patients was introduced over the past few years that SDH has added to its clinical measure focus in all reviews. SDH quarterly results for the past few years are represented as a "composite" in Figure 7.1-10. These measures included in this composite are stroke patients receiving VTE prophylaxis, discharged on antithrombotic therapy, anticoagulation therapy for atrial fibrillation, thrombolytic therapy, antithrombotic therapy by the end of day two, discharged on statin medication, provided stroked education and assessed for rehabilitation. These results were reviewed and actions developed with 2013 results showing marked improvement in all components.

SDH also tracks measures pertinent to key service lines including Women's services. A measure that demonstrates better outcomes for expectant mothers is ensuring that elective deliveries before 39 weeks of gestational age are performed only when clinically beneficial to the baby and mother. SDH quarterly results for the past three years is represented in Figure 7.1-11. This measure excludes certain appropriate indications for early delivery, so full compliance is considered at a 2% level. These events are becoming increasingly rare and SDH has been at below one tenth of one percent for the past two years. SDH has demonstrated a beneficial trend with performance that compares favorably to TJC and HCA.

To support the goal of providing Exceptional Care, SDH has a focus on Clinical Excellence. Two efforts include reducing the need for packed red blood cells used in transfusions and

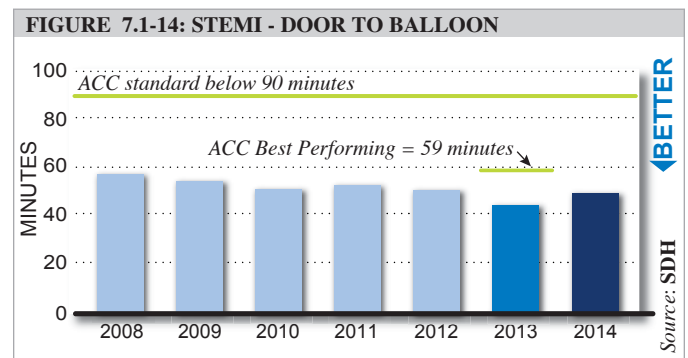


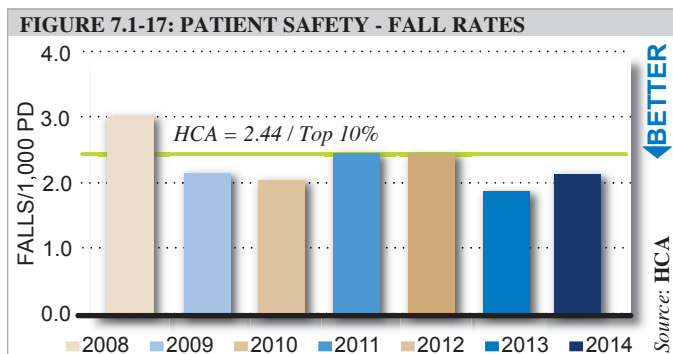
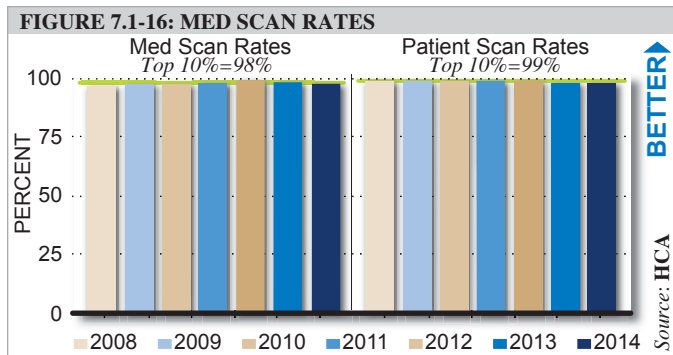
FIGURE 7.1-15: ASC MEASURES

Event Type	1Q12	2Q12	3Q12	4Q12	1Q13	2Q13	3Q13	4Q13	1Q14	2Q14
Burns	.14	.14	.00	.00	.00	.00	.12	.00	.00	.00
Wrong Site	.14	.14	.13	.00	.00	.00	.00	.00	.00	.09
Loss of Vision	.00	.00	.00	.00	.00	.00	.00	.00	.00	.00
Foreign Bodies	.00	.00	.13	.00	.00	.00	.00	.00	.00	.09
DVT/PE	.14	.00	.00	.36	.00	.00	.12	.00	.00	.00

Data Source: SQI

optimizing route and selection of antibiotics. The review of clinical literature by physicians suggested an opportunity to educate physicians and to define appropriate use of packed red blood cells (pRBC). This data was shared with physicians and then tracked monthly beginning in 2010 and expanded as a best practice to the other SDH hospitals through 2011. Sample SDH results for pRBC spend per adjusted patient day are presented in Figure 7.1-13 and represent a 36% reduction over a four year period. Another Clinical Excellence focus was driven from the growing resistance to antibiotics globally with research showing that the wide use of more expensive newer broad spectrum antibiotics could be replaced with appropriate narrow spectrum products. Through a collaborative effort with clinical pharmacists and physicians, the team identified and optimized dose route and selection of antibiotics to patients, that not only benefited patient care, but also showed reduced resistance. The additional benefit of this project was a substantial reduction in costs as represented in Figure 7.1-12.

Through its cardiac service line, SDH participates in a national effort aimed at improving the timeliness of care for heart attack patients. The goal of the American College of Cardiology (ACC) collaborative was to reduce the time from when an acute heart attack patient arrives at the door of the emergency department until the patient's obstructed heart vessel is revascularized, commonly referred to as "door to balloon" time. Through collaborative efforts with physicians, ambulance services, EDs and cath lab leaders, SDH reduced process variation related to communication, initial EKG timing and cath lab staffing to achieve the ACC best-performing time of 43 minutes for all of 2013 (Figure 7.1-14).



Facility Fall Rate	2008	2009	2010	2011	2012	2013	2014
SDSAMC	3.87	2.50	2.16	2.29	2.27	1.41	1.55
SDMC	2.13	1.68	1.92	2.31	2.46	1.57	1.42
SDNAMC	2.87	1.63	1.88	2.29	2.62	1.92	2.37
SDRRMC	3.41	2.57	2.03	2.81	2.76	2.91	3.57
SDGH	2.80	2.42	2.21	2.67	2.56	2.31	3.54

The Ambulatory Surgery Centers participate in a standardized set of quality measures through HCA's ambulatory surgery division in the SQI database. Reports are generated for each center and allow for comparison to HCA's performance across the country. Figure 7.1-15 is a summary example of several of the measures contained in the SQI database. The SDH ASCs have had no wrong site surgeries through 2013, only 1 retained foreign object in 2 years in over 62,000 surgical cases and have reduced DVTPE from 4 in 2012 to only 1 throughout all of 2013.

Patient Safety Results. In the area of patient safety, SDH participates in the annual Leapfrog Survey and conducts safety assessments from the perspective of staff through the annual employee and physician engagement surveys. The results from these comprehensive surveys are used by the Market Patient Safety Committee to drive specific improvements in the area of patient safety. SDH's competitors in the market do not participate in the Leapfrog survey constraining comparisons in these measures which are available on-site.

Two key measures of patient safety for SDH are medication scan rates and the Fall Rate that reflect the number of falls by the number of inpatient days. This allows adequate comparisons between facilities of varying size and patient volume. SDH has implemented systems designed to identify errors in the delivery of medications to patients. Each medication a patient receives is electronically scanned before administration to the patient to ensure that the right patient receives the right medication, in the right dosage, at the right time and in the right route. The scanned medication is cross-checked in a database to ensure patients only receive the medication designed for optimal care. SDH has steadily improved the total percent of medications scanned (Figure 7.1-16) over the past four years. SDH achieved its goal of 97% in 2009 and achieved and sustained its

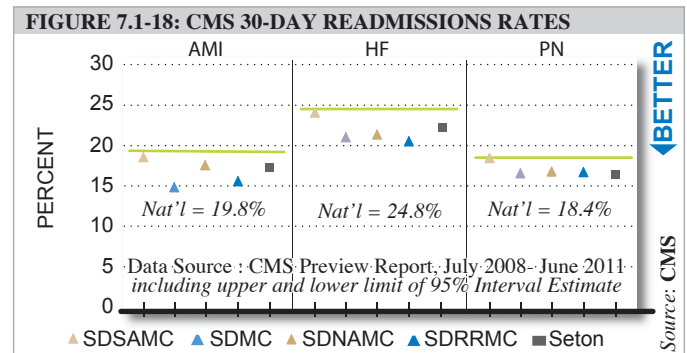


FIGURE 7.1-19: SDHMG CLINICAL METRICS

Clinical Measure % – compared to MedAxiom Cardiology Database (Lower number is better)	Top 25 '13	Nat Avg '13	SDHMG			
			2010	2011	2012	2013
Ratio office echocardiograms	19	25	21	19	18	20
Ratio imaged stress studies	13	13	15	14	13	11
Ratio office nuclear exams	8	10	11	10	9	9
Ratio of Caths to new Patients	19	24	17	17	17	20

Source: MedAxiom

goal of 98% since 2010 across all facilities. This has led to the establishment of a higher internal goal of 99% in 2013. Senior leaders recognize that there are approximately 8 million doses of medication delivered to patients each year, so one percent improvement reflects 80,000 more doses being scanned and potential errors avoided.

The patient fall rate (Figure 7.1-17) is a key measure of patient safety and action plan progress (Figure 2.1-4) reported quarterly in the Quality Review, calculated as the number of falls per 1,000 patient days. SDH has standardized, in collaboration with nursing from every hospital, the initial fall risk assessment tool, protocols for communicating high risk to all caregivers through signage and the use of colored armbands and socks. In addition, during the hourly patient rounds, staff are instructed to be proactive in assisting patients to the restroom, instead of waiting for patients to indicate the need for toileting.

Reducing avoidable readmissions to the hospital within 30 days is a focus of Medicare health care reform and SDH action plans for 2013 (Figure 2.1-4). Medicare currently posts results that are representative of a three-year period of time. SDH results are represented in Figure 7.1-18. These measures include readmissions to any hospital within 30 days of being discharged for the populations of AMI, HF and PN patients. With one exception, SDH facilities are favorably below the national readmission rates and better than its competitor, Seton. To address readmissions, SDH has analyzed the data to reveal that patients discharged to self-care comprise the highest percentage of readmissions. Thus, current innovation efforts [2.1a(2)] focus on working collaboratively with post-acute providers to track patients after discharge

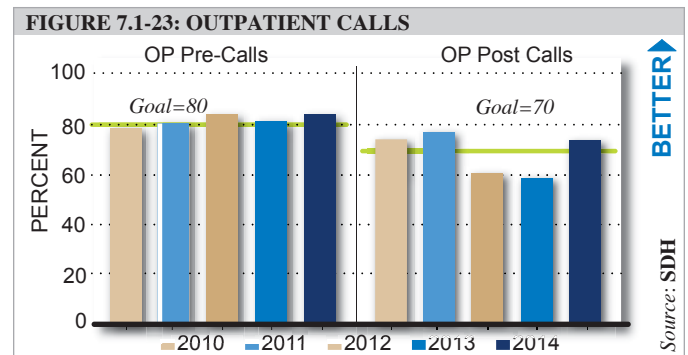
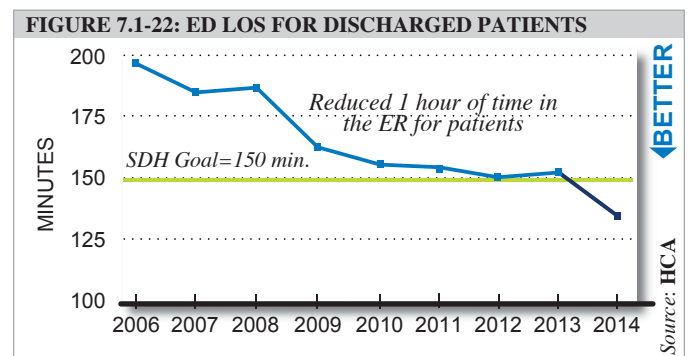
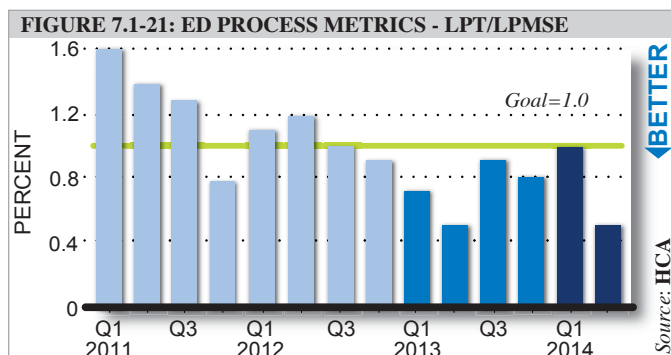
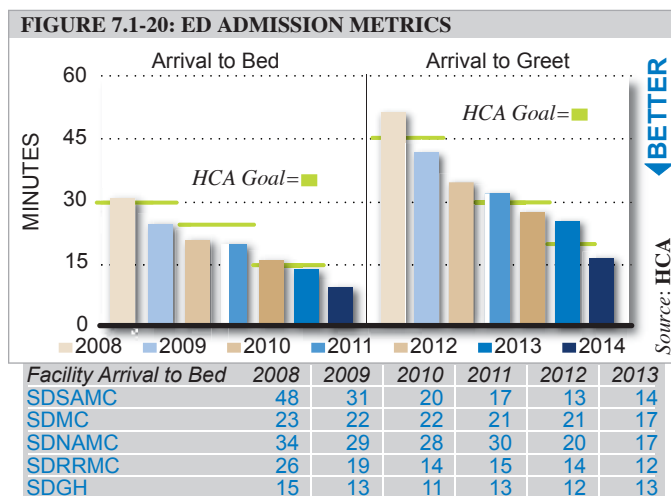
and ensure compliance with medications and follow-up care. SDHMG utilizes data from MedAxiom (Figure 7.1-19) to evaluate the clinical outcomes and utilization within cardiology physician practices. MedAxiom comparisons allow SDHMG to benchmark itself against leading practices and protocols from nationally recognized cardiology clinical experts. The four measures included in this figure represent decreasing rates of the use of more expensive and invasive procedures based on improved assessments of the patients visiting the physician's offices. MedAxiom data was reset due to national trend that shifted more outpatient exams to hospital based outpatient departments in addition to physician offices and the vendor updated historical data trends for 2013.

