

PREFACE: ORGANIZATIONAL PROFILE

P. 1 Organizational Description

P.1a(1) SSM Health Care was founded 130 years ago by Mother Mary Odilia Berger, who migrated with four other sisters to the United States from Germany. The sisters arrived in St. Louis on November 16, 1872, during a small-pox epidemic. The Sisters of St. Mary, as they were named, began nursing smallpox patients the next day. In 1987, the Sisters of St. Mary and the Sisters of St. Francis reunited to form the Franciscan Sisters of Mary.

Today, sponsored by the Franciscan Sisters of Mary, SSM Health Care (SSMHC) is based in St. Louis, MO, and operates as a private, not-for-profit health care system. SSMHC entities are located in the Midwest in four states--Missouri, Illinois, Wisconsin, and Oklahoma.

Ninety percent of SSMHC's revenue is derived from health care services provided at its hospitals. Primary among these services are emergency, medical/surgical, oncology, mental health, obstetric, cardiology, orthopedic, pediatric, and rehabilitative care. SSMHC delivers its health care services in inpatient, outpatient, emergency department, and ambulatory surgery settings associated with 17 acute care hospitals. Sixteen of the hospitals are owned and operated by SSMHC, and one is managed by the system, but jointly owned with another health care system.

Secondary services, which support SSMHC's core hospital business, include physician practices, skilled nursing (long term) care, home care, and other nonpatient business services. Physician diagnostic and treatment services are provided through the offices of SSMHC's 209 employed physicians. The physician practices refer patients to SSMHC's hospitals. SSMHC provides skilled nursing care primarily through three nursing homes, each associated with one of the acute care hospitals. SSM Home Care provides home care and hospice services in a variety of geographic areas. The nursing homes and SSM Home Care assure continued quality care for patients who are discharged from the hospital.

SSMHC has structured its organization into three levels: system, network, and entity. At the system level, System Management, supported by the Corporate Office staff, establishes the overall direction for the organization, ensures regulatory compliance, facilitates sharing of knowledge, monitors organizational performance, and uses the system's size to achieve economies of scale. SSMHC's networks coordinate the delivery of care; facilitate communication, cooperation, and sharing of knowledge and skills; and provide support services (planning, finance, human resources, physician practice management) for the entities within a specific market. The entities focus on meeting their communities needs and delivering care to their patients.

Recognizing that health care is delivered locally, SSM

SSM Health Care's Vision Statement

Through our participation in the healing ministry of Jesus Christ, communities, especially those that are economically, physically and socially marginalized, will experience improved health in mind, body, spirit and environment within the financial limits of the system.

Figure P.1-1 SSMHC Vision Statement

SSM Health Care's Mission Statement

Through our exceptional health care services, we reveal the healing presence of God.

Figure P.1-2 SSMHC Mission Statement

SSM Health Care's Core Values

In accordance with the philosophy of the Franciscan Sisters of Mary, we value the sacredness and dignity of each person. Therefore, we find these five values consistent with both our heritage and ministerial priorities:

- Compassion
- Respect
- Excellence
- Stewardship
- Community

Figure P.1-3 SSMHC Core Values

SSMHC's Quality Principles

- Patients and other customers are our first priority
- Quality is achieved through people
- All work is part of a process
- Decision making by facts
- Quality requires continuous improvement

Figure P.1-4 SSMHC Quality Principles

Health Care has established geographically based organizational units serving south central Wisconsin; Blue Island, IL, and southern Illinois; St. Louis, Jefferson City, and Maryville, MO; and central Oklahoma. Each market area has a board of directors and single governance structure. Networks coordinate delivery of services in three major markets: SSM Health Care St. Louis in greater St. Louis, SSM Health Care of Oklahoma in central Oklahoma, and SSM Health Care of Wisconsin in southern Wisconsin. These networks integrate the hospitals, nursing homes, physician practices, clinics, managed care organizations (where existing), and other business units in these areas. SSM Home Care is managed centrally.

Three of the owned hospitals are specialty hospitals: rehabilitation (SSM Rehab/St. Louis), pediatrics (SSM Cardinal Glennon Children's Hospital/St. Louis) and orthopedics (Bone & Joint Hospital/Oklahoma City).

Cardinal Glennon provides pediatric services at its hospital campus as well as through Glennon Care for Kids, which has more than 30 sites in Missouri and Illinois, including six sites at SSMHC hospitals. SSM Rehab has inpatient comprehensive medical rehab units at three SSMHC hospitals and more than a dozen outpatient sites in the St. Louis area.

P.1a(2) SSM Health Care's culture is reflected in its vision, mission, core values, and quality principles (Fig. P.1-1-4) The mission and core values were developed by employees systemwide in 1999. During the recent years of tumultuous change and challenge in health care, these cultural touchstones have provided constancy of purpose for SSM Health Care employees. Two of the strongest cultural influences ensuring constancy of purpose are (1) the organization's history and tradition and (2) a long-term commitment to continuous quality improvement.

SSMHC committed to continuous quality improvement (CQI) systemwide in 1990, and was among the first health care systems in the nation to do so. Sr. Mary Jean Ryan, FSM, President/CEO, and the system's senior leadership team made this commitment after research showed strong parallels between SSMHC's values and quality principles. The focus on CQI and assessment of progress using the Criteria for Performance Excellence has transformed SSMHC's culture into one of teamwork, continuous learning, innovation, breakthrough performance, and systems thinking. SSMHC has become a national role model for health care organizations across the country, even internationally, that are striving to create a culture of continuous improvement. Each year, SSMHC's senior leaders host many visitors from other health care organizations and share best practices at national, state and local health care meetings.

The SSMHC culture is also characterized by consensus building and decision-making at the level of greatest impact and responsibility. SSMHC employees responsible for implementing decisions as well as those impacted by those decisions work together in teams to reach consensus on action plans. This promotes an understanding of the rationale for the decisions and buy-in for deployment of the action plans. The organization's broad-based leadership system, which includes approximately 190 executives from across the system, facilitates consensus building and decision-making among the leaders. This culture is also reflected in the degree of autonomy exercised at the local level. SSMHC carefully balances the need for standardization with the benefits of local autonomy. Within SSMHC, local networks and hospitals have a great deal of authority and freedom to address their own market's unique challenges. As a result, the organization reaps the benefits of flexibility and more rapid decision-making. In addition, each employee is considered a leader and expected to contribute to his or

her fullest potential, both within and beyond their job description.

P1a(3) Nearly 5,000 physician partners and 22,041 employees work together to provide health care services. The system's health care staff is diverse and includes nurses (patient care and administrative), physicians, executives and managers/supervisors; support, clinical and technical professionals; lead clinical/technical professionals; allied health; support services; and administrative assistants/coordinators/office clerical. Eighty-two percent of the employees are women, and 18 percent represent minority groups. SSMHC has no unionized employee groups. Periodically, contract workers are used to supplement the workforce.

Special safety requirements for employees include ergonomics, exposure control through sharps alternatives, hazardous and biohazardous material management, life and environmental safety, and emergency preparedness.

P1a(4) SSM Health Care is a vast organization with owned facilities totaling more than 11.5 million square feet. These facilities include acute care hospitals, nursing homes, outpatient care buildings, physician and other office buildings, and clinics. SSMHC's major medical equipment supports diagnostic and treatment services within its acute care settings. This equipment includes state-of-the-art technology, such as MRI, CT, ultrasound, diagnostic imaging, angiography, and surgical lasers. For example, St. Marys Hospital Medical Center in Madison, WI, and Bridge Medical Inc. received the Healthcare Innovations in Technology Systems partnership award from Healthcare Informatics magazine for their creative use of emerging technology to improve patient care quality. St. Marys helped develop and has since implemented the Bridge MedPoint™ software system, which uses bar-code technology to intercept medication and blood transfusion product errors at the bedside.

A standardized, systemwide information system supports SSMHC's assessment, measurement, accountability, and e-health activities. The infrastructure initiated in 1992 includes local area networks (LANS); system-spanning wide-area networks (WANS); access to external, government, and commercial databases; video conferencing; tele-radiology; and other services.

P1a(5) The system operates under the requirements of the federal sector, including OSHA, EEOC, and EPA (health, safety and environmental), and within city, state, and county regulations. While SSMHC is not legally required to meet EEOC regulations, the organization has elected to do so because of its strong commitment to diversity. SSMHC is committed to exceeding regulatory requirements, and considers compliance a minimum standard. All hospitals, nursing homes, care sites, and

Patients & Their Families	Key Requirements
<ul style="list-style-type: none"> • Inpatients 	<ul style="list-style-type: none"> • Responsiveness, Pain Management
<ul style="list-style-type: none"> • Outpatients 	<ul style="list-style-type: none"> • Wait Times, Pain Relief
<ul style="list-style-type: none"> • Emergency Dept. 	<ul style="list-style-type: none"> • Wait Times, Pain Management
<ul style="list-style-type: none"> • Home Care 	<ul style="list-style-type: none"> • Timeliness, Accuracy
<ul style="list-style-type: none"> • Long Term Care 	<ul style="list-style-type: none"> • Technical Skill

Figure P.1-5 Key Customer Requirements

services are fully licensed and accredited by all appropriate federal, state and local agencies.

SSMHC is the only health care organization in the nation to qualify for and adopt the Corporate Parent Model Master Trust Indenture (MTI), a legal platform for coordinating external borrowing. The MTI has given SSMHC the ability to streamline corporate borrowing through tax exempt revenue bonds and to be flexible in affiliating and building relationships with other entities.

SSMHC tracks charity care and community benefits to ensure that it fulfills the organization's Vision and maintains tax exempt status as a nonprofit health care organization under IRS financial regulations. The Corporate Responsibility Process (CRP) ensures that SSMHC's entities comply with Medicare and Medicaid fraud and abuse requirements and regulations enforced by the Office of Inspector General (OIG). SSMHC's HIPAA Project is preparing the organization for U.S. Department of Health and Human Services' regulations on patient confidentiality under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

P.1b(1) SSMHC views patients and their families as its primary customer group. SSMHC further delineates this customer group by five key patient groups: inpatient, outpatient, emergency department, home care and long term care. Surveys have shown family members, who act in behalf of children or relatives not competent to make decisions, have the same key requirements as patients. See Fig. P.1-5 for key customer requirements. All patient segments expect accuracy, good communication, and positive health care outcomes.

P.1b(2) SSMHC has selected the following key suppliers to represent and distribute supplies systemwide: Cardinal Health (pharmacy & pharmacy automation), Burrows, Owen & Minors, and Allegiance (regional medical/surgical), Alliant (food service), Fischer (laboratory), and Diagnostic Imaging (radiology). SSMHC uses Premier, Inc., the nation's largest health care purchasing group, to obtain cost savings. As one of

several hundred owners of Premier, SSMHC also receives periodic dividends. SSMHC's key requirement for Premier is cost savings. SSMHC screens its suppliers, and has established strict controls to monitor and ensure quality products are received.

In addition to ongoing communications by telephone, mail and e-mail, an SSMHC representative meets in person with key contacts from each of the suppliers quarterly to conduct a formal business review and planning session. The meeting is designed to review the supplier's performance and plan future improvements; to discuss SSMHC's goals, requests, and unresolved issues regarding products and services; and to explore new products and programs. Electronic links to suppliers are provided on the SSMHC intranet.

Physicians are critical to SSMHC's success because they are the primary source of patient referrals, and essential partners in improving clinical outcomes. Therefore, SSMHC considers physicians its most important partner group. All physicians who admit and treat patients at SSMHC hospitals must apply for medical staff membership and be granted specific privileges appropriate to their education, training and experience. The system's most important supplier partners are medical equipment and supply distributors. SSMHC identifies partners as those with whom it has a reciprocating relationship--one that carries dual requirements. See Fig. P.1-6 for supplier-partner key requirements.

SSMHC seeks to make physicians clinical partners, sharing in the organization's mission, decision making, strategic planning, and clinical performance improvement opportunities. SSMHC works closely with approximately 5,000 medical staff physicians systemwide, including 209 who are employed, and participates in 39 joint ventures

<p>SSMHC Requirements of Suppliers</p> <ul style="list-style-type: none"> • Timely availability of inventory • Invoicing accuracy • Cost savings/Sales
<p>Supplier Requirements of SSMHC</p> <ul style="list-style-type: none"> • Timely payment of bills (DSO)
<p>SSMHC Requirements of Physicians (Partners)</p> <ul style="list-style-type: none"> • Business growth/patient referrals • Resource management • Exceptional patient care/Outcomes (shared)
<p>Physician Requirements of SSMHC</p> <ul style="list-style-type: none"> • Nursing responsiveness & Reduced turnover • Administrative responsiveness & Facility improvements

Figure P.1-6 Supplier/Partner Key Requirements

with physicians. One of the most successful examples of physician partnering is SSMHC's long-standing relationship with Dean Health System in Wisconsin. Since the late 1980s, Dean Medical Center, a component of Dean Health System, and SSMHC have had a 50/50 joint venture called St. Marys Dean Ventures, Inc., which provides primary care services in rural Wisconsin through 92 physicians, 19 optometrists, and 2 podiatrists in 23 clinics, 3 ambulatory surgical centers, and 12 eye offices. This partnership has enabled SSMHC to be the leader in the south central Wisconsin market.

A systemwide Physician Leadership Council was established in 2001 to coordinate activities to develop physician leaders in the organization. The Council consists of seven physicians representing employed, appointed and elected medical staff leaders. The Council has implemented monthly medical leader conference calls; established an intranet listserv for physicians; organized a pre-session for physicians at the annual SSMHC Leadership Conference; and planned a two-day retreat that includes updates on the system's goals. Physician executives also receive SSMHC's weekly electronic newsletter, *SSM Link*. All physicians receive *SSM Network*, SSMHC's bimonthly newspaper. More formal communications occur in person at team or Clinical Collaborative meetings, conferences, sharing sessions, Board and committee meetings. Physicians selected by the medical staff serve on network/regional boards.

P.2 Organizational Challenges

P.2a(1) SSMHC is the 10th largest Catholic health care system in the nation ranked by staffed acute care beds. In 2001, the system had \$2.4 billion in assets and \$1.7 billion in total operating revenue. The health care industry is very competitive in SSMHC's major markets and managed care penetration is high. Despite these pressures, SSMHC is currently increasing market share in all its major markets.

SSM Health Care St. Louis competes with BJC Health Care, the area's largest provider; Tenet, the first national for-profit company to enter this health care market; and St. John's Mercy Medical Center. SSM Health Care St. Louis, second in size with 18 percent of the inpatient market share, is known as the most physician-friendly network in the St. Louis area. Cardinal Glennon Children's Hospital, the nation's only Catholic-sponsored children's hospital, is a national role model for compassionate care for dying children through Footprints, funded by a Robert Wood Johnson Foundation grant.

SSM Health Care of Oklahoma competes with Integris, the largest provider network; University Health Partners; Deaconess Hospital; and Mercy of Oklahoma. SSM Health Care of Oklahoma, third with 17.1 percent market

share, is the fastest growing network in Oklahoma City. Bone & Joint Hospital is a national role model for knee and hip surgery. In 2002, Bone & Joint was named one of the nation's top ten orthopedic hospitals in the country by AARP and was the only facility in Oklahoma to receive two five-star ratings in orthopedics from Healthgrades.com.

SSM Health Care of Wisconsin competes with Meriter Health Services and the University of Wisconsin Hospital. Other competitors in Wisconsin include Reedsburg Hospital, Sauk Prairie Hospital, and Divine Savior Hospital. SSM Health Care of Wisconsin, first with an 18.8 percent market share, is the lowest cost provider in the Madison market. In 2002, St. Marys Hospital Medical Center in Madison was designated a national nursing role model, one of only 50 magnet hospitals in the country, by the American Nurses Credentialing Center for its use of the shared governance model.

SSMHC's key collaborators are Dean Health System, a joint venture partner in Wisconsin; affiliated colleges and universities that provide physician and nurse staffing and assist in professional health care staff recruitment; affiliated hospitals that increase market share; the American Hospital Association and state hospital associations that assist in advocacy efforts; and a variety of local, regional and national organizations that partner with SSMHC entities and networks on Healthy Communities projects.

SSM Health Care expands access to health care and referrals through affiliation agreements with rural hospitals in Missouri, Illinois, Wisconsin, and Oklahoma.

In addition, SSMHC participates in approximately 100 clinical affiliation agreements with colleges and universities around the country providing internship and residency sites for physicians and other health care professionals. The four primary collaborators are the University of Wisconsin, Saint Louis University, Oklahoma State University, and University of Oklahoma.

P.2a(2) The following factors give SSMHC a competitive edge and differentiate it in the marketplace: A culture of continuous quality improvement that encourages teamwork, learning, and innovation; use of the Criteria for Performance Excellence to assess approach and deployment of processes; a commitment to partnering with physicians; systemwide Clinical Collaboratives to improve clinical outcomes; and the Catholic tradition of giving compassionate health care services to all, but most especially to those who are poor and vulnerable. Other factors contributing to SSMHC's success include a governance structure that promotes rapid decision making; systemwide survey processes that provide in-depth insight into the needs and requirements of SSMHC's patients and other customers along with software that enables drill-down analysis; a reputation for

being a good partner, especially among physicians; Strategic and Financial Planning Process (SFPP) that enables the system to focus on the future and respond to a competitive and rapidly changing environment with agility. The entities also are strengthened by being part of SSMHC, a national system, and its regional networks, which promote sharing of knowledge and resources. SSM Health Care was one of only a small number of health care systems across the country to report a substantial financial improvement (\$56 million) between 1999-2001. This financial improvement enabled the system to pursue a \$240 million bond issue to fund 2001 capital expenditures for technology and hospital/nursing home facilities and reimburse past capital expenditures. SSMHC expects these capital improvements to enhance its health care services and result in increased market share.

P.2b SSM Health Care's key strategic challenges are:

- patient safety
- nursing shortage
- increasing financial pressures, including capital investment costs and declining reimbursement
- growing customer expectations.

P.2c SSM Health Care uses the Criteria for Performance Excellence as a business model and assessment tool. Thirty-six applications for state and national quality awards have been made by SSMHC and its entities since 1995. SSMHC received site visits by examiners from both the Missouri Quality Award and the Malcolm Baldrige National Quality Award during 1999. SSMHC was awarded the 1999 Missouri Quality Award. SSMHC received a second MBNQA site visit in 2001.

The application process each spring helps the organization to assess the effectiveness of its approaches. Members of the systemwide category teams involved in gathering data for the application learn more about how the entire organization operates and how they can improve in their own areas.

After the feedback report is received at the system level, a small systemwide team works with consultants to analyze the report and prioritize improvement initiatives based on available resources and value to the organization. Sub-teams of experts are called together when specialized expertise is required to define next steps. System Management (defined in 1.1a(1)) discusses the team's recommendations and decides which improvements to pursue. The Quality Resource Center holds an educational videoconference on the feedback for employees and physicians at the network and entity level. Special educational sessions and progress updates are presented to System Management and the Innsbrook Group. The feedback is also considered by the Innsbrook Group in its February planning session for the Strategic, Financial & HR Plan. Teams are assigned to improve

existing processes or to develop and implement new processes.

The strengths and opportunities for improvement as well as improvement plans are communicated broadly throughout the organization using the communications methods listed in Figure 1.1-1. Sr. Mary Jean Ryan, FSM, and the regional presidents present the key feedback findings to the administrative councils and employees and physicians during the January/February annual entity visits.

Improvements are made at the entity, network and system level using a continuous quality improvement (CQI) methodology. Improvement teams use the same Plan-Do-Check-Act (PDCA) steps of the CQI model, with some modifications, for both design and redesign of processes. The CQI Model-Process Design Approach is used to design new processes, and the CQI Model-Process Improvement Approach is used to redesign processes. (See Fig. 6.1-1)

SSMHC keeps focused on the need for improvement through its Performance Management Process, which is described in Item 1.1 and Item 4.1.

SSMHC fosters best practice sharing throughout the organization in the following ways.

- An annual Sharing Conference highlights 40 or more best practices from around the system
- Best practices are exhibited at the system's annual Leadership Conference
- Best practices are shared at annual systemwide meetings of functional area leaders
- Quality improvement teams notify the Quality Resource Center of new projects and send their story-books to be shared with other entities.
- Teams participating in SSMHC's Clinical Collaboratives share lessons learned through teleconferences and face-to-face meetings of participants
- Information is shared through the system's intranet site and in an e-mail newsletter, *SSM Link*, distributed weekly to the executive leadership group.
- Shared team learning is tied to SSMHC strategic initiatives in the system's bimonthly newsletter, *SSM Network*, whose mission is "Sharing Ideas to Advance Our Common Mission." This newsletter is distributed to all employees and physicians.

SSM Health Care's employees and physicians were deliberate in selecting the word "exceptional" to be used in our Mission Statement: *Through our exceptional health care services, we reveal the healing presence of God. We know that it sets a high standard, and we are determined to work together to reach that standard. We do it because we share in the commitment to give the same exceptional and compassionate care to every person, regardless of her or his ability to pay.*

CATEGORY 1 - LEADERSHIP

1.1 Organizational Leadership

1.1a(1) SSM Health Care is committed to providing exceptional health care services to every person who comes to us in need of care. SSMHC's Board of Directors sets the organization's Vision Statement (Figure P.1-1) and affirms the Mission and Core Values statements (Figures P. 1-2 and P.1-3) developed by employees throughout the system. The Board consists of nine members, both religious and lay persons, and meets four times a year. Four regional boards and three local boards, operating under guidelines established by the SSMHC Board, are responsible for medical staff credentialing and performance assessment and improvement for SSMHC entities within their service areas. The regional/local boards meet six times a year.

Approximately 190 regional and system executives, entity presidents and administrative council (AC) members, physicians, and corporate vice presidents make up **SSMHC's leadership system** (see page xv). Physician executive leaders, who are typically vice presidents of medical affairs, medical directors, or chief medical officers at the entities or networks, are fully participating members of the leadership system.

The leadership system contains the following primary mandated groups:

- * **System Management**, 11 senior leaders, who meet monthly. See page xvi.
- * **Operations Council**, 9 senior leaders, subset of System Management, who meet monthly.
- * **Innsbrook Group**, 31 system, network and entity senior leaders, who meet three times a year. The Innsbrook Group consists of all members of System Management and all hospital presidents, plus representative physician organization, network, home care, and information systems executives.
- * **Network leadership** consists of the network president/CEO and his or her direct reports, 8 to 10 people, who meet weekly or biweekly.
- * **Entity leadership** consists of presidents and members of their leadership teams, called administrative councils, and medical staff leaders, 8 to 10 people, who meet weekly or biweekly.

Nearly 3,000 SSM Health Care employees and physicians participated in focus groups across the system to define the organization's mission and values during 1999. Out of this discussion came recommended wording for a single, more concise and memorable mission statement and core values. During 2000, educational sessions were conducted at each of the entities to communicate the new mission and core values to all physicians and employees. The education, designed to give definition to the mission

and values, included group discussions of the personal meaning of the mission and values to individuals. A "Meeting in a Box" tool kit, including a video, brochures and pocket cards was used to facilitate consistent deployment. Educational programs conducted in 2001 for the deployment of the 2002-4 Strategic, Financial & HR Plan (SFP) served to reinforce the mission and values.

SSMHC is a mission-and-values-driven organization. Every executive leader throughout the system is responsible for ensuring that SSMHC's mission and values are communicated and deployed. The corporate vice president-mission awareness develops SSMHC's mission initiatives with input from the Mission Think Tank of about a dozen employees and entity/network mission awareness representatives. System Management requires each entity to have a **mission awareness team (MAT)**, made up of a cross section of employees. These teams sponsor an annual retreat day for their co-workers and a variety of works of mercy, for example, fundraising for local charities, that emulate the mission and values. Mission and values statements and Quality Principles (Figure P.1-4) are reinforced in system, network and entity publications, such as *SSM Network*, SSMHC's bimonthly newspaper, and posted in conference rooms throughout the system.

The Innsbrook Group sets the organization's short- and long-term strategic directions and performance expectations through the **Strategic, Financial & HR Planning Process (SFPP)** (Figure 2.1-1). They develop goals that support the Vision and Mission statements. Interactive processes occur within each entity and network to finalize the entity/network Strategic, Financial & HR Plans (SFPs). Use of the SFPP also enables the Innsbrook Group to create and balance value for all of its stakeholders (patients and their families; employees; all active and associate physicians; major suppliers; and payors) by ensuring the goals reflect each stakeholder's requirements.

System Management translates short- and long-term directions and deploys organizational values and performance expectations to all employees through a systemwide tool called "**Passport**." SSMHC employees receive a "Passport" - a card that contains the SSMHC mission and values; the characteristics of exceptional health care services identified in the 2002-4 SFP; spaces for entity, departmental, and personal goals and measures; and a place for the employee and manager signatures and date. The Passport creates "line of sight" from personal goals to the organization's goals.

SSMHC's senior leaders use communication plans (which identify key messages, audiences, leader spokespersons, methods, and timelines) and tools like "Meeting in a Box"

to ensure consistent communication of values, directions, and expectations throughout the leadership system and to all employees and employed physicians. See Figure 1.1-1 for other communications methods used by senior leaders to communicate values, directions, and expectations and to facilitate the sharing of knowledge and skills.

The effectiveness of communications and deployment of values, directions and performance expectations is assessed (“checked” in the PDCA) firsthand when Sr. Mary Jean Ryan and the regional presidents make their annual entity site visits during January and February. The visits enable two-way discussions with entity administrative council members, physicians, and physician representatives as well as randomly selected employees.

1.1a(2) Through their unwavering commitment during the past 12 years to a culture of continuous quality improvement (CQI), SSMHC’s executive leaders have created an environment that empowers and encourages all employees to be innovative and to seek the knowledge they need to anticipate and manage industry changes. The SSMHC culture fosters organizational agility by deploying decision making to the immediate level of impact. This philosophy was established at the time the system was formed in 1986 and is based on the religious heritage of SSMHC’s sponsors, the Franciscan Sisters of

Mary, and reinforced in governing policies. Shared Accountability, an organizational structure that gives nurses greater decision-making authority and overall accountability for nursing practice at their entities, is an example of deploying decision making to the immediate level of impact. This concept was one of several strategies that emerged from SSMHC’s 2000 Nursing Summit to address the nursing shortage. St. Marys Hospital Medical Center in Madison, WI, which had operated under Shared Governance, a model of Shared Accountability, for 12 years found that the structure significantly reduced its nurse turnover rate. System Management approved systemwide replication of this best practice and required all SSMHC entities to develop a plan for implementation in 2002.

SSMHC executive leaders model learning and innovation by being in the forefront of health care as, for example, with the early introduction of CQI. Sr. Mary Jean Ryan, FSM, president/CEO, was presented with the 1997 Governor’s Quality Leadership Award from the Governor of Missouri. To help other systems just beginning their CQI journey, Sr. Mary Jean and Bill Thompson, senior vice president-strategic development, wrote a book, *CQI and the Renovation of an American Health Care System: A Culture Under Construction*, published by ASQ Quality Press in July 1997.

Key Methods	Frequency	Audience
Site Visits by President/CEO & Regional Presidents	Annual	Entity administrative councils, Employees & Physicians
SSM Link (electronic)	Weekly/ PRN	Executive & Physician Leaders & Directors/Managers
SSM Network (print & electronic) & entity newsletters	Bimonthly	Internal & External Stakeholders
President/CEO’s Column published in entity employee newsletters	6X a year/ PRN	Employees, Physicians, Volunteers
Exec Presentations at Orientations, Educ Forums, Functional Area Meetings	Annual or PRN	Employees & Physicians
Mission Awareness Teams	Monthly	Employees & Physicians
Leadership Conferences (System & Network)	Annual (S) & Quarterly (N)	Employees, Physicians, Suppliers
Ethics Committees	Monthly or PRN	Employees, Physicians, Patients & Families
Environmental Committees	Continuous	Employees, Physicians
Meeting in a Box	As needed	Employees, Physicians, Volunteers
Employee Councils	Monthly or PRN	Employees & Physicians
Town Hall Meetings	Quarterly	Employees & Physicians
Medical Staff Meetings	Semiannual	Physicians
Department Meetings	Monthly	Employees & Physicians
Showcase for Sharing/Sharing Conf.	Annual	Employees & Physicians
Nursing Summit & Clinical Summit	Annual	Nurses
Clinical Collaborative Learning Sessions	Every 6 months	Employees & Physicians

Figure 1.1-1 Communication and Knowledge/Skill Sharing Methods S=system, N=network, E=entity

System Management sponsors two well-attended annual systemwide events designed to share best practices internally. About 40+ best practices are highlighted in breakout sessions for 200+ SSMHC employees and physicians at an annual Sharing Conference held for the past six years and an annual Showcase for Sharing exhibit at the annual Leadership Conference. Clinicians benchmark and share their best clinical practices through the system's ongoing Clinical Collaborative learning sessions and annual Clinical Summit Conferences. Eighteen SSMHC hospital teams have also participated in six clinical benchmark studies as part of the National Institute for Healthcare Improvement (IHI) Breakthrough Series.

The Opportunities for Improvement (OFI) complaint management software is an example of a Sharing Conference best practice that is being replicated at all SSMHC hospitals (Item 3.2a(3)). The OFI process and software were developed by Bone & Joint Hospital in Oklahoma City.

1.1b(1) SSMHC executive leaders use a systemwide **Performance Management Process** to review and assess organizational performance as it relates to achieving the SFPP short- and long-term goals; and in meeting changing health care service needs. The process facilitates identification of the root causes of performance variations and establishes clear accountabilities for implementing corrective action. This Performance Management Process was developed during 2000 by the systemwide Accountability Team. The process improves accountability and monitoring of performance at all levels of the organization. Figure 1.1-2 depicts the leadership review forums, frequency, and reports/indicators reviewed. The reports are also used to monitor competitive performance and to ensure regulatory compliance. The first refinement made to the Performance Management Process involved development of common definitions to ensure consistent and accurate measurement of performance across the system in 2001. SSMHC is striving to increase balance in this process by adding more clinical indicators and competitive benchmarks at the system level.

The Performance Management Process defines the roles and responsibilities of leadership groups in managing the performance of SSMHC and its entities; defines a consistent set of performance reporting tools used throughout SSMHC; and establishes standardized definitions and indicators to ensure consistency in the measurement and evaluation of performance. The operational process covers three general areas of reporting: financial, customer satisfaction, and clinical quality performance.

System Management assesses the overall health of SSMHC monthly by examining the Combined Financial Statements and 16 **System Level Indicators** on a consolidated basis for the services of hospital operations, home health, long-term (nursing home) care, and physician practices. The Operations Council analyzes the operational performance of SSMHC monthly using the **SSMHC Operations Performance Indicator Report (IPR)**, also known as the Stoplight Report, which contains the same 16 indicators reviewed by System Management (Figure 1.1-3), plus other key measures. This report covers performance by network and freestanding campuses. If an unfavorable variance occurs for one of these system level indicators, the Operations Council looks at the **Hospital Operations Performance Report** to determine causal factors.

The Innsbrook Group and related administrative councils review progress related to SFPP goals twice a year using the **Combined Financial Statements** for SSMHC, a synopsis of the system performance prepared by Corporate Finance, a report of their consolidated results for their entity or network, and a report on the operating income (loss) and variance for all SSMHC entities. Individual entity and network leaders use **Operations Performance Indicator Reports**, which contain an expanded set of indicators (49) as the primary tool for evaluating the performance of an individual entity or network. Selected entity and network leaders are currently piloting a **Daily or Weekly Operations Report** that monitors productivity, staffing and patient volume. This mechanism for the review of inprocess indicators is being evaluated for replication systemwide.

System, network, and entity leadership groups and the regional boards assess quality improvement and patient safety at SSMHC hospitals through the **Quality Report**, which will be integrated into the PIR by the end of this year. This quarterly electronic report contains 14 indicators in four categories: customer satisfaction, employee safety, clinical quality, and patient safety. It also contains information related to risk management, infection control and environment of care issues. Corrective action plans are required to remedy unfavorable variances.