7.1b Work Process Effectiveness Results

7.1b (1) Process Effectiveness and Efficiency. Results for each of SDH's key work and support processes are presented here and throughout Category 7 as indicated in Figures 6.1-1 and 2. SDH manages and reviews the work processes by functional departments instead of by specific work processes presented in Figure 6.1-1 so the results are presented below by departments. These results represent a sample of process measures from across SDH's main service offerings of emergency, outpatient, inpatient and physician practice service. Segmentation for all measures is available on site.

Emergency Departments. SDH's Emergency Departments track cycle-time measures to analyze admission and treatment times in the EDs as well as overall patient volume and outcomes. A sample of these cycle time measures – ED arrival to bed, ED arrival to being greeted by a physician, percent of patients who leave prior to triage and overall LOS for discharged patients – are presented in Figures 7.1-20 to 7.1-22.

Based on the knowledge that patient and family expectations continue to shift towards lower wait times in the ED and con-



firmed on feedback from patients through the patient satisfaction survey and focus groups, SDH decided to set a goal of 20 minutes from the time patients arrive until they are taken to an ED bed. As Figure 7.1-20 shows, SDH has improved its performance on ED arrival to bed since 2008, reducing the amount of time by over 40%. Through the implementation of specific improvement projects, including a LEAN ED project, SDH's EDs were able to achieve and surpass the 20-minute goal. A new goal has been set for 10 minutes for 2014. Patients have also indicated that time from arrival to being seen by a physician in the ED is a key factor impacting their satisfaction. These results are presented in Figure 7.1-20 based originally in 2008 on a goal of 45 minutes. A multi-disciplinary process improvement team implemented strategies like "any open bed" and accuracy in triage, in collaboration with the contracted ED physician group to improve these results. In each of these metrics, the goals have been adjusted over the past five years to drive towards lower wait times overall for patients and their families.

Another ED process measure shown in Figure 7.1-21 is the percentage of patients that Leave Prior to Triage (LPT) or Leave Prior to a Medical Screening Exam (LPMSE). This measure is an indicator of the patient's tolerance for the wait

time and is a reflection of the effectiveness of the wait time strategies and action plans.

SDH also knows that approximately 85% of patients are discharged home from the emergency department and a key satisfier for this population is the length of total time spent in the ED. ED Length of Stay (LOS) for discharged patients (Figure 7.1-22) tracks the time from when patients arrive in the Emergency Department (ED) to the time they leave the ED when not admitted to the hospital. Specific improvement actions were developed and implemented over the past 5 years having a direct impact on the LOS for low acuity patients who comprise over 40% of SDH's ED volume. Part of the strategy of SDH was to open several FSEDs in convenient geographical locations so that patients did not have to travel as far for care. Recently this particular measure was added to the CMS website and SDH's EDs have consistently lower lengths of stay than their competitors.

Outpatient. Two measures reflecting the processes to ensure service excellence in the outpatient setting include both the percent of discharge phone calls made to patients before the patient visit and immediately after their visit (Figure 7.1-23). Through the customer service initiatives in the outpatient setting, reducing the number of no shows and increasing the number of calls made to patients after their visit, ensures that the patient receives the communication regarding their care. Calling the patient before the appointment ensures both that the patient is fully prepared for their visit and increases efficiency for outpatient area staffing.

Surgical Services. A web-based OR "dashboard" contains several key process indicators for the day of surgery. Three

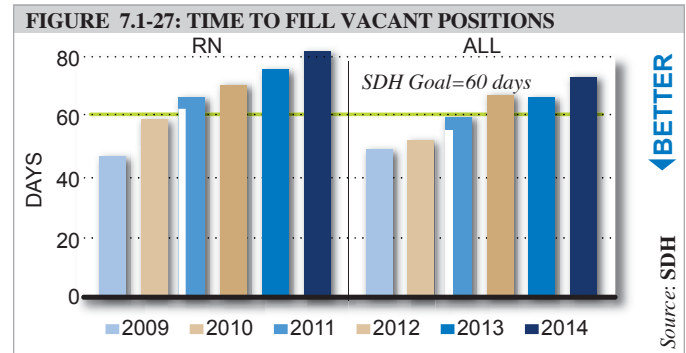
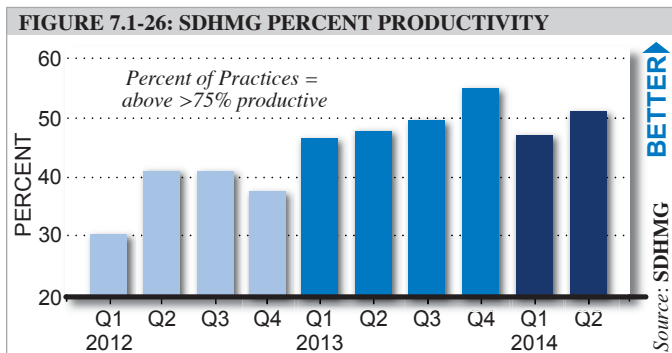
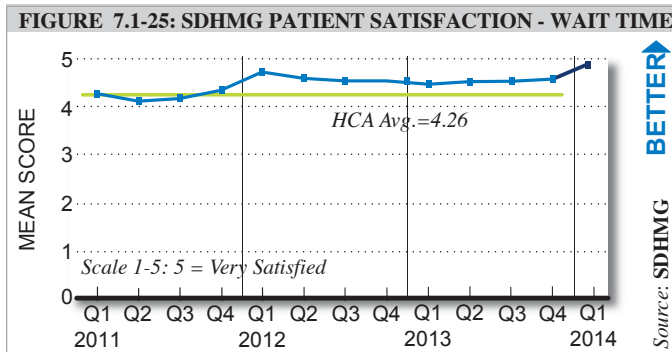
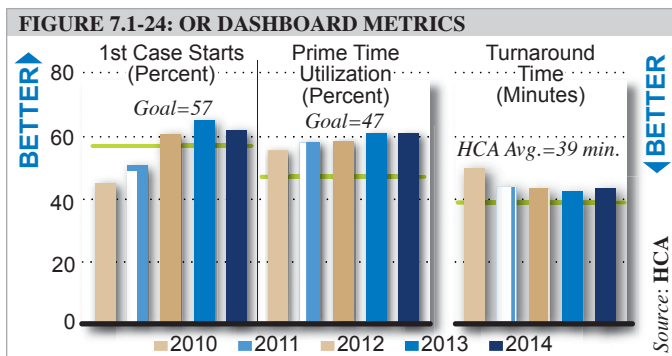
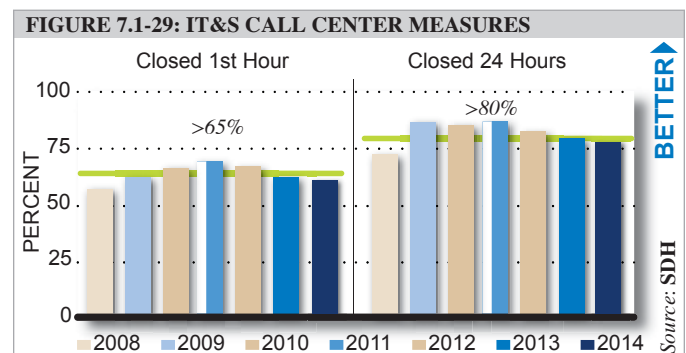


FIGURE 7.1-28: CASH COLLECTIONS

Collections (\$M)	'10	'11	'12	'13	'14 YTD/Proj
SDH Cash collections	780	1,156	1,233	1,284	923 / 1,385



represented here reflect the percent of time that the first surgical case in the day started within specified time limits, the percentage of available prime time that the OR is utilized, defined as between 7am and 6pm and the amount of time to turnover for an OR room when the surgeon follows him or herself in the same room (Figure 7.1-24). These metrics reflect the admission and treatment key work processes in addition to the clinical process measures presented in 7.1(a). SDH has ongoing improvement work in the surgical area in collaboration with surgeons' offices, schedulers and anesthesia anticipating continued improvements in all of the metrics on the OR dashboard.

SDHMG Physician Practices. Since the development of the SDHMG, several disparate reporting systems have had to migrate towards a standard reporting as physician practices are aligned with SDH. Two of the indicators of the admission and treatment key work processes within the physician practices are the patients' perception of "wait time" reflected in the satisfaction of wait time in Figure 7.1-25. The other measure used is physician "productivity" which reflects the percent of physicians who are operating at 90% capacity based on the number of relative work units (RVU's) that an individual physician accomplishes in a given day. (Figure 7.1-26).

Key Support Processes. Sample measures for several key support processes (Figure 6.1-2) are presented here. Measures for Supply Chain Management are presented in 7.1c, and most measures for the Workforce and Financial Management support processes are presented in 7.3 and 7.5, respectively.

Human Resources. In addition, SDH has improved the time to fill vacant positions (Figure 7.1-27), which addresses the key process requirement of availability. The average time to fill an RN position in 2006 was 86 days. Over the past two

years, time to fill all positions has held consistently at 60 days, despite increased local competition and national nursing shortages. The improvement is due in part to SDH's electronic HR system, which streamlines requisitions, recruiting and hiring.

Financial Management. To ensure timely financial management, SDH tracks cash collections (Figure 7.1-28) Cash collections continue to improve year over year and reflect the improvements made to improve communication to patients and family up front regarding the financial obligations of receiving care. SDH also has multiple policies governing how charity care and write-off's are managed that contributes to the overall mission and vision of SDH.

Information Management. Since the centralization of the IT function occurred, several measures are in place to assist leaders in evaluating the effectiveness of customer service from the IT&S call center function. These measures (Figure 7.1-29) include the percent of tickets closed within the first hour and those closed within 24 hours. Since the inception of the IT&S call center, calls have increased by 1,000 a month; the call abandonment rate has been reduced by 50%; almost two-thirds of the calls are resolved with only one phone call; and the average time to answer has decreased from 166 seconds to 80 seconds.