1.1b(2) If an unfavorable variance occurs beyond an established performance threshold in any of the 16 System Level Indicators, a network or freestanding (non-network) entity is required to develop and implement a corrective action plan using a standardized format. Corrective action plans include a root cause analysis, detailed implementation plans, description of the support needed, timelines, and responsibilities. These plans are reviewed by the SSMHC's executive vice president and the Operations Council. The network/entity has implementation responsibility with oversight provided by

Forum	Frequency	Reports Monitored	Purpose
SSMHC Board of Directors	Quarterly Annually Annually	<ul style="list-style-type: none"> Financial Condition of the System Healthy Communities Report CRP & HIPAA Reports 	<ul style="list-style-type: none"> 2 2, 3, 4, 5 5
Regional Boards	Quarterly	<ul style="list-style-type: none"> Quality Report Competency Report CRP & HIPAA Reports 	<ul style="list-style-type: none"> 3, 4, 5 3, 4, 5 5
System Management	Monthly Quarterly	<ul style="list-style-type: none"> SSMHC Combined Financial Stmtts SSMHC PIR (16 indicators)/Qlty Rpt Quarterly Ranking Rpt (Pat. Loyalty) 	<ul style="list-style-type: none"> 2 1, 2, 3, 4 2, 4
Operations Council	Monthly	<ul style="list-style-type: none"> SSMHC PIR (16 indicators) Network/Entity Comb Financial Stmtts Entity Variance Report Hospital PIR (49 indicators) Corrective Action Plans: PIR/Qlty Rpt 	<ul style="list-style-type: none"> 1, 2, 3, 4 2 2 1, 2, 3, 4 2, 5
Innsbrook Group	Twice a year	<ul style="list-style-type: none"> Combined Financial Statements 	<ul style="list-style-type: none"> 1, 2, 3, 4
Network Leadership/Entity AC	Monthly Quarterly	<ul style="list-style-type: none"> Network/Entity Comb Financial Stmtts Hospital PIR (49 indicators) Entity Quality Report Corrective Action Plans: PIR/Qlty Rpt Complaint Reports 	<ul style="list-style-type: none"> 2 1, 2, 3, 4 3, 4, 5 2, 5 3, 4

Figure 1.1-2 Leadership Review Forums 1=competitive performance; 2=performance plan review; 3=changing needs evaluation; 4=organizational success; 5=regulatory compliance

the executive vice president/COO and Operations Council. The network leadership/entity administrative council also monitors progress on corrective actions. The Ministry Effectiveness Analysis (MEA), also known as Portfolio Analysis, is a tool used by SSMHC's entities and networks when corrective action plans do not result in the desired performance improvement. Correlation analyses are used to prioritize opportunities for improvement or innovation at all levels of the organization.

SSMHC's senior leaders deploy the organization's performance results to employees at the appropriate system, network and entity levels. They communicate system performance review findings, priorities for improvement, and opportunities for innovation in their areas at System Management, Operations Council and Innsbrook Group meetings. The network/entity presidents communicate findings, priorities and opportunities for their network/entity at administrative council and entity department meetings. Network/entity presidents appoint teams or other accountable groups to deploy the corrective action plans. Entity presidents and other leaders deploy performance results to physicians at medical executive committee meetings (monthly), medical staff meetings (at least annually), and employed physician board meetings (monthly). A medical staff survey provides a steady stream of feedback that allows real time corrections. Hospital-based physicians join with other staff in teams to develop corrective action plans. Physicians in private practice participate on teams within their medical

groups to improve results. The corporate vice president-support services shares findings with suppliers, as appropriate, during regularly scheduled meetings to leverage their capabilities to reduce supply costs.

1.1b(3) SSMHC uses its Performance Management Process in combination with the systemwide Leadership Development Process to improve the effectiveness of executive leaders, including senior leaders, and the leadership system as a whole. Executive leaders at all levels monitor the PIRs to evaluate their own leadership effectiveness as well as organizational effectiveness. Entity leaders also monitor results from the **patient satisfaction, HR Solutions employee, and medical staff surveys** on questions related to the entity's administrative performance in order to assess their own performance in meeting patient, physician and employee satisfaction requirements.

SSMHC defines the line accountability (Figure 4.1-1) of its leadership groups at all levels of the organization in the Performance Management Process policy. As part of the systemwide Leadership Development Process, executive leaders, including senior leaders, are evaluated on their ability to achieve superior results in clinical, operational and financial performance as well as their ability to ensure satisfaction of employees, physicians and patients.

The **Leadership Development Process**, drawing input from a 360-degree evaluation, is based on established

System Level Indicators	March 2002 Results/Plan
Inpatient Loyalty Index	49%/54.5%
Operating Margin % (Consolidated)	1.3%/2.3%
31-Day Unplanned Readmission Rate	4.8%/4.4%
Acute Admissions	37,864/ 37,614
Employee Satisfaction	Not available yet
Physician Satisfaction	Not available yet
Prevalence of Daily Physical Restraints	2%avg/8%nat'l
Home Care Patient Loyalty Index	56%/64%
Unrestricted Days Cash on Hand	214/220
Patient Revenue Per APD	\$1,345/ \$1,331
Operating Expense Per APD	\$1,343/ \$1,315
Operating Margin % (Hospitals)	3.6%/4.5%
Operating Margin % (Skilled Nursing)	4%/<3%
Operating Margin % (Home Health)	12%/9.6%
Net Revenue Per Physician	\$33,783/ \$31,407
Practice Direct Operating Cost %	70%/70.9%

Figure 1.1-3 16 System Level Indicators with March 2002 Monthly Results vs Plan

performance expectations that provide a standard for accountability and form the basis for learning. Desired behaviors are based on the system's organizational values as well as the following seven management practices:

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

Annually, executives participate in a 360-degree evaluation process, receiving input regarding their behavior and management skills on a 1 to 3 scale. The results drive the executive's annual personal development plan. Opportunities for development include participation in professional and community organizations, development seminars, mentoring, SSMHC's Leadership Conference and other educational sessions. Each executive customizes the survey with one or more questions

designed to measure her/his particular area of development.

The annual Baldrige feedback provides a comprehensive evaluation of the effectiveness of the entire leadership system and prompts action plans for improvements. This process is described in the Organizational Profile. In addition, the senior vice president-human resources monitors trends in the 360-degree evaluation results from all system executive leaders to identify systemwide leadership education/development needs.

1.2 Public Responsibility and Citizenship

1.2a(1) SSMHC implemented a systemwide organizational ethics effort called the **Corporate Responsibility Process (CRP)** in 1998. Designed by a CQI team, CRP includes a process and mechanism to address societal requirements associated with regulatory, legal, and ethical compliance in providing health care services. The CRP aligns with the elements of the national Office of Inspector General's (OIG) model compliance plan. But it goes beyond compliance with the OIG's model plan to ensure that SSMHC values are reflected in all work processes. Employees, physicians, volunteers, and key vendors are empowered through training and a confidential Helpline to raise questions about any part of their job. All reported issues are investigated and appropriate action taken in a timely manner. KPMG has identified SSMHC's CRP as a best practice nationwide.

The Corporate Office identifies new or modified regulations related to OSHA, CMS, EEOC, EPA, CDC, and HIPAA through literature research, networking, and participation in the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) assessment. The CRP Team reviews the changes, obtains legal input, and recommends policy or procedural changes to System Management. This information is shared electronically with the entity CRP coordinators, who share and deploy required changes at the entity/network level. Twice a year, the Catholic Healthcare Audit Network (CHAN) performs focused audits to assess compliance in priority areas identified by the CRP team.

Corporate Risk Services (CRS), a Corporate Office department, works with the Quality Resource Center (QRC) to ensure a safe environment for patients, employees, and visitors. Risk managers for patient and employee safety serve as a resource to the entities. As part of a three-year action plan, CRS is developing an improved Risk Management Program Assessment tool. See Figure 1.2-1 for Key Processes, Measures and Goals for Public Responsibility and Citizenship.

1.2a(2) System Management established the **SSM Policy Institute** in 1998 to keep abreast of changing trends and proactively anticipate and address public

Requirements	Key Processes	Measures	Goals
Regulatory/Legal	<ul style="list-style-type: none"> • CRP • Contract Review • Licensure 	<ul style="list-style-type: none"> • # Govt Investigations • Turnaround Time • Licensure 	<ul style="list-style-type: none"> • 0 • 24-48 hours • Licensure
Accreditation	<ul style="list-style-type: none"> • JCAHO Survey 	<ul style="list-style-type: none"> • Scores (Fig. 7.4-17) 	<ul style="list-style-type: none"> • 100%
Risk Management	<ul style="list-style-type: none"> • Public Safety 	<ul style="list-style-type: none"> • Infection Rates • Dangerous Abbreviations(Fig. 7.1-4) • Restraints (Fig. 7.1-6) • Patient Falls 	<ul style="list-style-type: none"> • 0 • 0 • 0 • 0
Community Health	<ul style="list-style-type: none"> • Charity Care • Healthy Communities Programs 	<ul style="list-style-type: none"> • Cost of Charity Care (Fig. 7.4-20) • Health Status in Selected Populations for Individual Projects (Fig. 7.4-19) 	<ul style="list-style-type: none"> • 25% prior year's Operating Margin • Project-specific

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

concerns regarding health care issues. The Institute is responsible for researching and analyzing health and social welfare issues, proposals, and project possibilities at the national and state level; advancing SSMHC professionals for appointments to city, state, and federal health and social welfare boards and commissions; and educating employees and physicians on current public policy issues. The Institute's president sends electronic reports on relevant and critical public policy or regulatory changes to members of System Management, entity and network presidents, and other SSMHC advocates. Reports on high level issues, such as major reimbursement or staffing, are discussed at System Management meetings and appropriate action taken. For example, in 2001 SSMHC's nurse executives worked with the Institute's staff to advocate in behalf of the Nurse Reinvestment Act. The Institute's Board is comprised of professionals from around the country who provide review and feedback on key policy directions. The Institute's staff and SSMHC's executives are active at the state and federal levels on major association policy committees and boards. Advocacy was a focus of the 2001 Leadership Conference.

During SSMHC's Strategic, Financial & HR Planning Process (SFPP), each network and entity conducts an annual external environmental and market assessment that includes an analysis of public policy and regulatory issues. This data and the surrounding discussion are used in developing and updating the network and entity's action plans. SSMHC's network and entity planners and marketers use primary and secondary market research to anticipate concerns regarding current and future services and operations within the communities served. The results from focus groups are used to address the concerns of consumers by, for example, providing new services or modifying existing ones. The Quality Resource Center also researches statutes and regulations concerning clinical practice standards to keep SSMHC executives abreast of changes.

SSMHC entities work with local task forces and public agencies on an ongoing basis to coordinate disaster planning. Following the September 11, 2001, terrorist attacks, SSMHC established the **Bioterrorism Task Force**, a systemwide team with broad geographic and professional representation, to coordinate and support the entities in caring for patients who might have been exposed to biological or chemical agents. All entities reviewed and revised their existing disaster plans to cover both biological and chemical exposures working closely with local agencies. The team distributed an "Anthrax Care Package" of articles with updated clinical information to assist physicians and nurses in diagnosing and treating anthrax exposure. A hot link with the Centers for Disease Control and Prevention web site on the SSMHC intranet and Physician Portal (single point of access for patient results, health information and communication tools) provides employees and physicians access to reliable updated medical information. Breaking news is published in *SSM Link*. A bioterrorism contact person was named at each SSMHC entity.

SSMHC's experts also served as resources within their local communities by participating in community meetings, training sessions, media interviews, and national, state and local teleconferences. Three SSMHC hospitals hosted community disaster planning seminars and educational forums on bioterrorism for community leaders, emergency and medical officials, and business managers.

SSMHC entities have a hazardous waste policy that stipulates the proper disposal and/or recycling of hazardous wastes. Entity safety committees monitor hazardous waste activities through a Hazard Report. The policy is reviewed at least annually and updates are provided to a variety of agencies, such as EPA, the Nuclear Regulatory Commission (NRC), JCAHO, and

state agencies. The entity leadership teams proactively analyze risk through completion of a hazard vulnerability form and a disaster preparedness checklist.

In October 2001, SSMHC began to implement a comprehensive systemwide **Patient Safety Program**, developed by a team representing Risk Services and the Quality Resource Center. The program includes: a new Clinical Collaborative called Achieving Exceptional Safety in Health Care (AES); newly established Patient Safety Council; and updated philosophy statement and guidelines for disclosing unanticipated adverse medical outcomes to patients and their families.

All of SSMHC's entities are participating in the new AES collaborative and have identified six entity-specific goals for improvement for 2002 along with the process changes required to achieve these goals. Sixteen safety practices will be implemented systemwide by 2004. In addition to the entity-specific goals, all of SSMHC entities are working to eliminate dangerous abbreviations; establish an entity safety center; and provide a quarterly safety report to the entity administrative council, employee and medical staff, and regional/local boards.

1.2a(3) SSMHC's religious heritage creates a culture of high ethical standards for the organization. SSMHC's **contract review process** ensures ethical, legal, and regulatory practices are adhered to in stakeholder transactions and interactions. The process defines which types of contracts require contract review. The remainder, those dealing with managed care, human resources, or certain low-risk areas are reviewed by staff specializing in those areas. Contracts considered high risk are reviewed by SSMHC's law firms. Specialty Counsel Coordination Protocols assist the system and its legal counsel to manage legal and regulatory compliance.

Ethical practices are first communicated through an ethics section in the orientation of new employees at the entities. They are reinforced by system policies such as the Standards of Ethical Behavior, Conflict of Interest, Corporate Responsibility, Equal Employment Opportunity/Affirmative Action, Confidentiality of Information, Sexual and Other Harassment, and Staff Rights to Refuse to Participate in Aspects of Patient Care; CRP confidential Helpline; and employee grievance process, which encourages reporting of unethical behaviors by management or others. Ethical practices are further reinforced through education required for all employees. All employees with decision-making capabilities for purchasing are required to review and sign an annual Conflict of Interest Questionnaire. Ethics committees in all the hospitals and nursing homes offer a forum for patients and their families and caregivers to discuss and review clinical/ethical issues, including patient rights.

1.2b Improving the health of the community has been an SSMHC focus since 1872 when the Sisters of St. Mary (now known as Franciscan Sisters of Mary) first walked the streets of St. Louis giving aid to any sick or suffering person they encountered. SSMHC launched a systemwide **Healthy Communities** initiative in 1995 to leverage the system's resources with those of the communities it serves in support of the Vision. The program was designed by a quality improvement team to bring measurable improvements in health and well-being to residents in specific geographic areas. Each SSMHC entity is required to actively engage in one or more community projects within its service area. Projects are chosen based on the identification of a community health indicator that needs to be improved; collaborating agencies or organizations with which to partner; and an indicator to measure the effectiveness of the intervention. The Board of Directors reviews an annual report on Healthy Communities projects and progress updates.

In keeping with SSMHC's mission and values, anyone who comes to its hospitals receives care regardless of the person's ability to pay. A system policy requires that a goal of at least 25 percent of the prior year's operating margin be designated for charity care at each entity.

SSMHC understands that an unhealthy environment negatively affects the health of the people in the communities we serve. Therefore, we engage in a variety of activities focused on environmental protectionism, which are consistent with our unwavering commitment to nonviolence. Each SSMHC entity has established a committee, typically called **Preservation of the Earth (POE)**, to foster environmental awareness and promote a healthy environment. Other methods of building community health include:

- * Serving on community and industry boards
- * Actively participating in civic organizations
- * Supporting state and national quality award programs
- * Advocating through the SSM Policy Institute
- * Operating the Regional Poison Center in St. Louis
- * Providing community health programs, screenings, health and wellness education programs, and support groups for persons with a variety of diseases.

A systemwide Community Benefit Team was formed in 2001 to review SSMHC's charity care policy and develop a community benefits policy. The team has also selected software to be used to measure and track charity care and community benefits across the system. The results will be presented in an annual report to System Management, government leaders, policymakers, and the general public. The report will include the amount of charity care SSMHC entities provide to persons who are poor; unpaid costs of programs for the public; and other activities that respond to community need and improve community health.