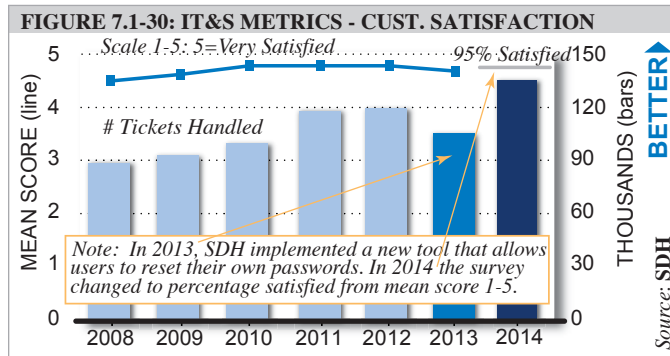
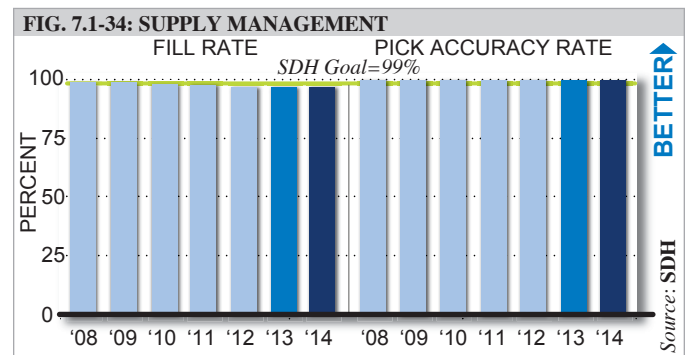
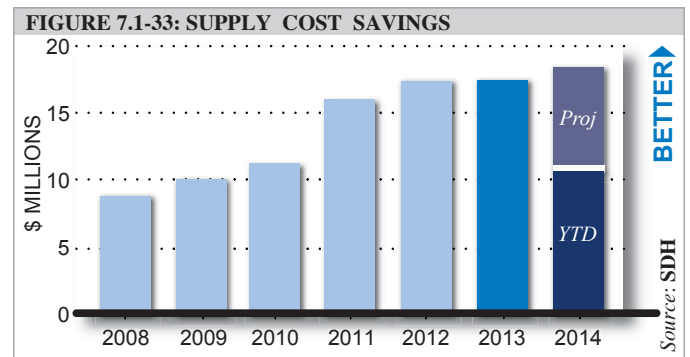
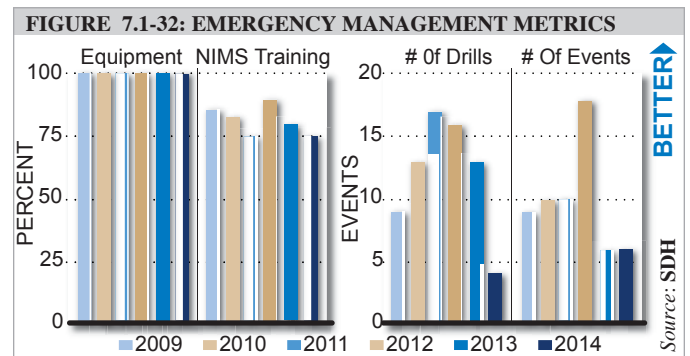


FIGURE 7.1-31: IT&S SECURITY

Sample Measures	2010	2011	2012	2013	2014	Goal
AD Machines w/Confirmed Operational Patch Mgmt	99.9	98.2	98.1	98.5	99.8	98
AD Workstations w/Current Antivirus Definitions	99.6	98.8	98.7	99.4	99.4	> 99.4
Encrypted Actionable Machines	99.9	98.8	97.6	99.1	99.9	> 99.5
Adherence to Threat Response SLA	100	100	100	100	100	100

2014 is an August snapshot



IT&S surveys a subset of any customer that has called the service desk for computer-related issues to determine levels of satisfaction with the solution and services provided. All negative comments are read and addressed with IT&S staff as a routine part of ongoing department reviews (Figure 7.1-30). Feedback from surveys is used to improve the quality of customer service. Included in this figure is the number of tickets created by the call center. A major source of calls were to simply reset user passwords so in 2012, SDH IT&S developed an on-line tool that allows users to reset the passwords themselves thus reducing the total number of calls.

Multiple measures are in place to allow IT&S to monitor and track the security of the network and individual computer workstations. Measures include unencrypted devices, patch management, current antivirus, high vulnerability machines, focus vulnerability and threat SLA. These are all used to monitor the system and ensure that machines, data and the network are secure (Figure 7.1-31). The security teams mentioned in 4.2 monitor and take action to remediate security of new viruses as they become apparent and take proactive measures to ensure the highest level of protection.

7.1.c Supply-Chain Management Results

SDH carefully manages its supply chain in collaboration with key supplier Parallon. Targeted efforts, including facility SMATs and participation in Parallon incentive plans, continue to drive significant savings in supply costs (Figure 7.1-33). In fact, annual cost savings doubled from 2008 to 2013, for a total of more than \$60 million. Supply cost as a percent of net revenue, which takes into consideration the outpatient as well as inpatient volume, has generally decreased over the past five years in the face of rising implant and supply costs across the nation. HPG also tracks several metrics to show steady performance in meeting the needs of the patient care team in each

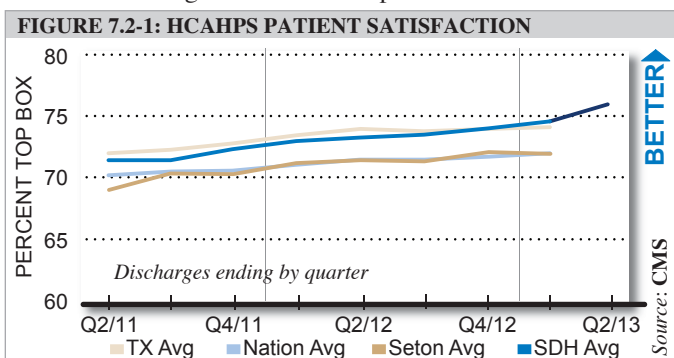


FIGURE 7.2-2: OVERALL SATISFACTION

PERCENT TOP BOX	2009	2010	2011	2012	2013	2014 YTD	Gallup 75th	Gallup 90th
Inpatient	69	71	73	76	76	76	72	79
Emergency	62	65	66	66	67	68	62	67
Outpatient Surgery	73	75	78	79	80	80	80	82
Outpatient Test/Trtmt	71	74	76	76	76	75	73	78

Source: Gallup

hospital as measured in the accuracy and ability to fill supply orders reflected in the fill and of pick accuracy rates (Figure 7.1-34). Parallon also achieved perfect or near-perfect fill and pick accuracy rates during the same time period as this reflects the result of the work of the SMAT Teams at each hospital and the effectiveness of the role of the local supply chain working with vendors to improve par levels and quality of supplies.

7.2 Customer-Focused Results

7.2a Patient and other Customer- Focused Results

To achieve its Customer Loyalty Goal and strive for its vision of being the finest care and service organization in the world, SDH measures patient- and other customer-focused results for its main service offerings of inpatient, outpatient, emergency and physician practice services; its services lines (market segments) of cardiac, neurosciences, women's, general surgery and orthopedics; its key patient groups of inpatient, outpatient, emergency and physician practice; and its facilities (Figure P.1-5), which represent its key service delivery mechanisms and locations.

7.2a (1) Patient and Other Customer satisfaction. The primary methods SDH uses to determine patient satisfaction for inpatients, outpatients and emergency patients across its service lines and facilities are surveys administered by Gallup. For inpatients, Gallup uses the nationally standardized HCAHPS survey, which asks 28 questions across 10 domains. Results for the questions and domains from this standardized survey are publicly available through the CMS website called Hospital Compare. Figure 7.2-1 reflects the past five years for SDH as well as the most current data for the national 75th percentile of all hospitals, SDH's closest competitor and the Texas average. While not yet at the 75th percentile, steady improvement across all domains reflects the implementation

FIGURE 7.2-3: SERVICE LINE OVERALL SATISFACTION

Service Line Overall Satisfaction Question	SDH					HCA				
	2010	2011	2012	2013	2014	2010	2011	2012	2013	2014
Cardiology	77	80	77	79	79	68	69	68	68	69
Neuro	67	75	69	69	72	64	64	65	65	64
Obstetrics	73	74	76	77	81	67	68	68	69	69
Ortho	68	69	74	73	74	69	70	69	69	71

Source: Gallup, 2013 data through Q3 Percent Top Box

FIGURE 7.2-4: PATIENT COMPLAINTS/GRIEVANCES

Patient Complaints Rate	2011	2012	2013
SDSAMC	2.73	2.65	2.58
SDMC	1.79	1.64	1.83
SDNAMC	1.36	1.14	1.11
SDRRMC	4.28	3.93	3.26
SDGH	1.47	1.72	1.73
SDH	2.07	1.94	1.93

Note: rate per 1,000 adjusted patient days

of the SDH Service Initiative. Internally, SDH reviews weekly the HCAHPS results for all domains and questions.

In the outpatient settings of the Emergency Department, Same Day Surgery and Outpatient Test and Treatment, SDH uses the Gallup Organization to survey a sample of patients each quarter. While over 25 questions tailored to those areas are assessed, SDH primarily uses the responses to “Likelihood to recommend”, “Likely to continue” and “overall satisfaction” on the Gallup surveys to understand, on an aggregate basis, loyalty trends and comparisons with other hospitals with similar patients (Figure 7.2-2). Satisfaction results are reported as percent of respondents who indicated the “top box” or highest response: 4=very satisfied, 3=satisfied, 2=somewhat dissatisfied, 1=very dissatisfied. In the emergency department, particular focus has been placed on reducing the overall time spent in the ED, a key patient expectation, and wait times.

Patient satisfaction for patients who have surgery on the same day has remained high for the past several years. SDH has focused attention through the service initiative on discharge phone calls, the information provided to families and the effectiveness of pain management for this patient population in an effort to improve the results year over year. Similarly, patients’ satisfaction with their outpatient tests and treatments has increased steadily over the past four years primarily due to contacts after discharge via discharge phone calls. These calls provide an opportunity for caregivers to connect and reinforce instructions after discharge, as well as provide an opportunity for the patients and their families to clarify any lingering questions about care.

For routine operational reviews SDH segments patient satisfaction for both inpatient (HCAHPS) and outpatients (ED, SDS and OPTT) by the individual hospital. SDH also seg-

ments the routine reporting by departments within each facility to identify opportunities for improvement, recognize effective strategies and identify best practices and effective strategies. In addition, SDH has the ability, through HCA, to segment patient satisfaction results by key service lines as depicted in Figure 7.2-3. In each case SDH is outperforming the rest of the comparison group in each service line in 2012. Top decile comparisons are not available for service lines, so SDH compares itself nationally to HCA, which uses a standardized definition of cardiac, neuro, ortho and women’s services. SDH outperformed HCA in 2010, 2011 and 2012, and ortho outperformed HCA in 2012.

Figure 7.2-4 reflects the trends and levels of patient complaints captured through the feedback system depicted in Figure 3.2-2. Staff has been trained in AIDET and the process for handling complaints to resolve issues as quickly as possible. Hourly rounding is focused on identifying issues quickly and providing feedback to patients and families and is used for input into process improvement.

The SDH Medical Group has programs in place to monitor patient satisfaction quarterly utilizing a different vendor than the hospitals (Figure 7.2-5). Several sample questions are presented that provide the physician feedback on how the patient perceived the care in the office setting addressing the key patient requirements of communication and responsiveness. In 2012, the Medical Group began the process of adapting the service initiative of SDH through courses provided by the IFL to the physician practice environment resulting in improved performance in patient satisfaction.

Figure 7.2-6 represents a crosswalk of key patient requirements from the organizational profile to the HCAHPS questions presented in Figure 7.2-1. These requirements have not changed over several years, but the expectations have increased in these areas. SDH tracks the percent “always” by every department across all six hospitals, reviews the results each month and compares itself to local and national benchmarks routinely.

FIGURE 7.2-5: SDHMG PATIENT SATISFACTION

Patient Satisfaction Mean Score	SDH				HCA	M3
	2011	2012	2013	2014	2014	90th
Office Wait Times	4.12	4.30	4.47	4.51	4.31	4.68
Recommend, family/friends	4.58	4.68	4.78	4.81	4.69	4.87
Provider Concern	4.75	4.81	4.82	4.88	4.81	4.93
Provider explanation	4.69	4.76	4.79	4.84	4.77	4.91
Exam Thorough	4.61	4.69	4.74	4.79	4.70	4.87

Source: SDHMG Mean Score 1-5: 5=Very Satisfied

FIGURE 7.2-6: PATIENT REQUIREMENTS

Patient Key Requirements P.1-7	Results depicted in Figure 7.2-1 for Inpatients
Consistent quality and service	Willingness to recommend question
Communication	Communication with nurses and doctors questions
Responsiveness	Responsiveness of staff question
Smooth transitions of care	Communication about Medication and Discharge information questions

FIGURE 7.2-7: PATIENT LOYALTY

PERCENT TOP BOX	2009	2010	2011	2012	2013	2014 YTD	Gallup 75th	Gallup 90th
Likelihood to Recommend								
Inpatient	79	79	81	83	83	88	82	87
Emergency	69	69	71	72	73	72	71	76
Outpatient Surgery	74	77	78	80	80	81	81	82
Outpatient Test/Trtmt	70	74	77	77	75	76	76	83
Likely to Continue								
Inpatient	76	77	79	81	81	81	81	87
Emergency	66	66	68	69	69	69	71	74
Outpatient Surgery	68	70	74	75	75	76	77	81
Outpatient Test/Trtmt	66	71	74	73	72	73	74	81

Source: Gallup

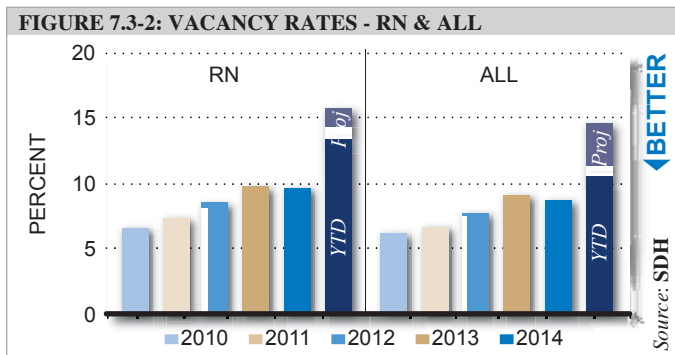
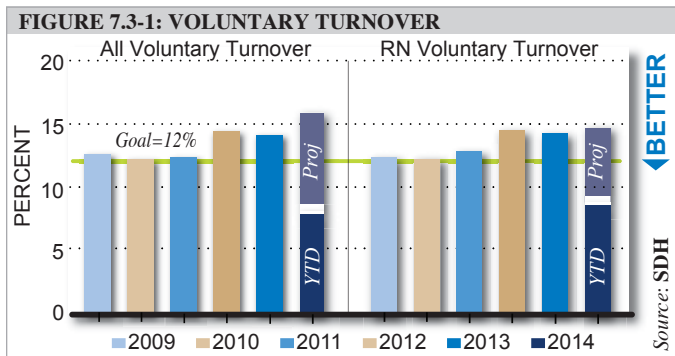
SDH is beginning to determine the best method for understanding feedback from its social media contacts. The initial data is limited and categorizes them for their level of advocacy for the organization. The low number of respondents has not adequately allowed SDH to appreciably ascertain the general sentiment of the community towards SDH, so SDH is organizing a more formalized structure to leverage social media feedback as a means for garnering patient and community feedback.

7.2a (2) Patient and Other Customer Engagement.

Gallup and HCA collaborated on identifying the crucial emotional characteristics of a hospital's best customers. These customers are not just "satisfied" or "loyal," they are emotionally attached to the hospital's services and brand. In the outpatient areas of ED, Same Day Surgery and Outpatient Tests and Treatment the question of "Likely to continue to use this facility" is a reflection of loyalty from these patient populations. The initial component of the service initiative is for staff to connect with patients through interactions that are coached using AIDET, hourly rounding and service recovery skills. These results are depicted in the inpatient and outpatient areas in Figure 7.2-7.

Figure 7.2-8 is a crosswalk of the key community require-

FIGURE 7.2-8: KEY COMMUNITY REQUIREMENTS	
Key Community Requirements Figure P.1-7	Results
Physician affiliations	Increased physician office volumes as depicted in Figure 7.4-21
Convenience	Increased number of access points through physician offices, urgent care centers and Free-Standing Emergency Departments as evidenced in total outpatient volumes in Figure 7.4-20



ments of sufficient physician selection and convenient locations for the community to obtain services. These factors are embedded in the strategic plan and results are depicted in Figure 7.4-20 and 7.4-21.

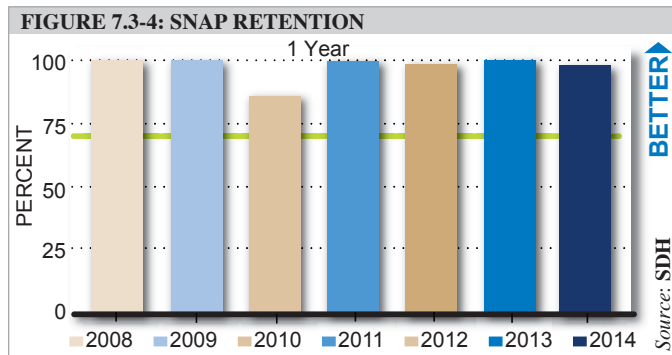
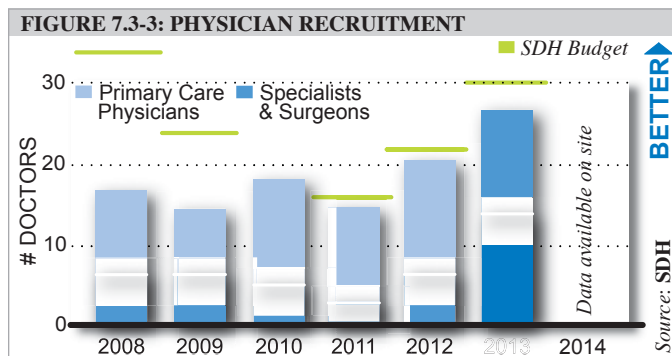
7.3 Workforce-Focused Results

7.3a Workforce Results

7.3a (1) Workforce capability and capacity. The key employee capability and capacity performance measure for SDH is voluntary turnover for all staff, specifically for RN's. Both are measures of "Customer Loyalty" on the performance dashboard. The results are reflected in Figure 7.3-1 for all staff and for the nursing (RN's) segment. In years 2009 through 2011 SDH saw a decline in turnover due in part to the suppressed economy and then the turnover increased as the economy improved. In addition competing hospitals opened in the area and offered incentives to entice staff to relocate. SDH was able to retain better performing staff through targeted efforts to reduce the impact.

In addition, SDH monitors the level of RN vacancy rate (Figure 7.3-2). The slight increase since 2010 is due in part to the turnover rate and the growth of available positions offered because of new and expanded SDH services that have come into existence over the past three years. Improving performance for the support process measure Time to Fill (Figure 7.1-27) impacts vacancy.

The annual physician recruitment plan is developed as part of the SPP to ensure SDH strategic objectives and service offerings have adequate physician coverage and leadership to be achievable. In addition, physician recruitment staff works with SDF to update a Community Needs Assessment (CNA) by facility which examines demographics, growth and utilization patterns to predict the number of physicians needed in the community by specialty to meet the needs of



a growing and aging population. Finally, physician recruitment staff uses the CNA and data provided by SDH medical staff services to update a Medical Staff Succession Plan which factors age, loyalty and value into an analysis of which physicians on our medical staffs are most at-risk (i.e. retiring, leaving the area, or moving business to a competitor). As a measure of physician capability and capacity, SDH monitors the number and specialty of recruited physicians against planned targets for the year [5.1a(1)]. Some years shown in Figure 7.3-3, the organization made a strategic and financial decision to stop short of the annual goal. However, SDH came closer to achieving its goal each year from 2008 to 2013, and the organization's success in recruiting primary care physicians supports a strategic initiative.

An innovative way SDH is retaining nurses is through its Specialty Nursing Accelerated Program (SNAP), which trains high-performing nurse graduates to work in areas such as intensive care and the emergency department [5.1a(2)]. Retention for first-year nursing graduates who participated in the SNAP program was 100% in 2013 (Figure 7.3-4), compared to 70% nationally. Second-year retention is also tracked and remains much better at 85% compared to the national rate of 45%.

Employee per Equivalent Occupied Bed (EEOB), in Figure 7.3-5, is a key measure of workforce productivity. PLUS Productivity systems (Figure 5.1-1) include established targets based on volumes in every department. This enables SDH to manage adequate staffing levels throughout the organization. Productivity reviews are conducted weekly to ensure the right number of staff is available to care for patients. HHA is included as of 11/01/2010. SDH has maintained better-than-budgeted performance at a system level and across all but two facilities since 2008.

As part of the Integrated Labor Productivity Management Process (PLUS, Figure 5.1-1), SDH also monitors key aspects of staff scheduling quality. (Figure 7.3-6). Completeness

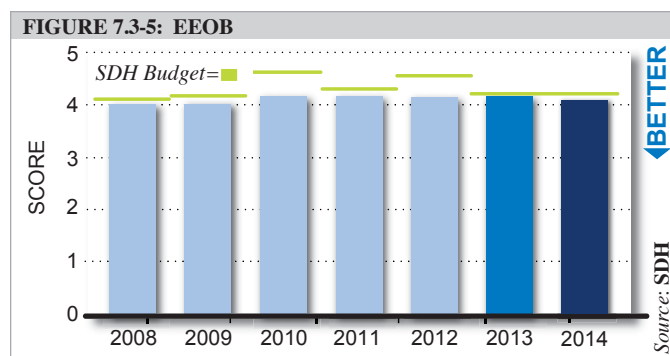


FIGURE 7.3-6: SCHED. EXCELLENCE RESULTS (FIG. 5.1-1)

Scheduling Excellence	2012				2013				2014	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Commitment	.06	.06	.06	.07	.08	.08	.07	.08	.08	.08
Completeness	.16	.15	.15	.14	.16	.14	.14	.15	.15	.14
Healthiness	.05	.05	.05	.05	.06	.05	.06	.06	.06	.05

Source: SDH Legend: Benchmark < .10
Lower is better performance

indicates the degree to which schedules are staffed to meet forecasted volumes; commitment is how fully SDH utilizes staff resources; and healthiness indicates the frequency of “unhealthy” shift patterns, related to work-life balance. Measures for commitment and healthiness have improved to better-than-benchmark levels since SDH began rolling out the Scheduling Excellence program. Completeness saw a temporary increase as the program was introduced to ancillary departments.

7.3a (2) Workforce climate. Each year for the past three years SDH has conducted a standardized Patient safety survey from AHRQ. This is in addition to the questions asked during the annual TNS Employee Engagement survey and PRC

FIGURE 7.3-7: PATIENT SAFETY SURVEY RESULTS

Sample Survey Questions		Top 2 Box %		
		2012	2013	BM
2	People support one another in this unit.	91.6	93.1	86
4	When a lot of work needs to be done quickly, we work together as a team.	89.3	89.2	86
7	We are actively doing things to improve patient safety.	87.1	88.5	84
10	Mistakes have led to positive changes.	68.0	69.4	64
12	When one area in this unit gets really busy, others help out.	74.1	77.4	69
14	After we make changes to improve patient safety, we evaluate their effectiveness.	72.7	74.1	69
19	Our procedures and systems are good at preventing errors from happening.	77.8	78.1	72
20	Supervisor/manager says a good word when he/she sees a job done according to established patient safety procedures.	78.7	78.6	73
21	Supervisor/manager seriously considers suggestions for improving patient safety.	79.8	81.6	76
34	Hospital management provides a work climate that promotes patient safety.	84.8	85.3	81
41	The actions of hospital management show that patient safety is a top priority.	81.3	81.8	75

Source: SDH Benchmark (BM): AHRQ

FIGURE 7.3-8: EMPLOYEE SAFETY RESULTS

Measure	2009	2010	2011	2012	2013	2014
Lost Time (lower is better)						
SDH	2.30	1.71	1.62	0.66	0.32	
HCA TEXAS	1.17	1.15	1.04	0.60	0.47	
Slip-Fall (lower is better)						
SDH	1.66	2.10	1.75	0.74	0.81	
HCA TEXAS	1.46	1.46	1.46	1.11	1.00	
Patient Management (lower is better)						
SDH	2.55	2.54	2.33	1.56	1.24	
HCA TEXAS	1.85	1.76	1.67	0.94	1.23	
Exp Blood & Body Fluid (lower is better)						
SDH	1.98	2.50	2.26	1.98	1.75	
HCA TEXAS	1.47	1.37	1.27	1.36	1.23	

Source: SDH Each measure is reflected as per 100 FTE

FIGURE 7.3-9: PHYSICIAN SURVEY

	SDH				Natl % Rank*			
	2011	2012	2013	2014	2011	2012	2013	2014
Perception of Pt Safety	42	53	55	52	75	91	90	87

Source: PRC Percentage Top Box *SDH percentile ranking

Physician Engagement Survey. During 2010, the facilities did not aggregate the results, but beginning in 2011, the approach was standardized using a web-based survey methodology. This allows SDH facility Patient Safety Committees to understand the opportunities for improvement based on a high participation rate of staff. SDH is also able to compare itself to a broader database of all participating hospitals that use this survey as shown in (Figure 7.3-7)

Key measures of workplace health and safety are included in the Safety Dashboard, including slips/trip and falls, blood and body fluid exposure and injury due to patient management (Figure 7.3-8). The Occupational Health Center and facility-based Injury Coordinators track and aggregate data as well as conduct workplace assessments to minimize risks and improve workplace safety for staff and a safe environment for patients to receive care. The Healthy Work Environment program has raised awareness and improved reporting in safety and security measures. Additionally, focused training during annual competency reviews refreshes staff awareness of proper technique to avoid such injuries on the job.