CATEGORY 2 - STRATEGIC PLANNING

2.1 Strategy Development

2.1a(1-2) SSMHC's **Strategic, Financial & HR Planning**

Process (SFPP) combines direction setting, strategy development, human resources, and financial planning. (See foldout, Figure 2.1-1.) The SFPP involves all of the organization's networks, entities and departments in a three-year (long-term) planning horizon, with annual updates (short-term). The SFPP integrates Quality Principles and methods and stresses planning as a way of learning more about patients and responding to their needs and expectations as well as market opportunities. The SFPP ensures that the networks and entities set strategic goals clearly oriented toward performance improvement.

(1S) The SFPP begins in December when the Vision Statement, set by SSMHC's Board of Directors, is reviewed. The Vision and Mission statements serve as the foundation for the planning process. (2S) Each January, corporate planning, in conjunction with corporate finance and HR, evaluates the SFPP by surveying the previous year's key participants.

Experience has taught SSMHC that three years provide optimal time to implement, fully deploy, and realize the results of its initiatives across the vast organization. Because of the rapidly changing health care industry, each year the SFPP participants study and validate the system's focus on patients, other stakeholders and markets (3.0), information and analysis (4.0), staff focus (5.0), and process management (6.0). Figure 2.1-1 depicts the steps in the process at the system, network, entity and departmental levels. At times during the planning cycle, these steps occur concurrently.

(3S) In February, the Innsbrook Group assesses key challenges, reviews comparative data, and sets the systemwide goals for the next three years, using the Vision and Mission Statements as a framework.

(4N&E) In March, a Governance Retreat is held for the parent, regional and local board members to provide an opportunity for input into the three-year plan. At the system level, during April and May, the Corporate Office departments, such as finance and human resources, and divisions, such as the SSM Information Center (IC) and Materials Management, which provide centralized services for the entities and networks, establish their plans with budgets. These department/division plans and budgets are consolidated in the Corporate Office/Information Center Plan (5S) and determine the annual corporate fees to be paid by the entities.

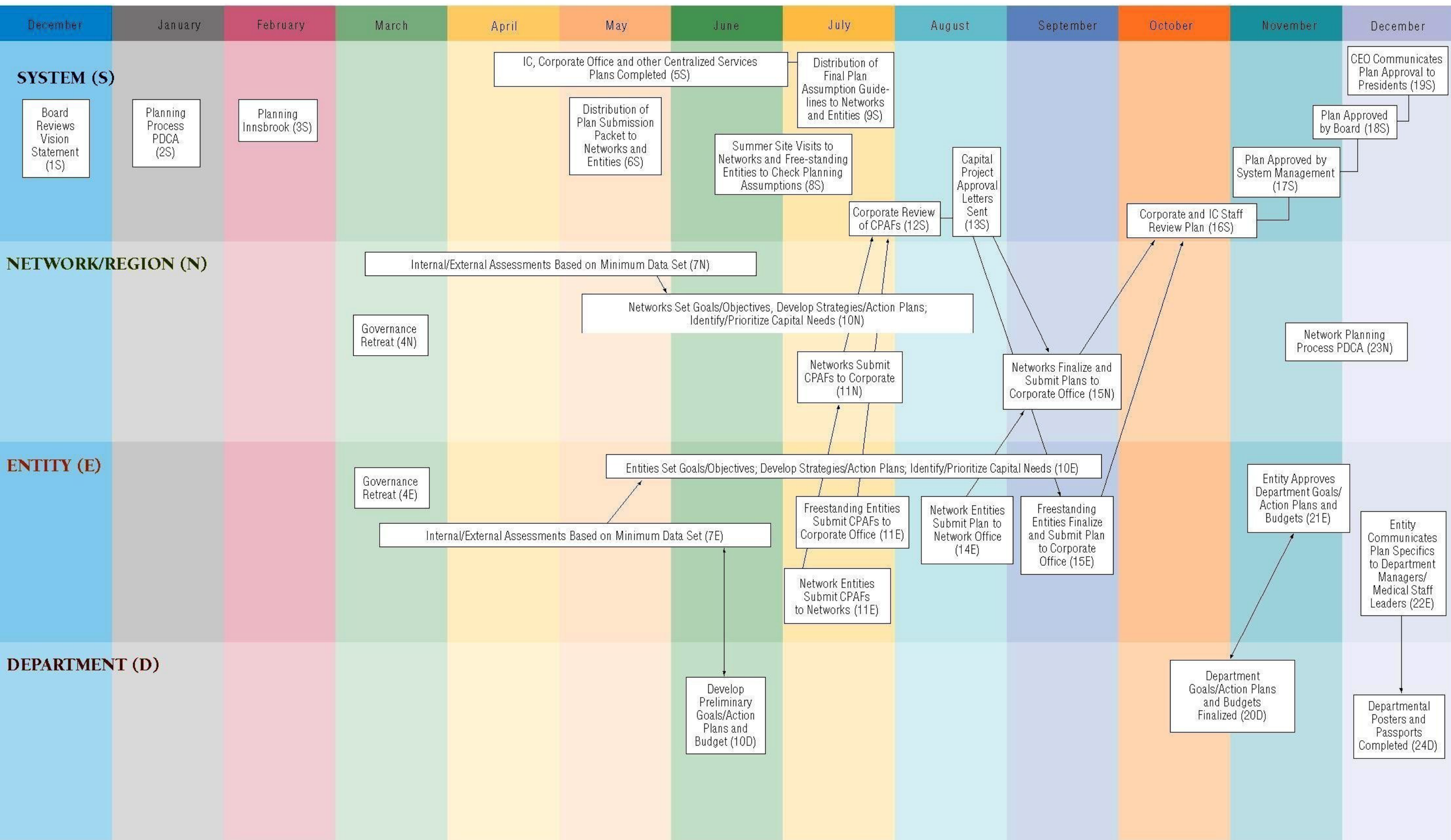
(6S) In late May, the networks and entities receive a submission packet with standardized forms and definitions to ensure a consistent format and alignment of network and entity plans with SSMHC's goals.

Beginning in March and continuing through June, the networks and entities are conducting (7N&E) **Internal and External Assessments** based on minimum data set requirements. This assessment is done every three years to develop the Strategic, Financial & HR Plan (SFP) and is validated annually. Data and information from a variety of internal and external sources are integrated to form the **minimum data set** (Figure 2.1-2). The planning staff at each entity and network gathers the information from various sources, such as departmental performance improvement plans, patient, medical staff and employee surveys, market research, and PIRs. This information provides the assurance that a comprehensive analysis has been conducted of those key elements impacting the business. The minimum data set, introduced in 1998, is a robust tool that ensures SSMHC maintains a balance in addressing stakeholder needs in a consistent manner.

During (8S) summer site visits, the networks and entities share the assessment findings and preliminary strategies and action plans with corporate planning, finance and human resources staff to ensure alignment. SSMHC Corporate Planning distributes the Final Plan Assumption Guidelines (9S) to the entities and networks in July. These guidelines ensure the consistent use of financial and economic assumptions across the system by network and entity staff preparing their strategic plans. The assumption guidelines contain information that affects the entities such as centralized service fees.

The entity or network leaders analyze the minimum data set findings to determine their organization's strengths, weaknesses, opportunities, and challenges and to identify gaps between current and desired performance levels. (10 N&E) The administrative staff and physician leaders for each entity and network then set measurable, three-year strategic goals to achieve the system goals related to exceptional health care services. Local networks and entities involve key stakeholders, including suppliers and payors in goal-setting when their capabilities impact achievement of the goals.

2.1b (1-2) SSMHC's key strategic objectives, indicators and timetable are presented in Figure 2.1-3. SSMHC has established five characteristics of exceptional care as its strategic objectives. In preparation for the 2001 three-year planning session, the Innsbrook Group completed a survey on what defines exceptional health care. The findings facilitated discussion that identified SSMHC's characteristics of exceptional health care services in light of current challenges and stakeholders



External Data	Internal Data
Consumer Information Analysis Patient satisfaction survey results, Market research, market share by product line	Medical Staff Analysis Medical staff survey results, supply by specialty compared to market needs, geographic distribution
Demographic/Socioeconomic Analysis Population trends by age, ethnic origin; Population-based use rates, Discharges by zip code	Product Line Analysis Profitability, volume and consumer perception of key product lines
Competitor Analysis Inventory of competitors, market share trends, marketing/advertising/competitive position	Physical Plant/Technology Analysis Major plant infrastructure and equipment assessment, IC plan, regulatory requirements
Emerging Technologies/Trends/Growth Opportunities Analysis Literature review, IC plan, Networking with colleagues in SSMHC's and other markets	Human Resource Analysis Employee satisfaction survey results, Market analysis of compensation and benefits, turnover and diversity rates, training needs
Payor Analysis Inventory of payors, payment rates, payor satisfaction/issues	Financial Analysis Net revenue, expense & operating margin, use of agency staff, payor mix trends; contract profitability
Public Policy/Legislative/Accred. Analysis Federal and state legislative and reimbursement trends, JCAHO and other regulatory standards	Clinical Quality Analysis Quality Report, Clinical Collaborative results, Departmental performance improvement plans, Regulatory survey feedback

Figure 2.1-2: Minimum Data Set: Examples of External & Internal Data Collected & Analyzed to Develop the SFPP (Examples are provided because of space limitations.)

needs. The group then identified system level goals needed to achieve these strategic objectives. This represented a significant breakthrough in SSMHC's approach to planning and goal setting. By first defining exceptional health care services, SSMHC was able to tie planning more closely to the Mission Statement, which resulted in more balanced goals. Clinical outcomes and patient, employee and physician satisfaction were placed on equal footing with financial results.

2.2 Strategic Deployment

2.2a(1) Following the setting of goals and objectives, each entity or network team (10E&N) defines strategies and action plans, with key measures, to support its three-year goals. They finalize their plans by allocating resources to support achievement of their goals and objectives. The **Capital Allocation Process** represents a system level approach to capital allocation. This process ensures the deployment of resources to projects that support achievement of SSMHC's strategic objectives. Figure 2.2.1 presents actions plans that are consistent among the system's networks and entities.

The Operations Council determines the maximum amount of available resources that may be spent on capital

expenditures below \$500K. Networks and freestanding entities allocate their under \$500K to their entities at their discretion. The entities allocate their own resources internally through a top down and bottom up approach. Each department is required to develop preliminary goals and action plans, including budgets, to support the entity's overall goals and objectives. These budgets are aggregated and evaluated relative to the entity's total available resources. With this information, entity leaders develop action plans with input from appropriate department staff, including physicians. The action plans incorporate identified champions, completion dates, expected results, and, if appropriate, volume projections, human resource needs, and capital requirements. They are approved by the entity leadership group and tracked by an administrative champion. The departments monitor their action plans using inprocess measures, enabling early identification of performance gaps. Root cause analyses and improvement plans are used to close gaps.

As a result of this process, each entity has a defined set of goals, objectives, strategies and action plans that are aligned with the system's goals, objectives, strategies and action plans while tailored for the individual market the entity serves. If the entity is a member of a network,

Strategic Objectives	Indicators	2002 Goals	2003 Goals	2004 Goals
Exceptional Patient Satisfaction	Inpatient Loyalty	53.1%	56.1%	60.1%
Exceptional Physician Satisfaction	Physician Satisfaction	79.9%	80.9%	81.9%
Exceptional Clinical Outcomes	Unplanned Readmission rate	3.49%	3.06%	2.63%
Exceptional Financial Performance	Operating Margin	2.5%	3.0%	3.3%

Figure 2.1-3 Strategic Objectives, Indicators, Timeline & Goals

Strategic Objectives	System Action Plans 2002	Key Indicators
Exceptional clinical outcomes	<ul style="list-style-type: none"> • Use Clinical Collaboratives to improve health care outcomes • Ensure patient safety 	<ul style="list-style-type: none"> • Unplanned readmission rate (Fig. 7.1-1) • Medication event rate • Dangerous Abbreviations (Fig. 7.1-4)
Exceptional patient, employee and physician satisfaction	<ul style="list-style-type: none"> • Improve patient satisfaction with pain management • Implement Nursing Shared Accountability Model • Increase diversity representation within leadership 	<ul style="list-style-type: none"> • Inpatient loyalty (Fig. 7.1-7) • Nurse turnover rate (Fig. 7.3-3) • Physician satisfaction (Fig. 7.3-8) • Employee satisfaction (Fig.7.3-1) • # Minorities in managerial professional ranks (Fig. 7.3-12)
Exceptional financial performance	<ul style="list-style-type: none"> • Increase revenue and reduce expenses • Achieve growth • Reduce financial support to employed physicians • Improve staff productivity amid labor pressures • Improve medical management 	<ul style="list-style-type: none"> • Operating margin % (Fig. 7.2-3) • Operating Revenue & Expense per APD (Fig. 7.2-4) • Admissions (Fig. 7.4-1) • Net revenue per physician (Fig. 7.2-6) • Paid Hours/Adjusted patient day (Fig. 7.4-3) • Average Length of Stay (Fig. 7.4-2)

2.2-1 Strategic Objectives, System Action Plans and Key Indicators

the network leadership ensures the action plans also align with the network.

(11N&E & freestanding hospitals) SSMHC implemented a systemwide Capital Allocation Process in 1998 to balance the operating needs and goals of the system, networks and entities. If the capital cost of a project exceeds \$500K, the network or freestanding entity (entity not affiliated with a network) develops a strategic and financial analysis and completes a standardized Capital Project Application Form (CPAF) and submits it to the Corporate Office. Entities affiliated with networks submit their CPAFs to the network leadership group. (12S) Corporate finance and planning staff analyze the CPAFs to ensure that a project is strategically and financially sound. This analysis is submitted to the systemwide Capital Allocation Council for consideration. The Council prioritizes projects based on the strategic and financial benefit to the system as a whole. (13S) Approved projects are communicated by approval letter to the networks and freestanding entities, who adjust their baseline projections.

(14E) Entities within networks finalize and submit their strategic and financial plans to the network planning, finance and HR staff for review. (15N&freestanding entities) The networks and freestanding entities then finalize and submit their plans to the Corporate Office and SSM Information Center staff for review (16S) and System Management's final approval (17S). The plans are consolidated into a single financial plan for the entire system by Corporate Office staff. The SSMHC Board of Directors (18S) reviews the system's overall financial plan and key network and entity strategies for approval. The SFP is reviewed by the Board of Directors each

December, and SSMHC's president/CEO communicates (19S) the Board's approval to entity and network presidents via letter. During this time, entity and network departments and service-line levels (20D) finalize their goals, operating plans and budgets with physicians, department managers, and staff. (21E) The entity leaders review and approve department plans.

Each entity president (22E) initiates ongoing communication about his or her entity's specific strategic and financial plan to department managers and Medical Staff leaders. To reach all levels of the organization, a variety of communication vehicles are used, including memos, newsletters, department meeting agenda items, and presentations. The strategic plan is also shared with regional boards. (23N) Networks do their PDCA evaluation of their SFPP at the end of the year.

(24D) Throughout SSMHC, specific goals and objectives from the department planning process are posted in the department on a poster. Posters provide a visual line of sight connection from SSMHC's Mission to the department goals. The departmental goals tie directly to the key department inprocess and outcome indicators. SSMHC uses its Passport Program to deploy strategic goals and action plan goals to all employees and to align network, entity, department and individual plans with overall organizational strategy. The Passport links the employee's work to the goals of the entity, network, and system. "Passport to Exceptional Health Care Services," a "Meeting in a Box," was presented in fall 2001 to entity administrative councils, vice presidents, and department supervisors and managers. This box contained a video by Sr. Mary Jean; overheads and speaker notes; and

	Short Term Goals 2002	Long Term Goals 2004	Benchmark
Consolidated Operating Margin (Hospitals Included)	2.5%	3.3%	3.0-4.0%
Unrestricted Days Cash	220 days	235 days	190-220 days
Acute Admissions	145,200	155,800	N/A
Patient Revenue/APD	\$1,399	\$1,486	\$1,805
Operating Expense/APD	\$1,434	\$1,506	\$1,508
31- Day Unplanned Readmission Rate	3.49%	2.63%	2.42%
Inpatient Loyalty Index	53.1%	60.1%	52.3%
Employee Satisfaction Indicator	73.0%	75.0%	74%
Physician Satisfaction Indicator	79.9%	81.9%	93.0%
Nursing Home Operating Margin	-2.29%	4.29%	<3.0%
Nursing Home Prevalence of Daily Physical Restraints	0	0	5%
Home Care Operating Margin	7.1%	8.4%	15.0%
Home Care Patient Loyalty Index	64.0%	71.0%	52.7%
Net Revenue per physician	\$32,971	\$36,593	\$32,971
Physician Direct Operating Expense	67.30%	61.55%	58.64%

Figure 2.2-2 Key Performance Indicators, Short/Long Term Goals and Benchmarks

posters showing the linkage between department and entity goals. The presentation helped managers identify department goals to support entity goals and to assist employees in developing individual goals to support department goals on their Passports.