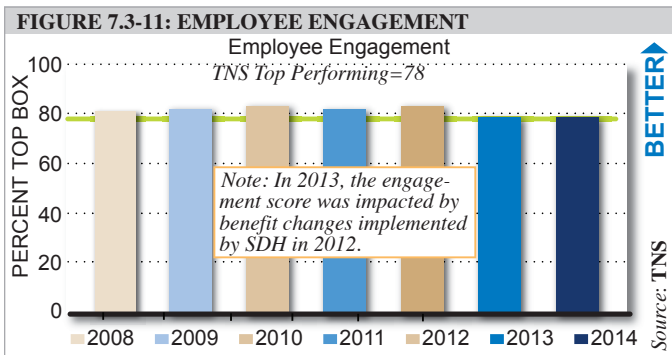
SDH measures physician perception of safety through the annual medical staff engagement survey (Figure 7.3-9). Results have steadily improved since 2009 to reach the national 90th percentile in 2012 and 2013.

As one of the largest employers in Central Texas, SDH tracks the benefit costs incurred as a percent of total salaries and wages. SDH uses this data to design future benefit plans for the employees balancing the needs of employees and their families and the cost of benefits. For the past four years, SDH

FIGURE 7.3-10: EMPLOYEE HEALTH & BENEFIT %

Metric	'10	'11	'12	'13	'14	Goal
Benefits Cost	29.5	27.6	28.9	28.3	29.2	<30
Emp. Health Screening	43	82	74	70.0	n/a	80
Emp. Personal Health Assessment	62	79	68	67.0	n/a	n/a

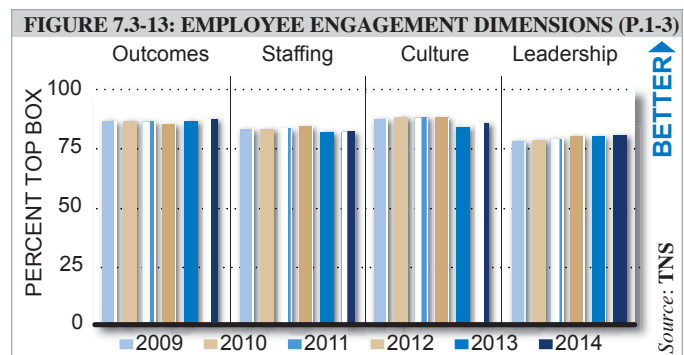
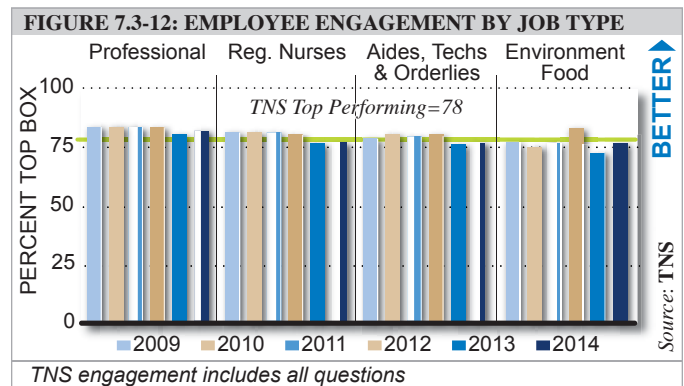
Source: SDH



has been able to maintain the benefit costs below 30%. One strategy, that is consistent with the values of the organization, is to increasingly encourage staff to have healthier lifestyles. As a part of the benefit plan design, SDH uses health screenings and personal health assessments as a way to encourage staff to understand their current health status. This provides the employee with valuable information about their health and gives them peace of mind in discussing their results with their health care providers (Figure 7.3-10).

7.3a (3) Workforce engagement. SDH recognizes that workforce engagement is critical to providing exceptional care to every patient, every day. The organization has been recognized in Central Texas as one of the Best Places to Work since 2007 and has also been recognized nationally as one of the Top 100 Best Places to Work by Modern Healthcare. Medical Staff Engagement survey vendor PRC recognized SDH with their top award called the President's Award for outstanding results in 2013 and recognized SDH with 68 recognitions in 2013.

The primary methods SDH uses to measure workforce engagement and satisfaction are nationally benchmarked employee and physician surveys that provide actionable information to drive improvement [5.2b(1)]. Formally, SDH assesses engagement and satisfaction through an annual employee satisfaction survey administered by a third party, TNS. The overall engagement scores reflect an aggregate of all 27 questions in the survey and provide SDH leaders with the opportunity to compare with other facilities using TNS as a vendor. TNS provides comparative data for high performing organizations which SDH uses to benchmark. TNS defines High Performance norms as being comprised of data from global organizations demonstrating above-average growth, financial returns and brand performance and employee satisfaction. These norms provide a high-level target for improvement for comparisons around the world in keeping with the SDH vision.



SDH's overall engagement scores have sustained each year until 2013 when planned benefit changes were introduced. (Figures 7.3-11, 7.3-12). Engagement scores are aggregated by engagement dimensions as defined by the research of TNS (Culture, Leadership, Outcomes, Rewards, Staffing, Voice and Work Schedule) to better understand feedback from the workforce. Significant improvement in a sample of these dimensions reflects the improvements made in these areas (Figure 7.3-13).

One of the questions asks employees about their "overall satisfaction" with the organization as a workplace. These results are depicted in Figure 7.3-12 segmented by job type. Through SDH's initiatives and focus on creating a great place to work, results have improved in every facility from the baseline in 2006. The employees in the SDHMG also participate in the same survey as physician practices are acquired and their results are depicted in Figure 7.3-14.

With a core competency of being able to align with physicians, SDH closely monitors physician satisfaction and engagement. Prior to 2010, SDH used the Healthstream survey to measure physician satisfaction and engagement. Changing survey vendors increased physician response rates from 30% to more than 80%. Since 2010, SDHMG and independent physicians on SDH medical staffs have taken the PRC medical staff engagement survey annually. Overall physician satisfaction (quality of care, place to practice) and engagement (likelihood to recommend) have increased each year to surpass the national top decile (Figure 7.3-15). Also, results for individual survey questions that map to the key physician engagement factors have improved each year (Figure 7.3-16). In 2013, SDH outperformed the top decile in 6 of the 9 questions and ranked in the top 20% for the remaining 3. The addition of hospital-based CMOs, physician satisfaction teams and PSRs [3.2b(1)] have all positively impacted these results.

FIGURE 7.3-14: SDHMG EMPLOYEE SATISFACTION

	2011	2012	2013	2014
Medical Group Overall Satisfaction	84	81	84	n/a
Medical Group Engagement	81	79	77	75

Note: "Overall satisfaction" question dropped by vendor in 2014

7.3a (4) Workforce development. To further engage the workforce, SDH offers and supports extensive workforce and leader development opportunities [5.2c(1)]. As a result, employee satisfaction with training has improved each year since 2008 and consistently and significantly outperformed the TNS high-performing group (Figure 7.4-1).

For nursing, which comprises more than a third of all employees, SDH supports nurses in obtaining certifications for their specific specialty areas. From 2006 to 2013, SDH funded 481 nurses for both initial certifications and re-certifications at an average cost of \$300 per certification (Figure 7.3-17). In addition, SDH offers SNAP, which trains high-performing nurse graduates to work in areas such as intensive care and the emergency department [5.1a(2)]. The innovative program has positively impacted retention rates (Figure 7.3-4) for RN's.

The St. David's Continuing Medical Education Program's mission is to enhance the knowledge and skills of physicians,

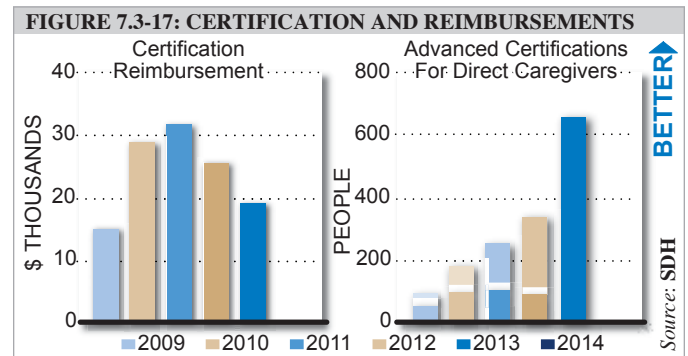
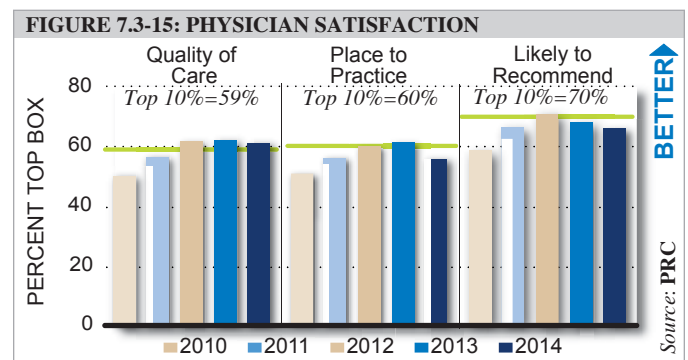


FIGURE 7.3-16: PHYSICIAN ENGAGEMENT MEASURES

Factors	Physician Engagement Factors - P.1-3	SDH Top Box					PRC Percentile Ranking				
		'10	'11	'12	'13	'14	'10	'11	'12	'13	'14
SC	Nursing Care and Treatment of Patients	42	51	53	55	55	78	91	92	92	93
SC	Nursing Assessment and Monitoring of Patient Status	34	41	47	48	48	84	90	96	96	96
SC	Nursing Collaboration with Physicians	40	48	53	52	52	86	94	95	92	92
SC	Overall Quality of Nursing Care	37	45	50	52	51	81	90	94	94	93
CO	Admin Timeliness of Communication with Physicians	29	32	38	40	40	84	78	89	89	88
CO	Admin Encouragement of Physician Input and Involvement in Operational Decisions	25	30	34	38	37	79	79	86	92	92
EP	Timeliness of Lab Results	29	33	41	49	37	55	67	87	87	74
EP	Timeliness of Radiology Reports	40	38	50	51	45	80	58	82	83	66
EP	Availability of Hospitalists to See Your Pts in a Timely Fashion	49	52	58	59	59	79	85	95	92	91

Source: PRC Database Legend: Staff Competence = SC; Communication = CO; Efficient Process = EP

resulting in improved patient outcomes and satisfaction by offering continuing medical education (CME) for the members of the St. David's HealthCare (SDH) Medical Staff. The programs for which CME credit is granted includes Grand Rounds, Cancer Conferences, General Medical Staff Meetings, special one-time conferences, seminars and workshops. Other CME opportunities occur in various settings such as Medical Staff department meetings, St. David's publications and correspondence and enduring materials, for which CME credit may or may not be granted.

CME programs target practicing physicians/ providers of all clinical disciplines on staff at any St. David's HealthCare facility. St. David's CME Steering Committee may consider requests from other St. David's HealthCare facilities, physician groups, or other groups to sponsor a joint CME activity in accordance with established policies. The expected result of the CME Program is to improve physician competence and patient outcome. These will be measured by assessing quality indicators, patient surveys, patient interviews and Physician pre and post tests with measurable outcomes, when possible. **Figure 7.3-18** demonstrates sample measures of attendance and credits offered. In 2012, SDH launched SDH Healthcast to further expand educational offerings to clinical staff offered through a dedicated web-site.

St. David's HealthCare Leadership Academy surveys directors, managers and supervisors at the conclusion of every course in the core curriculum and Service Excellence curriculum. It aggregates the scores on nine survey questions that relate to the effectiveness of the courses to create an overall rating for leadership training effectiveness. On a scale of 1 to 5 with 5 being best, participants consistently rate the course effectiveness very high (**Figure 7.3-19**).

Five questions from the annual engagement survey have been categorized around various leadership principles that are taught in the Leadership Academy core curriculum to help assess the effectiveness and impact of SDH's leadership

FIGURE 7.3-18: PHYSICIAN CME

Metric	2010	2011	2012	2013	2014
AMA Cat 1 credits offered	164	172	240	247	174
Physicians attending	1,977	2,261	2,726	3,002	1,828
Non-Physicians attending	805	1,073	1,627	1,637	1,239

Source: SDH *2014 is YTD through June

FIGURE 7.3-19: LEADERSHIP COURSE EFFECTIVENESS

Leadership Academy Course Evaluations	2007	2008	2009	2010	2011	2012	2013	2014
Course was effective	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.8
Valuable use of my time	4.9	4.8	4.8	4.9	4.9	4.9	4.9	4.8
Course obj. achieved	4.8	4.8	4.8	4.8	4.8	4.8	4.8	4.8
Course was relevant	4.9	4.9	4.9	4.9	4.9	4.9	4.9	4.8
Would recommend	4.9	4.9	4.9	4.9	4.8	4.9	4.9	4.8

Scale 1-5: 5=Very Satisfied. Goal = 4.8 or above.
Segmented results are available by facility and course.
Source: SDH Institute for Learning.

development program. These principles reflect a combination of work performance and cultural dimensions essential to SDH's success. These five questions, analyzed individually are tracked against TNS High Performing Norms (where available) and trended over time. SDH's performance against these principles continues to demonstrate outstanding performance and a strong linkage between leadership development and leader performance as shown in **Figure 7.3-20**.