2.2.a (2) Figure 2.2-1 shows systemwide action plans to support the strategic objectives. These plans typically have short- and long-term goals associated with them, as appropriate. Progress on these plans is monitored through key indicators on the PIR and Quality Report. SSMHC is focused on providing exceptional health care services. Unplanned readmission rate has been identified as a key indicator of exceptional clinical outcomes. As part of the strategy to decrease unplanned readmissions, the organization is engaged in identifying the primary drivers of the unplanned readmission rate and will use this information to expand and enhance the number of clinical measures in the Performance Management Process.

2.2.a (3) Human resource planning is integrated into the system's SFPP as a result of process improvements in 2000. Entity and network human resource and nurse executives provide data for the planning process as part of the Minimum Data Set and actively participate in strategic planning sessions. At the entity and network levels, HR needs and financial impact are tied to each action plan

during the SFPP to ensure adequate resources are allocated to support strategies.

The key systemwide HR action plans for 2002 focus on implementing Shared Accountability and ensuring a diverse staff. Every SSMHC entity is beginning the implementation of a shared accountability model for nurses and plans to increase the number of minorities in professional and managerial positions.

2.2a(4) See Figure 2.2-2 for indicators that track progress in achieving system action plans. Annual evaluation of the Performance Management Process (PIR) to monitor the goals and action plans set through the SFPP ensures alignment. The entire Performance Management Process is evaluated annually using Baldrige feedback.

2.2.b Figure 2.2-2 reflects performance projections of SSMHC's key system level indicators and comparisons with other organizations. Benchmark sources are given in Category 7.

CATEGORY 3 - FOCUS ON PATIENTS, OTHER CUSTOMERS, AND MARKETS

3.1 Patient/Customer and Health Care Market Knowledge

3.1a(1) During the **Strategic, Financial & HR Planning Process (SFPP)**, which is applied at system, network and entity levels, environmental scanning is used to identify potential customers, customers of competitors and future markets every three years with annual update assessments for validation. The minimum data set for this scan includes market research; market share by product line; population trends by age and ethnic origin; population-based use rates; discharges by zip code; an inventory of competitors; market share trends; and marketing/advertising/competitive positions.

To learn specifically about customers of competitors, network and entity planners and marketers monitor data from the annual medical staff surveys and physician contacts and conduct literature searches, telephone surveys, and focus groups of competitors' customers. Collaborations with area nursing homes and call lines for families and visitors provide additional opportunities to learn of potential customers. The data are fed into the planning process at the appropriate organizational level.

For example, through environmental scanning, planners at St. Anthony Hospital learned that in their market demand for cardiology procedures had increased dramatically; a cardiology physician group was breaking up; and a competitor was considering opening a heart hospital. With

this knowledge, St. Anthony recruited a staff of cardiologists and enhanced its cardiac services by developing a heart hospital within the existing facility. St. Anthony opened Oklahoma City's first heart hospital in February 2002. The local business newspaper awarded St. Anthony its Innovator of the Year award for utilizing existing resources by creating a hospital within the main hospital.

SSMHC has defined patients and their families as its key customer group. SSMHC further delineates this customer group into five categories based on site of care: inpatient, outpatient, emergency department, home care, and long term care patients. Entities further segment each of these customer groups based on community needs as well as internal and competitor assessments. The inpatient care setting represents 90 percent of SSMHC's revenue. Accordingly, primary emphasis is given to this care setting with respect to key requirements, processes, and measures. Physicians are SSMHC's key partner group, but are recognized to have many of the characteristics of customers. In fact, it is common for employees to treat physicians as customers in their daily work relationships.

3.1a(2) A robust set of listening and learning tools are used to determine as well as define and differentiate the requirements, expectations, and preferences of former, current and potential customers. The data collected from these listening and learning methods (Figure 3.1-1) are aggregated, analyzed, and used in the SFPP each year to update strategies and action plans and by quality improvement teams on an ongoing basis to improve the organization's services to customers. SSMHC's corporate planning

Customer & Use	Listening & Learning Tools & Frequency	Primary Owners
Former & Current Patients & Families (1)(3)(4)	<ul style="list-style-type: none"> • Satisfaction Surveys: Inpatients, Outpatients, ED, Rehab, Ambulatory Surgery, Home Care, & Long Term Care (Continuous) • Primary-Secondary Market Research (Annually/PRN) • Comment Cards (Continuous) • Complaint System & Informal Feedback (Continuous) • Selected Patient Followup Calls (Continuous) • Internet-Web Pages Response System (Continuous) 	Corporate Planning Network/Entity <ul style="list-style-type: none"> • Planning/Marketing • Hospitality/Quality • Quality/Risk • Departments • PR/Marketing
Potential Patients & Future Markets (1)(2)(3)(4)	<ul style="list-style-type: none"> • Primary-Secondary Market Research (Annual/PRN) • Survey Research (Annual & PRN) • Published Studies (Annual & PRN) • Community Contact Telephone Lines (PRN) • Internet-Web Pages Response System (Continuous) • Professional Associations, Courses, Journals, and E-mail Newsletter Subscriptions & News Abstract Services (Continuous) 	Network/Entity <ul style="list-style-type: none"> • Planning/Marketing • Planning/Marketing • Planning/Marketing • Planning/Marketing • PR/Marketing • Planning/Marketing

Figure 3.1-1 Tools Used to Determine Customer Needs & Contact Requirements Use of Information: (1) health care service planning (2) marketing (3) making improvements (4) other business development

staff relies on the semiannual regression analysis of patient satisfaction survey data to validate these requirements.

The network and entity leadership groups are the primary focal point for information gathered through the listening and learning methods. The breadth of the methods enable the collection of information reflecting current and former patients/customers views. From this basis, the factors contributing to patient loyalty have been determined and this indicator is monitored as one of 16 system level indicators in the PIR. In addition, the patient satisfaction survey is structured to gather information from each of the patient care settings. This information is segmented and analyzed using the patient satisfaction software.

In 2001 and 2002, the corporate planning staff performed correlation analysis of key system level indicators to further define which key system level indicators strongly correlate, positively or negatively, with inpatient loyalty and satisfaction. The results of the analyses were presented at the Innsbrook Group planning sessions. This type of insight provides further guidance for planning efforts by clarifying the cause and effect relationship between SSMHC system strategies and business performance.

3.1a(3) SSMHC has found most listening and learning tools add the greatest value when used and managed at the local level. Network and entity owners of these tools continuously evaluate them and make improvements at least annually. Evaluation is done primarily through customer surveys and validation of results using alternative tools and literature research. Improvements are made when the results are found to be no longer applicable or not actionable by internal users. As health care services are added or significantly modified, consideration is also given to the best approach to gain feedback from the appropriate stakeholders. This effort may drive the addition or expansion of current approaches to listening and learning.

The corporate planning staff evaluates the systemwide patient satisfaction survey through:

- Review of survey questions for relevancy and validity
- Literature and web-based research
- Monitoring of regulatory guidance
- Baldrige and state quality award feedback
- Input from entity patient satisfaction coordinators and other entity staff with responsibility for functional areas. This is done formally on an annual basis and informally on an ongoing basis.

3.2 Patient/Customer Relationships and Satisfaction

3.2a(1) Physicians have an essential role in meeting the key customer requirements of patients and in improving

Key Access Mechanisms
<p>Obtain Services</p> <ul style="list-style-type: none"> Entity & physician locations or offices Healthy Community projects Clinics & outreach programs
<p>Seek Information</p> <ul style="list-style-type: none"> Direct contact with hospital staff, senior executives & physicians SSMHC caregivers & patients rights brochure Internet sites Ethics committees Educational programs & support groups Speakers bureaus Poison Center Health Information & Referral Line
<p>Make Complaints</p> <ul style="list-style-type: none"> Direct contact with hospital staff, senior executives & physicians Entity complaint processes CRP Helpline Patient satisfaction surveys

Figure 3.2-1 Key Access Mechanisms

clinical outcomes. The physician relationship with SSMHC and with the patient, therefore, is considered critical to the organization's success. SSMHC develops partnership and loyalty with physicians through the physician partnering process and by meeting their key requirements. (See Item 6.2 for more detail on the physician partnering process, which includes relationship building strategies.) SSMHC's networks and entities have physician liaisons and other staff members who focus on physician relations, recruitment and retention.

SSMHC's Healthy Communities projects facilitate relationship building with local communities, businesses and civic leaders. SSMHC also builds relationships with freestanding hospitals and nursing homes within its communities as a key way of acquiring new patients. These relationships are often formalized through affiliation or management agreements. (See P.2a(1))

SSMHC's key customer requirements are those factors determined by correlation analysis of patient satisfaction data to most strongly correlate with patient loyalty. The corporate planning staff provides monthly reports to the entity and network patient satisfaction coordinators and a Quarterly Ranking Report for System Management that depicts trends and gaps between current performance and goals in measures of patient loyalty for each entity. To develop loyal patient relationships, the networks, entities and system monitor customer requirements and take action to improve areas of dissatisfaction identified through the surveys, and patient/physician complaints. Entity departments or customer satisfaction/patient satisfaction

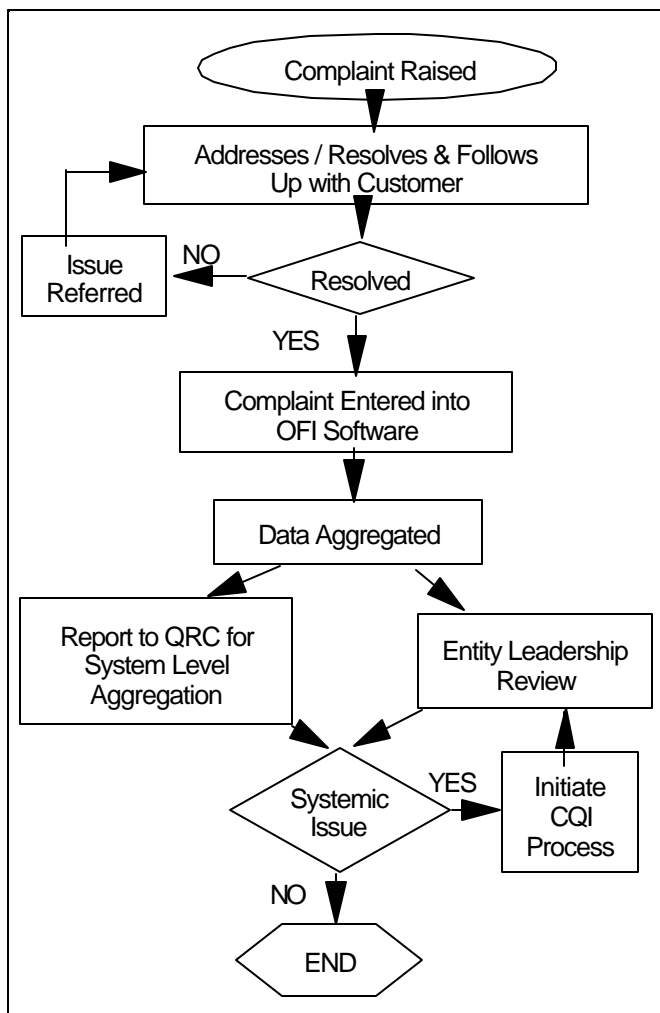


Figure 3.2-2 Complaint Management Process

teams have responsibility for addressing issues identified through the patient satisfaction surveys, SFPP, or focus groups.

To build loyal patient relationships, Clinical Collaboratives and other improvement projects are structured in response to key drivers of patient loyalty. Fourteen entity process improvement teams, for example, are participating in the systemwide Clinical Collaborative Using Patient Information to Improve Care and Achieve Success (UPI). The teams used patient satisfaction survey data to identify specific areas of improvement in patient/caregiver communications and to measure progress. In addition, entity classes, support groups, and e-health information empower patients to proactively manage their disease/condition and, in the process, builds loyalty. As another means to enhance patient loyalty, SSMHC's ambulatory surgery departments make follow-up phone calls to patients who have gone home.

3.2a(2) SSMHC uses the results of customer satisfaction surveys and other listening and learning tools (Figure

3.1-1) to identify customer contact requirements. The corporate planning staff conducts impact analyses on the results of the patient satisfaction survey to determine and prioritize the contact requirements of each of SSMHC's five key patient groups, which receive customized survey questions. In addition, at the local level, the network and entity owners of other listening and learning tools analyze data gathered through these tools to validate customer contact requirements. Even though SSMHC's patient care settings are different, the contact requirements for all patient care groups have been found to be basically the same: responsiveness, accuracy, good communication, and good health care outcomes.

Deployment is reinforced through job descriptions and the Passport. Job descriptions at SSMHC entities include service standard competencies. Most entities also include their service standards on individual employee Passports, which contain the SSMHC core values. The Passport tool is introduced during employee orientations and tied to employee performance evaluations. At the system level, customer satisfaction with service contact is tracked through related questions on the patient satisfaction surveys. See Figure 3.2-1 for key access mechanisms.

3.2a(3) Each SSMHC entity has implemented a **Complaint Management Process** (Figure 3.2-2) that provides timely resolution, follow-up with patients/families, and complaint tracking. Patients/families are given information about how to make complaints upon arrival at the entity. SSMHC employees are empowered and trained to evaluate a breakdown in service and when possible to "fix it now" or refer the patient to someone who can.

SSMHC has learned from experience that a complaint management process is most effective at the entity level. To ensure consistent handling, resolution, and tracking of complaints throughout the organization, SSMHC's Quality Resource Center is implementing standard definitions and common software for tracking complaints at the entity level. The process and software, called Opportunities for Improvement (OFI), were developed by a process design team at Bone & Joint Hospital in Oklahoma City in 1994 and underwent several cycles of improvement. OFI, which was shared, recognized as a best practice, and piloted at several entities, is now being implemented systemwide. The entity staff follow up with patients within established time frames to make sure complaints have been resolved to the patients' satisfaction. Entity quality staff aggregate complaint data and send it to the QRC for system-level aggregation. Entity leaders monitor the aggregated complaint reports at least quarterly to identify systemic complaint issues and appoint teams to improve the related processes. The entity presidents feed complaint issues that may be systemic to the network leadership group. The network presidents in turn bring any potential

systemwide issues for discussion at the monthly meetings of System Management, of which they are members. The System Management team determines whether complaint issues brought forward will be addressed systemwide or within a network/region.

3.2a(4) During the Internal and External Assessment step in the SFPP (Item 2.1), SSMHC evaluates its approaches to building relationships and to providing patient/customer access. Network and entity finance officers, planners, human resources and quality staff work with the medical staff leadership to conduct an external and an internal analysis using the minimum standard data set (Item 2.1a(2)).

Patient Access: The external consumer information analysis asks: What do consumers think about our products and services compared to those of our competitors? What do our customers expect? What do market trends tell us about consumer behavior? Exploratory research on unmet consumer needs (for example, out-migration) is conducted as part of this analysis.

Local Communities Relationship: The external demographic/socio-economic analysis asks: Who are we currently serving? What are the needs of the customers that we are serving? How will we change over the next five years to meet those needs? The external public policy/legislative analysis asks: How will emerging legislative issues impact us as an employer? How will emerging legislative issues impact us as a provider?

Physician Partnering Relationship: The internal medical staff analysis includes data collection on physician expectations for the various types of network and entity relationships. A key question in the medical staff analysis is: How does our medical staff perceive the products and services we provide compared to our competitors? The key question on the external physician analysis is: What is the trend in physician practices relative to their relationships with competitors?

If factors are detected that require a change in how we relate to and/or work with others in the marketplace or communities we serve, these changes are incorporated into the Strategic, Financial & HR Plan strategies and action plans. The MEA and focus groups are used when more detailed analysis of external/internal changes is needed.