SDH also tracks internal promotion rates for all identified leadership positions included in the Leadership Academy leadership development program (Charge Nurse, Supervisory, Manager, Director). **Figure 7.3-21** depicts SDH performance in this area. SDH continues to far exceed the All Industry Average of 29%, identified in a 2012 research study conducted by Robert Half Management. The study concluded that this low rate of internal promotions may not be a condemnation of the ability level of workers, but rather an indication that companies are not doing a good job preparing workers for managerial positions. Traditionally, organizations that demonstrate higher percentage rates for internal leadership promotions are characterized with strong cultures, fiscal strength, and deep bench strength.

7.4 Leadership and Governance Results

7.4a Leadership, Governance and Societal Responsibility Results

7.4a (1) Leadership. SDH's two workforce groups have identified leadership (employees) and communication (physicians) as key elements that engage them in achieving the organization's mission and vision. To ensure that senior leaders are addressing these key engagement factors, they monitor performance on specific questions in the employee and physician surveys. The impact of leader rounds and the

FIGURE 7.3-20: LEADERSHIP DEV. EFFECTIVENESS

Engagement Survey Question	'10	'11	12	'13	'14	Top Perf
Contributes to the success	94	94	94	93	94	92
Takes an active interest	77	76	79	80	81	75
Makes good use of skills	91	90	91	89	90	82
Recognizes contributions.	82	82	84	83	85	81
Shows a sincere interest.	82	81	84	86	87	79

FIGURE 7.3-21: LEADERSHIP DEV. EFFECTIVENESS

Description	'09	'10	'11	'12	'13	'14	Top Perf
SDH Leadership positions filled	151	220	224	263	287	169	66
Internal Transfers	44	101	95	121	145	68	33
Promoted	53	54	79	75	88	77	25
External Hired	54	65	50	67	54	24	8
% Filled promotions	50	45	61	53	62	76.2	76
% Filled within	64	71	78	75	81	86	88
% Filled externally	36	30	22	26	19	14	12

All industry average - internal promotion rate 29%

impact of senior leader communication and commitment to professional development is reflected in questions on the annual employee engagement survey (Figure 7.4-1). The questions include “I understand how my work contributes to the overall success of the organization,” and a question about senior leader support for training.” Two additional questions relating to “I am kept informed about where the organization is going” and trust in senior leaders are reflected in Figure 7.4-2. Communication improvements over the past three years, including employee forums, newsletters and rounding on staff contribute to high levels of staff confidence in senior leaders.

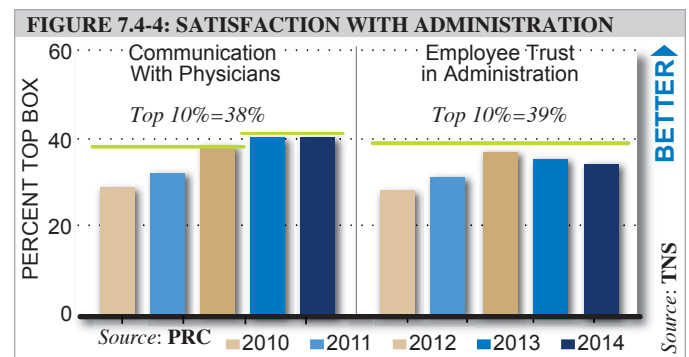
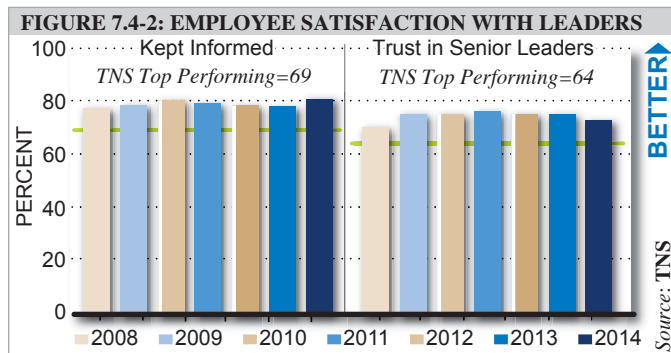
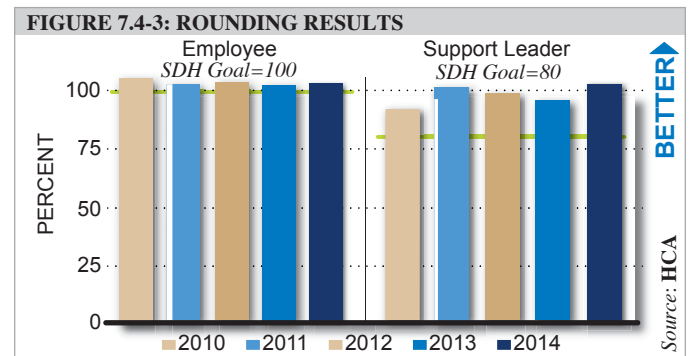
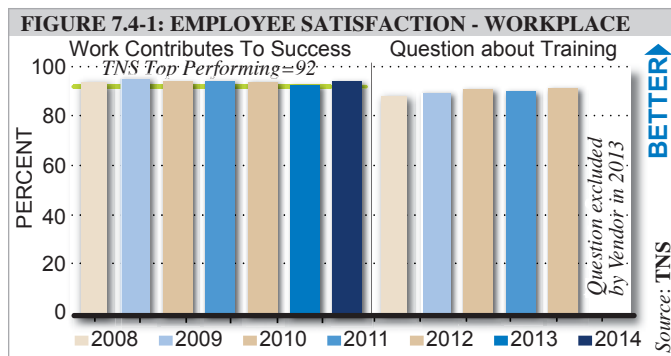
Various types of leader rounding are explained in 1.1(b)1 including senior executive leaders rounding on departments, directors rounding on every employee at specified intervals, support leader rounding on departments they serve and leaders rounding on patients. The compliance with rounding expectations and other must have’s for the service excellence culture are documented and reviewed each month by senior leaders using the Must Have Matrix tool. Results for leader rounding have exceeded organizational goals each year since 2010 as reflected in Figure 7.4-3.

Physician satisfaction and engagement are measured informally every day but also formally through the structured annual survey administered by PRC. Response rates for this survey have been over 80% for the past three years that provide validation of the results truly reflecting the voice of the physicians who choose to practice at SDH facilities. Figure 7.4-4 represents just two of the questions relating to physician perceptions of the leadership and culture of SDH. In both the “frequency and adequacy of communication” and the “Trust in administration” questions SDH as a whole has performed well each year for the last three years in comparison to the PRC national database.

7.4a (2) Governance. As evident in 7.5, SDH continues to leverage its core competency of having a strong operating discipline, with fiscal accountability to the Board of Governors and each of its sponsor organizations.

Through the innovative joint venture agreement that established SDH [P.1a(1)], St. David’s HealthCare distributes cash from net cash from operations to its partners. Distributions of cash are made quarterly in amounts sufficient to cover federal, state and local income and other taxes payable by HCA as a result of its participation in the Partnership. In addition, special distributions may be made with the approval of the Board of Governors of the Partnership based upon an analysis of current and future cash flow. All distributions are in proportion to each partner’s sharing percentage in effect at the date of the distribution and shown in Figure 7.4-5. The portion distributed to St. David’s Foundation is returned to the community through grants to 55 not-for-profit agencies and other community support activities (Figure 7.4-14).

The philosophy of the SDH BOG is to continue to grow the business without incurring debt. Such a philosophy positions the organization well for future growth and sustainability. The cash to debt ratio for SDH has been zero compared to



Moody's AA rating for top performing organizations in the health care industry. SDH's external auditors have issued unqualified opinions for years 2008 through 2012 as reflected in Figure 7.4-6.

SDH, in collaboration with HCA, conducts multiple audits and reviews of its facilities throughout the year. In Figure 7.4-7 the number of audits conducted over the past five years for each facility is displayed. There are multiple types of audits that are conducted that include internal audits for compliance on policies, laws and procedures, ethics and compliance process reviews, regulatory reviews and quality surveys. The findings of these audits are shared with the audit committee of the Board and used to improve the functioning of the organization. No significant findings have been reported over the past 5 years as a result of these audits.

7.4a (3) Law, regulation and accreditation. SDH considers violations of laws seriously and tracks disciplinary actions taken for privacy violations and EEOC charges (Figure 7.4-8). None of these charges have been substantiated. The rate per 100 employees has remained stable during the past four-year period and is in line with other organizations of similar size and complexity.

On a formal basis all six acute care hospitals are fully accredited by The Joint Commission. All facilities have successfully maintained accreditation since their inception (Figure 7.4-9). In addition, several facilities have achieved Disease Specific Certification above and beyond the formal Joint Commission accreditation. These certifications are strategically important in the service lines of Neuro-sciences, Cardiology and Orthopedics.

	2009	2010	2011	2012	2013	2014
Cash to Debt Ratio	(N/A) SDH has no debt					
Financial Audit Res.	Unqualified 2008-2013					
Charity Care - % of Net Revenue	14.09	10.03	10.01	8.62	8.47	9.23

ORGANIZATION	2009	2010	2011	2012	2013
SDSAMC			4	1	0
SDMC		3		2	0
HHA			1	2	1
SDNAMC	5			1	0
SDRRMC			3	1	1
SDGH		3		2	0
SDH	5	6	8	9	2

2014 results available on site

EEOC Charges	2009	2010	2011	2012	2013
SDH	0.17	0.06	0.07	0.13	0.12
Substantiated	0	0	0	0	0

Source: SDH | Rate per 100 FTE's

7.4a (4) Ethics. In support of the ICARE value of Integrity, SDH monitors the organization's ethical environment through the Ethics and Compliance program. SDH tracks the percentage of employees who take Code of Conduct training as a key measure of ethical behavior both upon new employee orientation and for annual refresher training. All employees acknowledge, via signature or electronically, the following: "I certify that I have received the HCA Code of Conduct, understand it represents mandatory policies of the organization and agree to abide by it." As Figure 7.4-10 shows, 99.79 – 100% of new employees have taken both the Code of Conduct orientation training and refresher training for the past three years. In addition, all members of the Board of Governors have completed annual Code of Conduct training for the past six years. SDH has tracked ethics line calls for the past five years.

In 2006, SDH implemented a Healthy Work Environment program requiring each facility to form an Employee Advisory Group to meet regularly to increase management awareness, address workplace issues, develop respect and trust and communicate the work of the group with other employees. In 2006, SDH also rolled out an Employee Dispute Resolution Policy to provide a consistent means for employees to resolve employment related problems. Of the calls received over the past 6 years, 100% have been investigated and closed – 66% were found to be unsubstantiated.

7.4a (5) Society. A key mechanism SDH uses to fulfill its societal responsibilities and support its key communities is through uncompensated care and charity care. Since 2008, SDH has provided more than \$1 billion in uncompensated care and the dollars continue to increase each year (Figure 7.4-11). SDH has provided at least 6% of its net revenue as charity

Required accreditations	Results
Joint Commission SDSAMC, SDMC, HHA, SDNAMC, SDRRMC, SDGH	Fully accredited with no lapse in accreditation for past 10 years
Texas Dept of Health	Full compliance
Medical Staff Licensure	100%
HIPAA – Patient Privacy	Full compliance
Surpassing requirements	
Disease Specific Certifications -Advanced Primary -Stroke Center (SDMC, -SDNAMC, SDRRMC) -Joint Replacement - -Hip and Knee (SDMC)	Certification Certification

	Goal	2009	2010	2011	2012	2013	'14 YTD
Board (%) [Oct. data]	100	100	100	100	100	100	0
W/in first 30 days (%)	100	100	99.8	100	100	100	100
1 Hour annual (%)	100	99.9	99.8	99.8	99.9	100	65
Ethics - Line Call		8	14	10	10	32	19

care since 2007 (Figure 7.4-12) — more than the 4% required under the SDF organization’s non-profit status.

To address the environmental well-being of the communities SDH serves, SDH participates in a collaborative effort with vendors, facility management teams and local energy suppliers to reduce the organization’s environmental footprint. One of the initiatives has focused on reducing solid waste (Figure 7.4-13). In 2013, the gains in year over year recycling and composting is directly contributed to local investment in infrastructure, support for the community sustainability programs and a process improvement to reduce local landfill use.

Under the joint venture agreement that established SDH, SDH pays a quarterly cash distribution to the St. David’s Foundation as referenced in Figure 7.4-14. SDF then along with its community-based Board decide how to invest the funds back into the community. Through SDF, SDH has contributed roughly \$140 million to community programs since 2007 (Figure 7.4-14). Community contributions have increased each year to reach \$45 million in 2013 alone. Each year the Foundation provides grants to over 55 local agencies that provide primary care, mental health programs, community health programs and dental health vans. For example, 6,300 school-aged children and adults received preventative and restorative dental care, and 200 students pursuing health science degrees were supported by scholarships from the Foundation. In addition to the grants provided by SDF, SDH invests in numerous health related community organizations. The contribution increased to more than \$1.4 million last year.

National Research Corporation has been engaged by SDH for many years to assist in understanding community perception and the impact of various communications. NRC utilizes a variety of mechanisms to ascertain the sentiment towards the organization. One of these mechanisms is the use of designed electronic focus groups that mirror the sociological make-

up of the primary and secondary service area. Figure 7.4-15 shows the primary reason for inpatient utilization compared to national norms as well as the community preference for SDH over the past five years. As depicted in P.1-7, the physician affiliation, convenient location and previous experience with SDH facilities are stronger in the market than what is typically seen nationally. Additionally, consumer preference has increased steadily over the past 5 years. This reflects the growing success of the strategies and culture of SDH.

7.4b Strategy Implementation Results

As highlighted in Figure 2.1-4, SDH uses two primary mechanisms for tracking achievement of organizational strategy and action plans: The Performance Dashboard (Figure 7.4-16) provides a high-level, strategic view of organizational performance relative to each Goal, while drill-down measures associated with specific action plans (Figure 7.4-17) provide more tactical detail.

Admissions, as seen in Figure 7.4-18, continue to grow as SDH has executed successfully on the ED and Women’s Health strategies primarily, but also strong surgery growth due to investments in key areas.

SDH’s realized and projected growth in ED visits (Figure 7.4-19) is due to a number of internal strategies and external

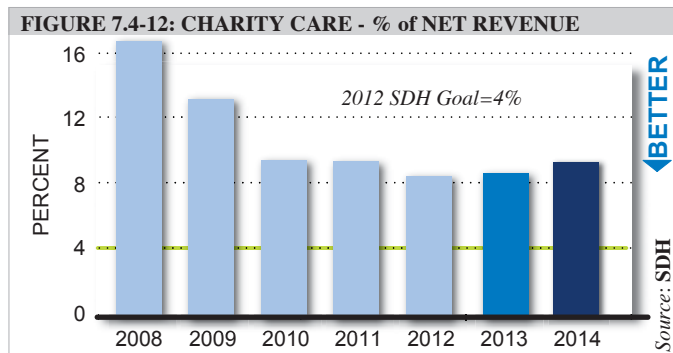
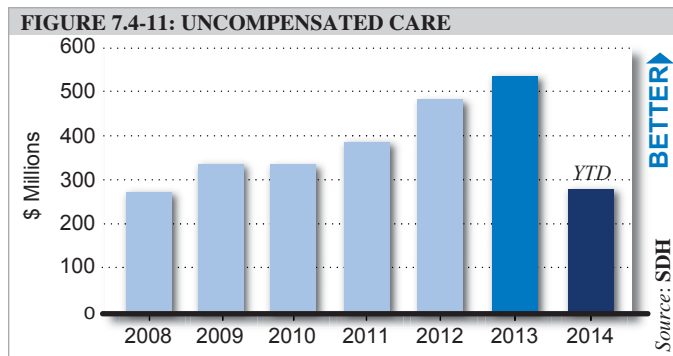
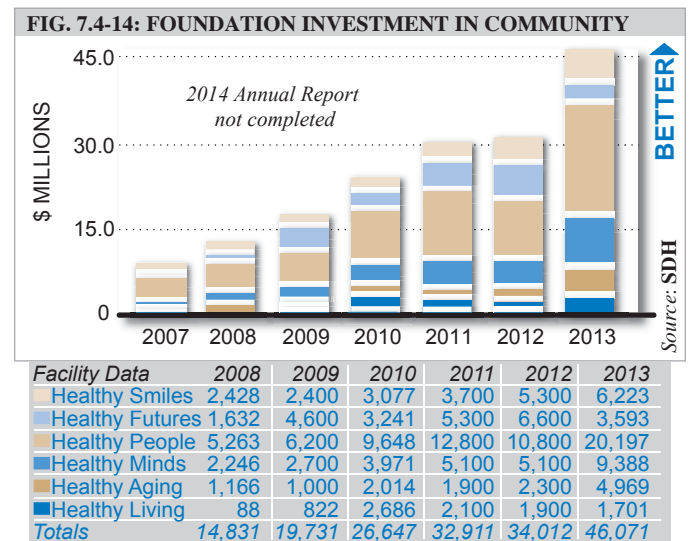


TABLE 7.4-13: SINGLE STREAM WASTE INITIATIVE

Recycling	'08	'09	'10	'11	'12	'13	'14
Total # of containers (thous.)	26.5	5.5	25.4	31.5	34.5	31.7	31.6
Pounds of CO ² emissions prevented (thous.)	33.9	33.6	33.4	41.3	45.8	55.9	42.7
Pounds of plastic kept out of landfill (thousands)	58.0	57.6	57.1	70.8	78.5	95.8	73.2
Pounds of cardboard kept out of landfill (thous.)	2.7	2.7	2.7	3.3	3.6	4.4	3.2
Gallons of gasoline saved (thousands)	1.7	1.7	1.7	2.1	2.4	2.9	2.1



market forces. Population growth, the uninsured and the shortage of PCPs have created increased demand for ED services. SDH has managed to capture an increasing portion of that growth despite new entrants through successful implementation of strategic objectives for both access points (e.g., 4 new UCCs, EMS relations) and growth of a particular service line (e.g., neuro-interventional services). The strong growth in 2011 is due to the inclusion of HHA and the opening of 2 new FSED's. Outpatient volumes, seen in Figure 7.4-20, include the ED volume, but also reflect the increased ancillary volumes for related tests and procedures and growth in the Texas Institute for Robotic Surgery based out of St. David's North Austin Medical Center.

SDH Medical Group tracks the overall volume of patients seen in physician practices, the number of providers and capacity utilization to understand the effectiveness of medical group performance (Figure 7.1-21). These results are reflective of the growing number of physicians who are managed through the medical group.

As a part of the outreach plan in Figure 2.1-4, several sample results are provided. The relationship with the University of Texas has two primary metrics including the number of admissions from sponsored UT athletic events (Figure 7.4-22). The decline in the number of heart screenings is primarily due to having completed heart screenings on a large portion of athletes.

Another action plan associated with the SDH strategic objective to expand access points is the number of patients transferred into SDH facilities through the One Call center [3.2b(1)]. During the center's first two years, annual patient movements including transfers in from outlying areas, transfers between facilities and

FIGURE 7.4-15: COMMUNITY PERCEPTION (P.1-7)

Primary Reason for Inpatient Utilization – NRC 2009-2013		National	SDH			
Doctor recommendation / affiliation		31%	38%			
Convenient location		18%	20%			
Previous experience		13%	14%			
NRC – SDH Total	2008	2009	2010	2011	2012	2013
Consumer Pref.	32.8	34.3	33.7	38.9	40.9	35.0

Source: NRC

FIGURE 7.4-16: PERFORMANCE DASHBOARD

	'11	'12	'13	'14	Fig.
Exceptional Care					
Mortality index	0.45	0.52	0.46	0.43	7.1-1
Complication index	0.86	0.69	0.78	0.94	7.1-2
Customer Loyalty					
HCAHPS Grand Composite	75	76.1	76.3	76.7	7.2-1, 2
Employees Engagement	82	83	78	79.0	7.3-1
Employees Vol. Turnover Rate	12	14	14	25 ^{proj}	7.3-1
Physicians Place to Practice	56	60	61	56.0	7.3-16
Financial Strength					
Tier-1 Market Share	43	44	45	48.0	7.5-12
EBITDA	310	319	347	194	7.5-1

coordinating transfers out has doubled (Figure 7.4-23).

The relationship with both Travis and Williamson County EMS is essential for SDH. The number of EMS runs to SDH facilities grew in 2010 and has leveled off at a very high volume for the organization as seen in Figure 7.4-24.

Figure 7.4-25 presents a crosswalk of how the results presented in category 7 relate back to the core competencies of the organization represented in the organizational profile in P.1a(2).

7.5 Financial and Market Results

7.5a Financial and Market Results

7.5a (1) Financial performance. In support of its Financial Strength Goal, SDH continues to leverage its core competency of managing financial performance to achieve exceptional financial results. Several measures of financial performance allow SDH to compare itself to the health care industry at large using the exceptional Moody's AA ratings. An important aspect of SDH's financial picture is the fact that SDH has no debt.

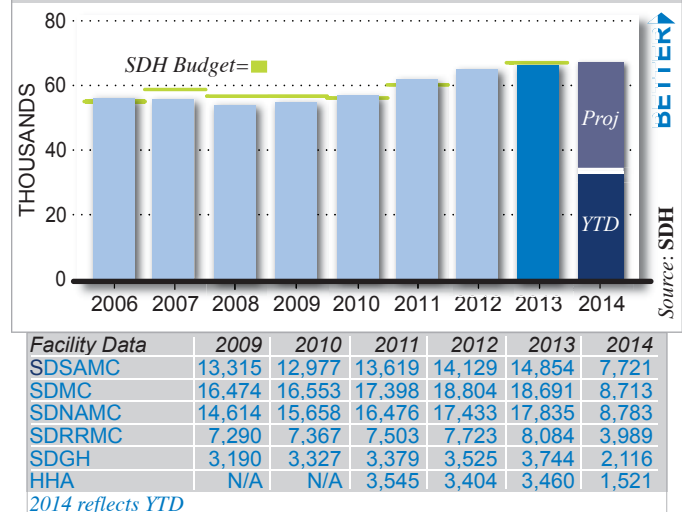
EBITDA is a Performance Dashboard measure and a key indicator of financial return for SDH. It has increased and surpassed the budget each year since 2008 (Figure 7.5-1), despite the economic challenges sweeping Texas and the nation.

FIGURE 7.4-17: STRAT./ACTION PLAN RESULTS (FIG. 2.1-3)

Strategy Result	Figure Ref
Core Measures	7.1-3 thru 10
Falls	7.1-17
Readmissions	7.1-18
HCAHPS Grand Composite	7.2-1
Turnover	7.3-1
Physician Engagement	7.3-16; 7.4-4
ED Visits	7.4-19
One Call statistics	7.4-23
EMS Runs	7.4-24
SDHMG Volumes	7.4-21
EBITDA	7.5-1.2
IP Market Share	7.5-12
Service Line Market Share	7.5-13

Source: SDH

FIGURE 7.4-18: ADMISSIONS



For that same time period, EBITDA margin also improved each year, with four consecutive years at levels four times the national benchmark (Figure 7.5-2). All but one of the SDH facilities demonstrated similar performance.

Net revenue has demonstrated equally exceptional performance, growing by more than 70% since 2007 and surpassing budget each year (Figure 7.5-3). Net revenue per adjusted admission improved each year but one (Figure 7.5-4).

Operating cash flow margin is a measure of the money that SDH generates from its core operations per dollar of net revenue. A high operating cash flow margin indicates that a company is efficient at converting charges into cash. A high cash flow margin means that an organization can rely more on internally generated cash to fund operations and capital expenditures. Since 2008, SDH operating cash flow margins have consistently measured at least twice that of the “AA” benchmark (Figure 7.5-5). This exceptional performance has allowed SDH to continue investments in capital, operational and human resource initiatives.

Return on assets is a measure of how profitable SDH is relative to its total assets. The metric is an indicator of how efficient the organization is at using its assets to generate earn-

ings. The SDH return on assets has been at levels five times the national benchmark since 2007 (Figure 7.5-6).

Measures of labor management — the largest line item in the budget — reflect SDH’s core competency of managing financial performance. SDH closely monitors its labor expenses and measures salaries, wages and benefits (SWB) as a percent of net revenue (Figure 7.5-7) and consistently outperforms budget expectations and comparable hospitals for this measure.