3.2b(1) SSMHC surveys patients and, when appropriate, their families for satisfaction/dissatisfaction and opportunities for improvement, using both formal and informal methods. SSMHC employees at all levels of the organization use the results from these various methods to make fact-based decisions regarding, for example, the need for new services or enhanced delivery processes.

The survey methods include a formal **standardized patient satisfaction survey** and entity complaint management process as well as informal discussions that occur between caregivers and patients and their families; executive leader visits with patients in the hospital; participation in community organizations; and suggestions from medical staff members on behalf of their patients. Focus groups are used to obtain additional data needed to further refine and understand patient responses. Impact analyses prioritize patient satisfaction improvement efforts. The owners of the various survey methods provide their findings to the entity/network leadership groups that are responsible for making ongoing operational improvements or systemic changes through the SFPP. The leadership groups appoint teams to make ongoing operational improvements. Through the Plan-Do-Check-Act/CQI Model, the teams identify opportunities, design and implement improvements, track the results and evaluate the impact of the improvement, and then standardize or adjust the improvement.

The corporate planning staff conducts the formal patient satisfaction survey, which is standardized systemwide and customized for all five patient segments. Analysis of the survey data is done monthly by the corporate planning staff to identify each entity's percentage of "loyal" patients. The survey and data analyses are designed to give SSMHC the ability to predict the future loyalty of its patients and anticipated interactions with them. Survey questions specifically draw out the patient's willingness/unwillingness to recommend the organization to others. Inpatient loyalty is one of the 16 system level performance indicators.

Based on semiannual impact analyses of patient satisfaction survey results, SSMHC's corporate planning staff validates the most important patient requirements driving satisfaction at each entity. Online analytical processing software facilitates detailed segmentation of patient satisfaction data with almost unlimited drill-down capabilities. Users can look at inpatient loyalty results for a particular nursing unit, for example, and compare those results to other units within the entity or any other entity within SSMHC. The patient satisfaction data are also cross referenced with Trendstar clinical and financial data enabling patient satisfaction coordinators to further segment the data by race, gender, age, DRG procedures, primary payor, and physician. Network and entity planning and marketing staff use primary market research, such as focus groups or telephone surveys, to further examine the survey findings when greater clarity is required.

The corporate planning staff analyzes the patient satisfaction survey results and electronically publishes:

- Semiannual survey improvement matrices that identify specific improvements that will result in the greatest gains

in patient satisfaction. These reports go to entity and network executives and entity patient satisfaction coordinators for review and discussion with impacted areas.

- Patient satisfaction survey results for all entities is updated monthly and available via WebDiver on the intranet to track the impact of improvements. This resource is available to entity and network directors and managers within a week of the close of a month.
- Monthly electronic executive summary reports show high level results of each entity's patient satisfaction surveys on a single page. This report also contains results from all SSMHC entities, which facilitates internal benchmarking. Summary reports are distributed to a broad audience of entity and network executives, and department directors, and managers for actionable followup.

Because SSMHC has used a consistent and reliable format for its patient satisfaction survey since 1993, the organization's entities have 10 years of patient satisfaction data available to them to use in improving trends and monitoring patient satisfaction. A statistician with the SSM Information Center and professor at Saint Louis University provides checks on the validity and reliability of survey event items and consults on statistical issues regarding the analysis of survey results.

3.2b(2) The entities have developed processes, such as the following, for prompt and actionable feedback from patients. Senior executives take part in daily rounds of hospitalized patients to ask them how the hospital's services can be improved. Patient concerns are addressed promptly with a follow-up report made to the patient. Comment cards and customer service hotlines are available to patients. Nurses and others who give bedside care ask the patient "Is there anything else I can do for you?" before leaving the room. This question enables caregivers to respond immediately to a patient's needs and reduces the number of calls for assistance. Patients often receive follow-up telephone calls, as appropriate to their level of care, after they leave the hospital.

3.2b(3) SSMHC gathers information on customer satisfaction relative to competitors and other health care organizations primarily during the SFPP. This information is analyzed and used to identify needed improvements and to develop entity/network goals and action plans.

As part of the minimum data set, the networks/entities compile a consumer information survey and analysis that focuses on consumer perceptions of SSMHC's products and services compared to those of competitors. This information is also collected through the physician satisfaction surveys, focus groups, and telephone surveys. SSMHC also benefits from the broader physician perspective on patient care. The physician satisfaction survey contains specific questions to elicit feedback on the performance of

SSMHC entities as compared to other hospitals in the community.

SSMHC obtains benchmark data from National Research Corporation's Health Care Market Guide (HCMG) for the inpatient, emergency department, ambulatory surgery/outpatient, and home care patient satisfaction surveys. The HCMG is an ongoing tracking study that focuses on the key drivers of patient satisfaction for more than 2,500 hospitals. SSMHC entities in Wisconsin, Illinois, and the St. Louis area use privately or publicly produced studies that compare all health care providers in a geographic area on issues relative to reputation and image as well as performance.

SSMHC sets its goals for patient satisfaction based on the benchmark and competitive data collected from these sources. When System Management detects gaps in patient satisfaction between current performance and goals, it drills down to understand root cause issues. Networks, entities and departments use a similar approach and tools. Established thresholds in the PIR process indicate when corrective action plans are required at the system, network or entity levels. Improvement teams are activated and use the CQI Model to redesign care delivery processes when process improvement is indicated.

3.2b(4) The corporate planning staff closely collaborates with the entity patient satisfaction coordinators on an ongoing basis to evaluate and improve the content of the patient satisfaction surveys. An annual evaluation includes statistical tests for validity and reliability by an outside statistician; feedback from entity patient satisfaction coordinators; trade and literature research; and an accreditation/regulatory requirements audit. Based on the findings, the planning staff makes proposed changes in the surveys and shares the survey drafts with entity patient satisfaction coordinators (who share them with other hospital staff) for feedback. The draft survey is revised based on entity feedback and then pilot tested with patients. The corporate planning staff makes any necessary refinements and the improved surveys are implemented.

Evaluation and improvement of internal customer and health care service needs have resulted in major improvements in SSMHC's patient satisfaction survey since 1985, including an electronic reporting system for the monthly survey data using DI-Diver software; an executive summary report to show high level results of each hospital's survey results compared to other SSMHC hospitals; and pain management questions added to the ED and ambulatory surgery surveys to further understand this key driver of patient satisfaction.

CATEGORY 4-INFORMATION AND ANALYSIS

4.1 Measurement and Analysis of Organizational Performance

4.1a(1) The **SSMIC Information Center (SSMIC or IC)** supports SSMHC's approach of gathering and integrating data for performance measurement through a robust information system based on common platforms that are systematically deployed across the organization. Indicator data are published in **Performance Indicator Reports (PIR)** (Figure 1.1-2) as part of the **Performance Management Process**.

Data for the indicators are gathered at the department level and consolidated at the entity level using a variety of systems. The entities use the General Financial and Materials Management System to integrate finance and materials management systems to provide real-time access and sharing of data across the organization. The Patient Satisfaction and Loyalty System and Employee Satisfaction System provide satisfaction data to determine satisfaction/dissatisfaction for each of these key groups. The Patient Resource Utilization and Analysis System and Maryland Hospital Assn. (MHA) are the primary sources for clinical quality data. These automated systems feed the entity data into the Performance Management Process reporting system.

The SSMIC publishes and distributes monthly electronic PIRs that roll up data on 49 indicators from the department to system level. System Management, Operations Council, network leadership and entity presidents and their administrative councils use these reports to monitor and manage organizational performance. Each PIR contains a color coded stoplight report that visually reflects if an indicator is within specifically defined parameters. The PIRs also include a detailed format that shows current month vs year-to-date data. If an indicator reveals an unfavorable variance outside defined parameters, corrective action plans are developed to recover. In addition to acute care hospitals, reports are available for SSMHC's long-term care (skilled nursing) facilities, home care, and physician practices.

Entity administrative councils monitor the **Hospital (Long-Term Care, Physician Practice or Home Care) Operations Performance Indicator Report** containing 49 indicators monthly. The integration of the entity level data provides entity leaders with the information they need to determine whether corrective action plans are needed at the entity level. Network leaders review the **SSMHC Operations Performance Indicator Report** monthly, which rolls up the same 49 indicators for all the entities within a network. It facilitates the identification of systemic issues requiring networkwide corrective action.

The Operations Council reviews an **SSMHC Operations Performance Indicator Report Summary** monthly. This report includes a rollup of the same 49 indicators for all SSMHC networks/freestanding acute care hospitals. The Operations Council uses this report to monitor the performance of each network and entity. Entities and networks with a significant unfavorable variance in any key indicator are required to submit and implement a corrective action plan to bring the indicator on plan (Item 1.1). Action plans are coordinated with the department leader(s) and put into place to adjust daily operations.

Sixteen indicators from the **SSMHC Operations Performance Indicator Report** are rolled up and refined for System Management and the Operations Council in the **PIR System Level Indicators** report (Figure 1.1-3). The 16 indicators include eight for hospital operations, two for nursing home (long-term care), two for home care, two for physician practices, and two consolidated operations indicators (profitability and liquidity). This report allows senior level leaders of SSMHC to evaluate the system's performance and identify areas where more detailed analysis and action followup is required. Daily or Weekly Operations Reports enable some entities/networks to monitor such indicators as productivity, staffing and patient volume. Figure 4.1-1 gives an example of the rollup of indicators from the department to system level.

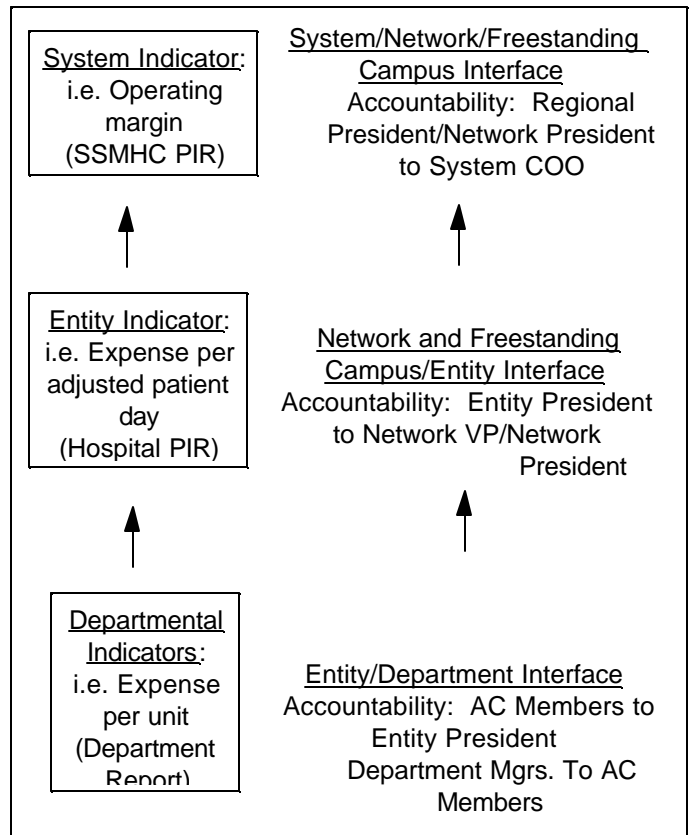


Figure 4.1-1 Example: Perf. Indicator Rollup

The SSMIC also publishes and electronically distributes the **Quality Report** quarterly. The Quality Report contains 14 indicators in four categories: clinical quality, patient safety, employee safety, and customer satisfaction. System, network and entity leaders and regional board members monitor this report to evaluate the system's performance in quality of care as well as patient and employee safety. Corrective action plans are required to remedy unfavorable variances. A team was appointed in 2002 to bring greater balance to the PIR process by integrating the Quality Report and additional clinical quality indicators into the PIRs.

4.1a(2) Performance results are tracked by patient; employee and physician satisfaction; clinical; quality; and financial indicators. The categories of indicators are identified through the SFPP (Item 2.1). Each entity's performance is monitored on the same set of indicators, which aligns the entities with the network, and system goals and objectives. The Performance Management Process is formalized and deployed through the System Policies & Procedures. To further align and deploy this process the system has adopted a standard set of definitions for all key indicators for performance reporting. These definitions and the sources of information used in their preparation are outlined in the Standard Accounting Policies and Procedures, available on the SSMHC intranet.

Further deployment and alignment of the system's goals and objectives is accomplished with the **Passport**. Each employee fills out her/his Passport, which outlines the mission, vision, goals, and measures, with the department manager. This tool, along with a department poster, creates line of sight from the employee level to the system level.

4.1a(3) SSMHC uses comparative information, both competitive and benchmark, to improve overall performance. Comparative information is used to assess the system's performance relative to other similar organizations, either competitors or through national databases, and to set stretch goals.

The need for and priority of comparative data are determined by answering these questions:

- Does the comparative/benchmarking effort relate to the strategies and action plans of the SFPP?
- Is the data available and reliable?
- Does the comparative/benchmarking effort relate to the department level indicators?

Criteria for seeking sources of appropriate comparative information and data or benchmarking partners include:

- Organizations similar in size and/or providing similar services (e.g., health care systems)
- Organizations that compete in SSMHC markets
- Organizations known to excel in the process.

SSMHC uses the International Benchmarking Clearinghouse's four-step **benchmarking process**.

Step 1: Planning the Study. Form a sharing network; decide what to benchmark; and determine how information will be collected and shared.

Step 2: Collecting Information. Collect information about SSMHC's process; seek out benchmarking partners; investigate how superior performance is achieved with the other organization's process.

Step 3: Analyzing Results. Compare own process to performance of others; analyze to find gaps; and uncover innovative approaches to close gaps.

Step 4: Adapting and Improving. Adapt the best practice or implement specific improvements to existing process; measure results after implement action.

This process is contained in The *SSM Health Care Benchmarking Guide*, available to employees in hard copy and on the intranet. The Guide also provides suggested benchmarking references in specific functional areas, i.e., readmission, surgery and pharmacy. SSMHC uses systemwide electronic benchmarking tools, including McKessonHBOC Trendstar, HBSI Action, HBSI Explore/EIS, HBSI Fathom, and MHA QI Project.

External visits are key to the benchmarking process. For example, the K.I.D.S. RULE customer service program at Cardinal Glennon Children's Hospital in St. Louis was developed and implemented through benchmarking with the Disney Corporation. The hospital's leadership group commissioned the Customer Service Team to take customer service from good to exceptional at Glennon. Disney was selected because, like Glennon, children are primary customers. Members of the team attended Disney Institute training and visited two other hospitals that have used the Disney approach. The team selected one of these hospitals to assist in designing an employee customer training curriculum. The team revised employee performance appraisals to include a customer satisfaction segment worth 40 percent and developed classes in Basic Customer Service Training and Phone Management; an employee recognition and reward program for excellent customer service; and a new patient admission packet. They also publish a newsletter highlighting satisfaction survey results/comments and hold focus groups with patients and the parents of patients to clarify their concerns. The team closely monitors Glennon's inpatient loyalty results, which trended up after K.I.D.S. RULE was implemented late in 1999.

4.1a(4) System Management is responsible for management of the PIRs. Through the rigorous annual assessment, SSMHC receives feedback on opportunities to improve its measurement system. Following an evaluation of the state and Baldrige feedback, System Management engages appropriate teams to define and make any necessary enhancements. An Accountability

Task Force of senior system/network executives and entity presidents was formed in early 2000 to better align indicators at all levels of the organization and establish greater accountability for performance results. Their work resulted in the current PIR system, which was improved in 2001 to reflect the new 2002-4 goals. A sub-team of senior executives is working in 2002 to better integrate clinical quality indicators into the PIRs. Changes are implemented by System Management, which revises related policies, and the SSMIC, which updates the reports. Changes in the reports are made in a way that preserves prior year comparisons.

4.1b(1) SSMHC uses a variety of methods to analyze different categories of data for review by executive leaders and for use in organizational planning. (Figure 4.1-2) Regression/impact analysis, for example, is used to identify opportunities for improvement from the patient satisfaction surveys. Through this statistical tool, the areas with the lowest satisfaction and highest importance to the customer can be determined. This helps SSMHC's employees understand, prioritize and address areas of importance to patients and their families. The percentage of loyal vs. at-risk customers and an impact index analysis is also obtained from patient satisfaction surveys to give a "Loyal Customer Index." SSMHC's patient satisfaction software is used at the entities to analyze and compare patient satisfaction data for more detailed understanding of patient needs.