SDH’s financial strength allows it to reinvest in its facilities each year through capital investment as shown in Figure 7.5-8. SDH has been able to reinvest more than \$1 billion in

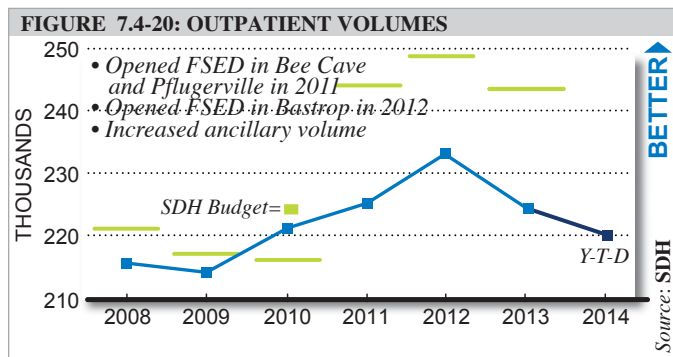
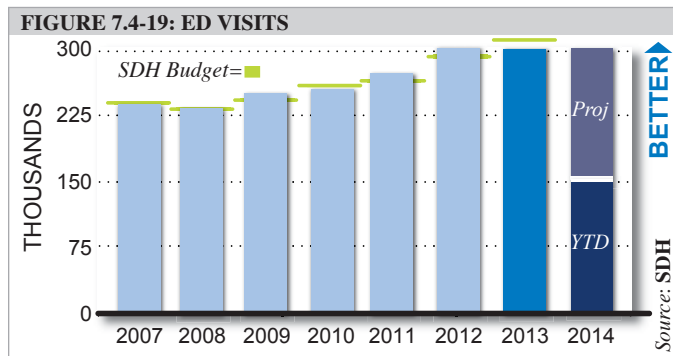


TABLE 7.4-21: SDHMG GROUP VOLUMES

	2010	2011	2012	2013	2014
Medical Group Volumes - Total Visits (thousands)	248	260	403	437	233
Medical Group Volumes - Total Procedures/Surg. (thou)	34	16*	40**	44.5	23.3
Medical Group Volumes - Total Cash Net Rev. (\$M)	46.8	50.5	74.9	76.9	41.5

Note Results: *from pulling imaging from Cardiology line; **from acquisitions 2014=YTD

FIGURE 7.4-22: ADMISSIONS FROM UT SPORTING EVENTS

	2010	2011	2012	2013
UT Athletes	4	46	49	30
UT Employee Insurance	38	42	48	53
UT Athletic Referral (Non UT Ins)	0	0	14	37
UT Event - Spectator Referral	0	26	25	24
Total Visits	42	114	136	144
Total Exp. Payment (\$ Thousands)	236	323	467	521

Note: 2013 reflects YTD data

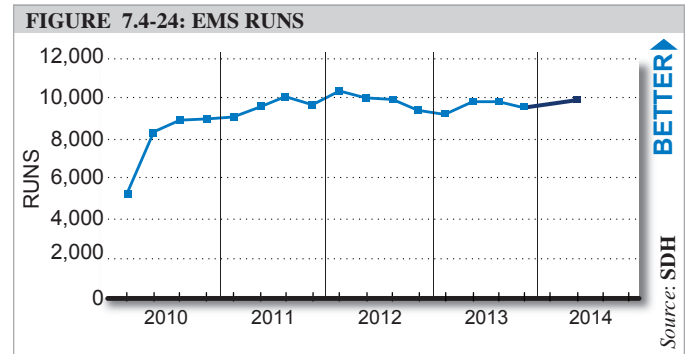
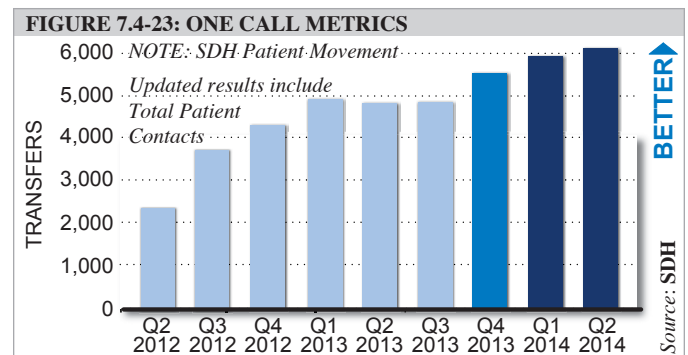


FIGURE 7.4-25: CROSSWALK OF CORE COMPETENCIES

Core Competency P.1a(2)	Results
Providing clinical expertise	Clinical Outcome results depicted in Figures 7.1-1 through 7.1-18
Delivering exceptional service	Patient satisfaction results depicted in Figures 7.2-1 through 7.2-3
Collaborating with physicians	Physician engagement results depicted in Figure 7.3-16
Managing financial performance	Financial results depicted in Figures 7.5-1 through 7.5-11

expansion, renovation and acquisition projects to support its strategic objectives over the past 12 years — without incurring any long-term debt. This gives SDH a major strategic advantage in the marketplace and ensures both financial viability and agility to meet the changing needs of the community. As further assurance of financial viability, the innovative joint venture agreement that established SDH [P.1a(1)]

allows SDH to obtain resources from its sponsors' financial reserves to address opportunities that require significant capital resources. Even in the current economic climate, SDH has been able to fulfill its quarterly cash distribution to these sponsors (Figure 7.4-5).

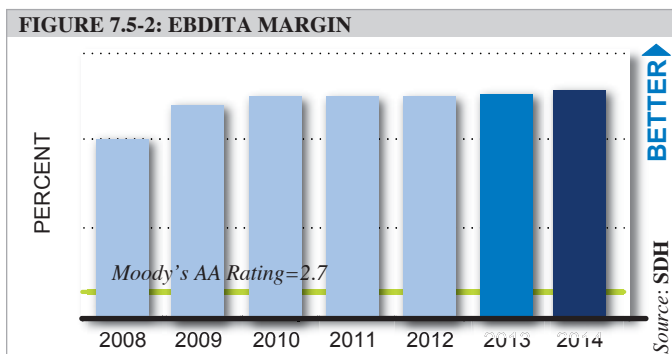
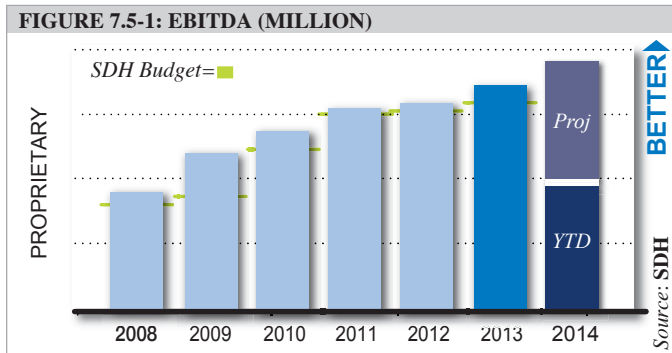
The Current Ratio and Average Age of Plant (Figures 7.5-9, 10) outperform industry Moody AA ratings. Average age of plant indicates the age of an organization's fixed assets and how much capital spending may be required in the near future. Although increasing in recent years, SDH's average age of plant is better than industry benchmarks.

Days in accounts receivable (Figure 7.5-11) measures the effectiveness of revenue cycle processes, a component of SDH's key support process of Financial Management. SDH results for this measure have remained better than the national benchmark since 2008.

Additional financial measures are found throughout Category 7:

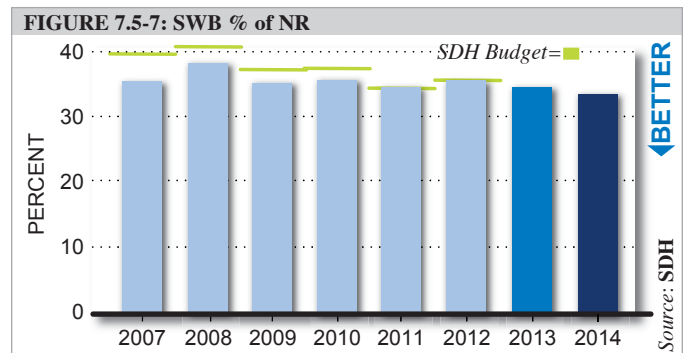
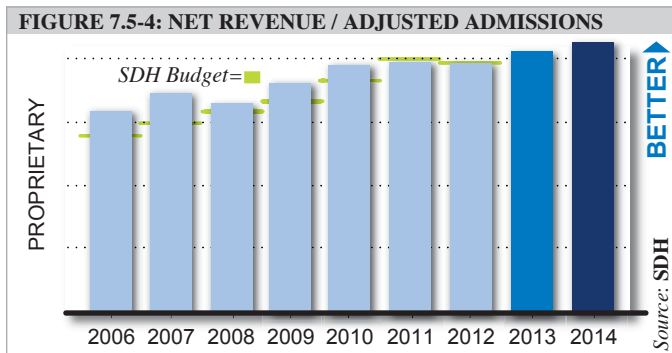
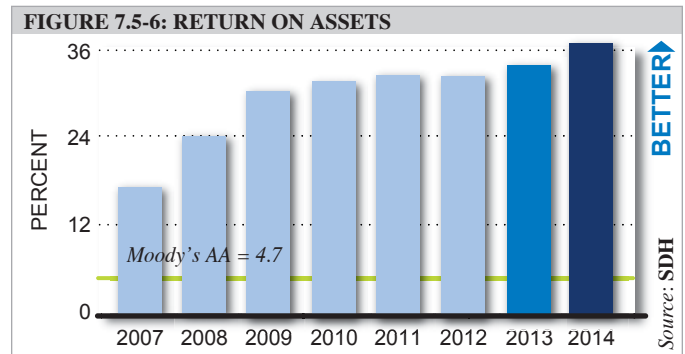
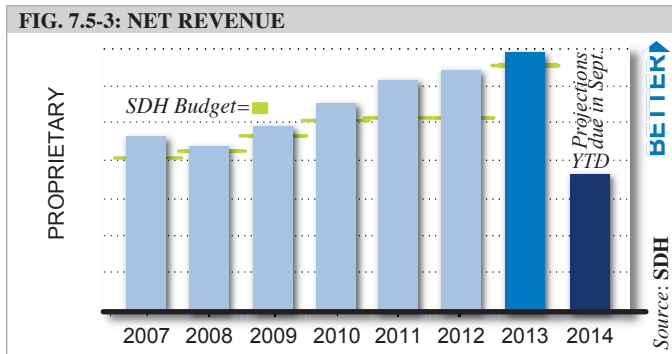
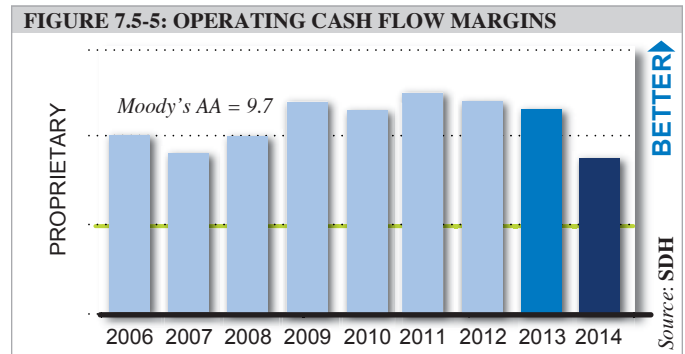
- Supply cost savings (Figure 7.1-33)
- Uncompensated care and charity care as percent of net revenue (Figures 7.4-11, 12)
- Foundation investment in community (Figure 7.4-14)

7.5a (2) Marketplace performance. SDH tracks inpatient



Facility Data	2009	2010	2011	2012	2013	2014
SDSAMC						
SDMC						
SDNAMC						
SDRRMC						
SDGH						
HHA						

PROPRIETARY



market share through the Texas Hospital Association and the Texas Department of State Health Services.

Figure 7.5-12 highlights IP market share progress by facility and key high-margin service lines identified in the SWAP. The opening of the St. David's Women's Center of Texas at St. David's North Austin Medical Center bolstered the share of SDNAMC and the system overall in 2009. SDH's core competency of aligning with physicians drove this market-shifting development. The only other significant change in share has been realized by SDMC, which, as a highly specialized medical center, has seen volume erode slightly as new and current entrants continue to expand their breadth and depth of services. Continued and increasing urban sprawl has also affected the growth of the centrally-located facility.

Figure 7.5-13 illustrates annual market share trends for SDH and key competitors for key service lines. As SDH does not compete in sub-specialized pediatric care, Dell Children's Hospital's volume is excluded except for neonatal services. As indicated on the chart, Seton has opened three new hospitals since 2007. The entry of these hospitals has had minimal impact on share of SDH to date, but is considered a strategic

challenge. Growth at the new hospitals represents the only share gains realized by the competition. The acquisition of HHA in 2010 captured an additional 2 basis points in share for SDH, while execution of the action plans each year has mitigated any gains by competition.