4.1b(2) Analytical results are packaged in the Performance Management Process reports, which become the foundation for reviews as described in Item 1.1b.(1). Operating indicator data are analyzed and integrated via the tools described in Figure 4.1-2 for monthly operational reviews and the SFPP. SSMHC improvement teams use these methods to improve department, entity, network or system processes. During the entity leadership reviews of the **Hospital Operations Performance Indicator Report**, administrative council members discuss results, as appropriate, and present performance improvement initiatives undertaken between review sessions. Year-end results and analyses are included in the SFPP during the Strategic Development phase. Systemwide progress is communicated to all employees by senior leaders in messages crafted to ensure understanding and to allow opportunities for two-way conversations.

In early 2002, the corporate planning staff conducted a correlation analysis of key system level indicators to validate which indicators strongly correlate, positively or negatively, to inpatient loyalty. The results were presented at the annual Innsbrook Group planning session to provide a basis for planning decisions and priorities.

Planning (SFPP)	
<ul style="list-style-type: none"> • External/Market Analysis (consumer, demographic, competitor, emerging technologies, payor, public policy & physician) • Internal Analysis (medical staff, product line, HR, physical plant/technology, financial, supplier and partner, & quality analyses) <ul style="list-style-type: none"> • Credit • Feasibility • Gap • Correlation • Market Basket • SWOT 	<ul style="list-style-type: none"> • Business Development • Sensitivity • Financial Risk Assessment • Development Needs • Capital Review • Public Perception
Performance Review	
<ul style="list-style-type: none"> • Mission Effectiveness Analysis (MEA) • Regression/Impact Analysis • Focus group • Syndicated customer research • Root cause analysis • Variation analysis • Segmentation • Literature research • Complaint management 	

Figure 4.1-2 Key Analyses to Support Performance Review & Strategic Planning

Analysis via the tools identified in Figure 4.1-2 is conducted to provide information related to the system's strategic initiatives. In addition, line graphs and control charts are used to analyze trends in financial, clinical quality, and customer data. Comparative data is used on graphs and charts to provide an opportunity to assess SSMHC on a relative basis.

4.1b.(3) During the SFPP, SSMHC's organizational goals and measures are established. The Performance Management Process is intentionally designed to provide predictive insight into organizational level achievement of key strategic objectives as defined through the SFPP. (Figure 4.1-1 provides an example of department to system level indicator alignment.) Analysis methods facilitate reconciliation of strategic and tactical data and provide a basis for prioritizing initiatives. Continuous and breakthrough improvements occur through corrective action plans and the built-in annual improvement cycles of the planning process. The SFPP both drives and draws from the Performance Management Process through the comparison of current performance to anticipated (or plan) performance. The gap between current performance and desired levels of performance provide the basis for action plans directed at incremental improvement. Breakthrough performance improvement needs are identified through use

of comparative data and are the basis for key organizational strategies.

4.2 Information Management

SSMHC's **Information Management Council (IMC)** determines the data and information needed by entity, network and system staff, suppliers/partners, stakeholders, and patients/customers through an **information management planning process** (Figure 4.2-1) that is part of the overall SFPP. The IMC is a multi-disciplinary subcommittee of System Management that represents the system, networks and entities. The IMC consists of approximately 20 System Management members, entity presidents, physicians and representatives from operations, finance, nursing, planning, and information systems. The information management (IC) plan is developed by the IMC and implemented by the SSM Information Center.

4.2a(1) Common information systems platforms are deployed in each entity via SSMHC's network. Key clinical, financial, operational, customer and market performance data for all entities and SSMHC as a whole are provided in automated information systems that allow for significant reporting capability. Based on best practices at several entities, the ePMI (Exceptional Performance Management Initiative) Team in 2002 recommended a systemwide model for redesigning the Financial and

Decision Support services within SSMHC. The new model enables improved monitoring of performance, additional decision support for executive leaders, and more rapid response to strategic opportunities.

Based on the needs of the organization, the IMC follows established criteria to classify its information systems into three categories: Required (standardized across the system and must be implemented at each facility); Standard (standardized systems that entities implement according to their needs); and Non-Standard (not standardized across the system and entities may implement according to their needs). There is a focus on standardizing information systems to ensure that standard data and information will be available for reporting at a regional and system level. The SSMIC works collaboratively with key functional areas (e.g., corporate finance) to ensure its systems meet common data definitions as, for example, with the systemwide Performance Indicator Reporting process. The required and standard information systems are deployed throughout the system by the SSMIC. The SSMIC has also implemented a sophisticated technical infrastructure that allows the physician partners to access data and information needed for their practice from any location at any time from multiple devices, including PCs, PDAs, pagers, and fax.

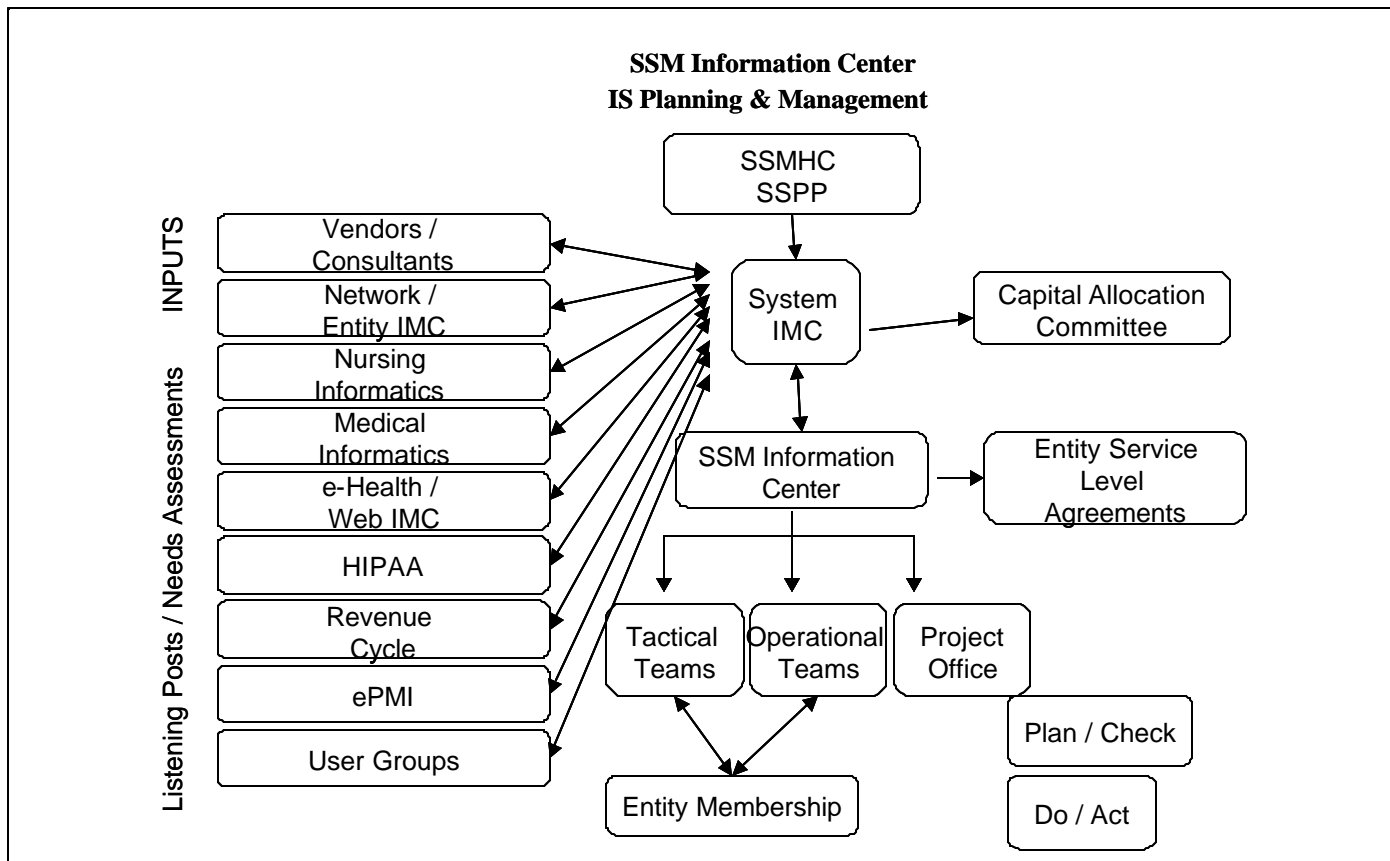


Figure 4.2-1 IS Planning & Management Process

The SSMIC has a technology management function that monitors its information systems to ensure high availability and access of data and information. This is accomplished through the Operations Center and the use of system monitoring tools such as Spectrum and ITO. A variety of file servers are monitored for disk and CPU utilization and system uptimes. This data is used for forecasting and planning server upgrades. Additionally, network performance is monitored to ensure access to the application systems. As appropriate, the SSMIC has implemented redundancy for specific systems and within its network infrastructure for high availability.

4.2a(2) The SSMIC's Compliance Administration Group (CAG) has developed **Security Policies and Procedures** that document the system's intentions and staff responsibilities regarding information confidentiality, privacy, and security. The policies and procedures cover all employees of SSMHC and physicians who use SSMHC information or information processing services during the course of their work. They also cover all consultants, payors, contractors, contract and resident physicians, external service providers, volunteers, and suppliers/vendors who use SSMHC information or information processing services.

To ensure data and information security and confidentiality, the SSMIC has established a department for Compliance Administration and Security, which is responsible for ensuring appropriate authorized access to its computer systems. A formal Computer Authorization process for granting access to systems and a process of routinely requiring passwords to be changed have been implemented. The department leader also is working with the project manager for HIPAA compliance and heads up the HIPAA Technical Security team to ensure that the confidentiality of electronic patient records is in compliance with federal standards.

Data integrity, reliability and accuracy is addressed through a multidimensional approach. The SSMIC's Decision Support department works with entity customers to audit the data and information loaded into its databases for accuracy. For electronic business partners, such as payors, the SSMIC has established checks and balances in the control process to validate the timely receipt and integrity of submissions for payroll direct deposit and electronic claims submissions. The SSMIC uses the **Catholic Healthcare Audit Network (CHAN)** to perform audits of information systems and processes for integrity, reliability, accuracy, timeliness, security and confidentiality. Hospitals also complete the MHA Conformance Assessment Surveys to check the accuracy and validity of clinical data and improve data reporting.

4.2a(3) SSMHC keeps its data and information systems current through the SFPP and IS Planning & Management

Process. Technology needs are assessed through the internal and external assessment step of the SFPP. The external emerging technologies analysis addresses the current situation in the industry and marketplace. The internal physical plant/technology analysis assesses the technology needs of SSMHC's entities and networks to support achievement of goals and action plans. The IMC uses the information collected through an SSMIC-sponsored IMC Education Day, and the SFPP and its own listening posts and learning tools to develop the information management (IC) plan, which incorporates network and entity information systems needs. Following approval by the IMC, the IC plan is incorporated into the system's SFP. The SSMIC communicates its goals and objectives to each entity and network through a Service Letter Agreement that details the products and services the SSMIC will provide to that entity and network during the year. A measurement system for evaluating the SSMIC's performance is a key component of the agreement.

The SSMIC also contracts with and participates in external industry research and educational groups, including the Gartner Group, Meta Group, Washington University's CAIT program, HIMMS/CHIME, and INSIGHT (participation by individual and board membership) as a way of keeping current with health care service needs and directions.

4.2b(1) The SSMIC has deployed Uninterrupted Power Supply (UPS) systems and is protected by its own power generator to ensure availability of hardware and software. The financial and payroll systems are covered under a hot-site backup disaster recovery program. The Network (LAN, WAN, & Internet) Security policy outlines the procedures, responsibilities of IS staff, and standards for safeguarding the hardware, software, and the Internet. The SSMIC also formally tests software product enhancements prior to implementing them into a production environment to make certain they are reliable and user friendly. Quarterly survey results and comments are shared with the leadership team and action plans for improvement are developed. The leaders monitor the initial survey results and comments as well as the action plans, insuring that organizationwide issues are appropriately addressed. They also ensure that each respondent receives feedback relative to their ratings and comments. Feedback from the Customer Satisfaction Program described above also helps to ensure that hardware and software are reliable and user friendly.

4.2b(2) Software and hardware systems are kept current through the SFPP and IS Planning and Management Process as described in 4.2a(3). For example, the SSMIC has assisted the organization to meet its patient safety initiative by implementing software designed to prevent medication errors, such as Electronic Signature and Bedside Medication Administration.

CATEGORY 5-STAFF FOCUS

5.1 Work Systems

5.1a(1) SSMHC organizes and manages its health care services through an organizational structure designed to be flexible and responsive to the needs of customers and partners. Work and jobs are organized and managed at all organizational levels (system, network and entity) according to functional responsibility, usually by departments. Each position has a clearly defined job description. Individual and department goals are aligned with entity, network and system goals through the Passport, creating a common focus.

As CQI has become a cultural norm, SSMHC has been transformed into a team-driven organization seeking to constantly improve. Teams are commissioned on a short- or long-term basis to achieve specific initiatives or to design or redesign work processes. Use of teams gives SSMHC the flexibility to pull together individuals with special expertise to quickly address changing customer, operational, and health care service requirements.

Employees and physicians throughout SSMHC participate on teams to design, organize, manage, and improve their work processes. CQI teams can be systemwide, networkwide or entity-specific. Systemwide teams address universal work-related issues. Networkwide teams deal with issues common to a particular region. The entities use teams as well as informal work groups to integrate the mission into work, provide patient care, problem solve, and so on. Employees validated “work” and “teamwork” as their two main satisfiers in the most recent employee survey as well as on surveys for the past three years. The satisfaction with teamwork reflects the impact the CQI management paradigm has had on the SSMHC culture.

SSMHC’s long-standing commitment to CQI Principles and teamwork promotes communication and cooperation as well as knowledge and skill-sharing within and across the work units, departments, and entities. CQI has created a common language and common set of tools enabling people to work together on entity, networkwide and systemwide teams and to share information, lessons learned, and methodologies. Team members share best practices within their departments.

SSMHC brings together system, network, and entity leaders for knowledge sharing at annual meetings, conferences, teleconferences, and learning sessions. Nursing executives (like other functional area leaders) meet annually to discuss systemwide nursing issues and develop policies and initiatives related to nursing. An annual Nursing Sharing Conference enables nurses from across the system to share improvement and best practices and gain indepth knowledge on issues from a

national expert. The 2002 Nursing Sharing Conference focused on Shared Accountability. Other methods of effective communication and knowledge/skills sharing among employees are depicted in Figure 1.1-1.

5.1a(2) SSMHC is in the early stages of implementing Shared Accountability, an accountability-based professional practice model, at all entities to foster empowerment and to give nurses and other employees greater decision-making authority. Shared Accountability builds on CQI and SSMHC’s commitment to place decision-making and accountability at the level where work is performed.

The SSMHC Quality Principle “Quality is achieved through people” is the bedrock of the organization’s culture. One of the seven management practices considered essential for success within SSMHC’s leadership system is “developing people.” This practice is defined as facilitating the development of others; having high expectations of individual skills and abilities; investing in employee development; and valuing and modeling lifelong learning. These behaviors are part of the Leadership Development Process (Item 1.1a(1)).

SSMHC utilizes mentoring at all levels to engage and develop new professionals. SSMHC launched a pilot **Diversity Mentoring Program** in 2000 with ten minority employees in professional and management ranks serving as mentorees and ten executive leaders serving as mentors. The program is now implemented systemwide and has been expanded to 20 pairs. The program supports one of SSMHC’s diversity goals: To increase the number of minorities in the professional and managerial ranks by preparing them for upward mobility.

5.1a(3) An annual staff evaluation process gives SSMHC’s employees an opportunity to discuss development needs with their supervisors and to identify opportunities to learn and gain new job skills. The performance of SSMHC clinicians is evaluated based on job-specific competency standards. Each entity and network has a performance review process in place for all other employees and employed physicians. Through the **Passport** program employees identify personal goals that are linked to organizational goals and are then evaluated on their performance in achieving these goals.

Within the SSMHC culture, we understand that an employee’s primary motivation comes from an intrinsic desire to perform well in her or his work. Therefore, creating an environment that supports and enables employees is important. We accomplish this by providing the information and tools employees need to do their work individually and in teams. At a more fundamental level, managers motivate employees primarily through two non-monetary approaches--coaching and recognition.

Formal coaching is built into the employee development process, although informal coaching is an ongoing process at all levels of the organization.

A comprehensive **Employee Recognition Policy** was developed and implemented in early 2000. All SSMHC entities have a formal process to recognize employees, physicians, and volunteers for their years of service, team contributions, and CQI efforts. Each entity also has a process in place to recognize individuals who live out the SSMHC mission in a way that goes above and beyond their job description. Formal and informal recognition is given to both individual employees and to teams. The primary method of recognizing teams as well as sharing results is through the annual Showcase for Sharing conference, a systemwide recognition event held in conjunction with SSMHC's annual Leadership Conference. Teams that have made effective use of the CQI process are also eligible to receive a plaque from the Quality Resource Center.

In keeping with its mission and values and the human resources strategic goal of competitive compensation, SSMHC develops compensation policies to be fair and equitable for all employees. Annual market surveys are conducted and pay ranges adjusted as necessary to ensure competitive compensation for all jobs within all the communities served by SSMHC. The compensation system also is evaluated annually and the results reported to the parent Board of Directors.

5.1a(4) Throughout the organization, including senior administrators and executive leaders, employees are encouraged through coaching to develop to their fullest potential on their career path within SSMHC. When openings occur, internal candidates are given a strong preference. Forty-nine percent of SSMHC's executives and 1,064 employees were promoted from within in 2001.

SSMHC's succession planning for executive leaders is called the **Executive Career Development Program**. The process is defined in the SSMHC Executive Leadership Handbook. Through this process, future leaders are identified and developed. The program begins with a leadership behavior assessment through a psychometric tool, such as Calipers or similar psychological testing, and use of a personal development plan within the first six months of employment. The program also includes an executive orientation; CQI training; and a Corporate Responsibility Process training session for executives within the first six months of employment. Executive leaders have mentors available to them and are expected to mentor others.

5.1a(5) SSMHC's executive leaders consider it essential to be the employer of choice because of the shortage of health care workers nationwide. The American Hospital

Association recognized SSMHC in 2002 as an exemplary employer and the St. Louis Business Journal named SSM Health Care St. Louis as one of two nonprofit employers of choice in the St. Louis area.

Caliper Profiles, or similar assessment tools, are used across the system to assess the personality characteristics of potential managers. This profile helps ensure SSMHC hires individuals that are a good fit with its values, core behavior expectations, CQI culture, and strategic initiatives. Key performance requirements are communicated to potential staff during the interview process.

SSMHC's human resources staff have identified general characteristics of successful and valued employees through institutional knowledge and many years of employee focus groups and surveys. Successful SSMHC employees are interested in good benefits and competitive wages; encouraged by being a team player; motivated by the intrinsic value of providing patient care; comfortable asking for needed information; honest; nonviolent; and responsive to patients and co-workers.

SSMHC human resources staff interview potential employees to assess whether they have the characteristics necessary for a good fit with the culture and the skills to fulfill the job requirements. If a decision to hire is made, extensive background checks are conducted, followed by a physical and drug screen. SSMHC human resources staff also check to verify credentials and post secondary education. They confirm the most recent five years of work history of candidates for professional and managerial positions and identify the cause of any gaps in employment history.

SSMHC uses a wide variety of recruitment methods. The recruitment efforts focus on SSMHC's commitment to quality and culture of teamwork to interest candidates who have the potential to be valued employees. SSMHC screens advertising outlets and sources of job candidates based on the SSMHC valued employee profile. The system also recruits electronically, both on its external Web site and from all SSMHC intranet pages. Openings are also posted on wall bulletin boards at the entities. During 2001, SSMHC recruited 2,459 employees via the web. An online application is available. Information about all applicants, including online applicants, is tracked electronically. (Figure 7.4-12) This tracking program helps HR staff to better focus their recruiting efforts.

SSMHC has addressed the industry's critical nursing shortage by bringing together nurse and human resources executives to develop innovative recruitment and retention strategies. System Management is taking the following actions based upon the recommendations of the five systemwide nursing recruitment and retention teams: (1)

implementing nursing shared accountability models at the entities, (2) improving nursing education and orientation programs offered within the system, (3) improving nursing access to technology, (4) developing programs to foster collaborative relationships between nurses and physicians, (5) offering a variety of benefits such as improved tuition reimbursement and bonuses for employees who recruit a peer.

Other recruiting strategies are student nurse internships and post-graduate clinical teaching site experiences. These programs are designed to give student nurses and postgraduate nurses an opportunity to work side-by-side with experienced nurses. As an example, in 2001, 84 percent of the student nurses stayed on as SSMHC St. Louis employees.

SSMHC's entities celebrate their diversity in many ways, including events that feature ethnic foods; observances of ethnic holidays and other events celebrating racial, ethnic, and religious significance.

5.2 Staff Education, Training, and Development

Continuous learning is considered essential for employees to stay abreast of changing health care technology, industry trends, market forces, and governmental regulations. Education and training is designed to support the goals and action plans of the system, networks and entities to meet these challenges.

5.2a(1) System Management determines whether educational topics support the organization's short- or long-term strategic objectives. Education programs that support long-term objectives and meet a requirement for consistency are offered systemwide. Those that support short-term strategic objectives and specific goals and action plans, for example, supporting use of new medical equipment, are offered locally.

Education and training in CQI, for example, are deployed systemwide to support SSMHC's Quality Principles and team and individual quality-in-daily-life approach to work. Teams are typically used to complete action plans throughout the system. SSMHC's CQI classes prepare employees and physicians to participate effectively as team members and team leaders (group dynamics) and to use the proper tools of analysis. When action plans involve systemwide processes or initiatives, such as HIPAA, specific training programs are designed and implemented systemwide. Other examples of systemwide training include Corporate Responsibility (CRP) and computer skill training.

All SSMHC hospitals assess staff development needs for clinicians on a hospitalwide, departmental, and individual level and use these assessments to plan staff education. For each employee, the human resources staff verifies

that education and training are consistent with applicable legal and regulatory requirements and hospital policy. They also verify that the individual's knowledge and experience are appropriate for his or her assigned responsibilities, including job-specific competencies. The primary assessment of individual knowledge and skills is completed each year with the performance review, which identifies future training needs. The entity human resources staff analyze trends and identify needed improvements in staff education. A summary of the aggregated data regarding competency of employees; analysis of patterns or trends; identification of training needs; and actions taken to address the needs are reported annually to SSMHC's regional boards of directors in the Competency Report.

5.2a(2) SSMHC's entities and networks conduct a human resource analysis and competency assessment, as part of the SFPP, to identify the training and education their employees will need to meet systemwide goals. Data are collected and analyzed by the entity/network staffs and incorporated into resource plans supporting the system/network/entity goals and strategies.

The results of this survey are combined with other sources of input, including performance review plans, employee satisfaction levels, formal needs assessments, direct requests, staff meetings, and direct observation. An analysis is conducted and educational priorities are set. Employees are surveyed to assess learning sites, course content, and delivery alternatives.

5.2a(3) The organizational training needs generated by the strategic objectives and system action plans developed during the SFPP are addressed at the appropriate system, network and/or entity levels.

Technology. System level technology education and training needs are driven and defined by the SFPP and the SSMHC. System level strategies, such as the conversion to ERP, that require the implementation and use of new technology are supported through the deployment of appropriate learning opportunities.

Management/Leadership Development. The Leadership Development Process is an approach to the development of people at many levels. Input from a variety of sources is used to identify appropriate learning and growth opportunities for employees who are or desire to serve in a leadership role.

New Staff Orientation. Initial education and training are delivered through a tailored orientation that includes system and entity-specific information. Executive leaders participate and welcome new employees into the organization, sharing the mission, vision, and philosophy. Topics typically covered include the Passport program (which includes strategic initiatives), patient rights, ethical concerns in patient care, CRP policies, principles of

quality improvement, and much more. Orientation to the individual work area is provided by the department.

Employee Safety. Required safety training is focused at the entity level on ergonomics (especially patient lifts and transfers), exposure control through sharps alternatives, hazardous and biohazardous material management, life and environmental safety, and emergency preparedness, including bioterrorism.

Performance Measurement/Improvement. All employees receive an orientation to CQI as part of their new employee orientation. Five CQI principles are discussed, including why and how every employee is expected to continuously improve their work. Employees also receive an orientation to their work unit and their specific responsibilities are identified. As part of their orientation, Passport goals and performance and skill standards for their own position are described. Through the employee development process, employees receive training from their supervisor about the development of performance improvement goals for their own position. The requirement for executive leaders regarding CQI training and personal development plans are outlined in the executive handbook. The Leadership Development Process includes assessment of individual strengths and development needs with subsequent education.

Diversity. A video on SSMHC's commitment to creating an inclusive environment and culture called "Experience the Difference Diversity Makes" is shown to new hires. Mandatory training related to diversity and sexual harassment policies is held annually for all employees.

5.2a(4) These include special systemwide education programs; entity, network, and system level orientation programs for new employees; on-the-job training; ongoing CQI classes and so on.

Education and training and the methods of delivery are tailored to meet the varied needs related to learning styles, locations, and subject matter. Lecture, computer-based/web-based training and simulation, skill demonstrations and testing, videotape, discussion, videoconferencing, self-learning modules, individual instruction, and group learning activities are all also used in meeting these needs. Software "super users," online help, and "train the trainer" classes are used for technology training. Skill-based training, such as cardiopulmonary resuscitation, requires hands-on learning and competency assessment through return demonstrations. Principles of adult learning are applied.

Specific individuals or dedicated education departments have been assigned responsibility for delivering education at the entities. Staff education is provided to employees on all shifts, 24 hours a day, 7 days a week. SSMHC employees are a diverse group of people. Some staff are professionals with graduate degrees, others have less

than a high school diploma. These factors are considered when tailoring delivery methods and course content.

General education, training and development programs are continuously evaluated and improved in accordance with SSMHC's CQI philosophy. Systemwide education that supports SSMHC's strategic objectives, such as CQI and CRP courses, are evaluated at the system level.

Continuous quality improvement training is evaluated by student and team evaluations. CRP training is evaluated using feedback surveys and post tests. Both types of evaluations are used as input for periodic training revisions. Learning Management System software tracks training participation and cost across the system.

Internal training is evaluated at the entity level by (1) evaluations immediately following the training, and (2) annual competency/performance review. Educators follow up informally with supervisors to assess whether training programs have met objectives and if employee performance is improved. Employees evaluate the content and presentation after formal educational programs. The entities aggregate findings and tabulate and trend them to determine improvement opportunities in program design and delivery, and the evaluation and outcomes are used to revise the education program.

5.2a(5) Job skills and knowledge are reinforced at the entities through observation of day-to-day performance by preceptors, supervisors, managers, mentors, and peers. Preceptors provide continuous and immediate reinforcement to staff following training. Educators reinforce training and job skills by providing informal follow up with supervisors, assessing whether training programs have met departmental objectives and employee performance has improved.

Supervisors and managers are trained to reinforce the use of quality improvement tools and techniques on the job. To maintain the highest quality patient care and customer satisfaction, entities assure that employees achieve expected levels of performance through ongoing competency assessments of patient care staff, with summaries of these assessments reported to the Board annually. Completed training is tracked through a learning management system and linked to personnel files.

5.3 Staff Well-Being and Satisfaction

5.3a The cornerstone for SSMHC's focus on staff well-being and satisfaction is the understanding that employee well-being and satisfaction are directly correlated to patient and physician satisfaction.

SSMHC has retained Marsh Risk Consulting Strategies, a risk control consultant, to make entity site visits to assess employee safety programs and loss prevention programs at least annually. A report on the assessment

Factors	Measures
Environmental Factors/Safety	<ul style="list-style-type: none"> • Lost-time injuries (Fig. 7.3-4) • OSHA incidents (Fig.7.4-18) • Back injuries (Fig. 7.3-6)
Staff Well-being	<ul style="list-style-type: none"> • Employee Satisfaction
Employee Satisfaction/Motivation	<ul style="list-style-type: none"> • Employee Turnover(Fig. 7.3-3) • Nurse Turnover (Fig. 7.3-3) • Employee Satisfaction (Fig. 7.3-1)
Diversity	<ul style="list-style-type: none"> • Number of minorities in professional and management positions (Fig. 7.3-12) • Employee Satisfaction

Figure 5.3-1 Key Measures for Staff Safety, Well-Being & Satisfaction/Motivation

with recommendations for improvement is provided to entity safety officers and the corporate risk manager for employee safety. The entity's leadership group approves any capital expenditure or appoints teams to make the necessary improvements to processes that impact employee safety. See Figure 5.3-1 for measures of environmental factors and safety.

5.3b(1) SSMHC determines the key factors affecting employee satisfaction, motivation, and well-being through analysis of results from an annual systemwide employee survey known as the **HR Solutions Survey**. An analysis is done based on the normative differential score, which compares SSMHC's scores with the National Healthcare Normative Data. The survey is administered primarily by paper, but has phone and Internet capability. It allows for uniform collecting and reporting across the system, rapid turnaround time from assessment to results; and provides actionable results summaries. Survey data is segmented according to SSMHC's main job categories: Nurses (patient care and administrative), physicians, executives and managers/supervisors; support, clinical and technical professionals; lead clinical/technical professionals; allied health; support services; and administrative assistants/coordinators/office clerical. SSMHC has customized the survey, which contains 124 questions, to provide segmented data on satisfaction among minority employees. The HR staff can drill down for survey results by ethnicity, pay status, gender, tenure, age, and department.

5.3b(2) Employees within SSMHC are employed full-time, part-time, occasional, and by contract, meeting both their needs and the system's need for flexibility because of changing patient volumes.

Some systemwide approaches used to enhance the work environment for SSMHC employees include flexible hours (seventy-two hours semimonthly is considered full-time with full-time benefits); work at home; SSMHC-sponsored

retreats (one day to reflect on the mission and reenergize); wellness programs; environment of respect; and job postings for internal recruitment. For example, employees may choose to work between 9 a.m. and 3 p.m., while their children are in school, and job sharing exists where needed. Entities commonly rely on internal float pools, as preferred to agency use, to provide supplemental on-call staffing and flexibility. Employees can also easily transfer between SSMHC entities within geographical areas.

SSMHC determines staff needs for services, benefits, and policies through the **SFPP**, with data collected, aggregated and analyzed through the human resource analysis step. Sources of input include the **HR Solutions employee survey**, market studies, employee councils, suggestion boxes, Town Hall meetings, etc.

Flexible Benefits Program: Employees select benefits that most closely meet their individual and family needs. The benefit structures are uniform across the system for comparable hospital, nursing home (long-term care), or physician. Executives and employees receive the same health insurance benefits plan, including choice of medical insurance plans, including indemnity and HMO options, with prescription drug coverage; dental insurance plan; vision care plan; life insurance and dependent term life; accidental death and dismemberment; LDA coverage-Legally Domiciled Adult; Long Term Care Insurance-insurance to provide coverage for times of extended care; Long-term disability; Health and Dependent Care pre-tax spending accounts; and Tax-Deferred Match Savings Plan.

Employee Assistance Program (EAP): Entities provide, at no cost to the employee, this confidential program of counseling for employees with personal, family, legal, financial, substance abuse and/or work-related problems.

Employee Emergency Fund: Many entities offer confidential monetary support to employees facing sudden financial crisis.

SSMHC also has systemwide policies providing: extended medical benefits (short-term disability); retirement plan; supplemental tax-deferred match savings plan; direct deposit; discounts for cafeteria and gift shop; credit union; tuition reimbursement / educational assistance; leave of absence programs for family medical, personal, educational, or military service; and adoption reimbursement. In 2001, SSMHC introduced a phased retirement option as a way of retaining older employees. Under this option, an employee 60 or older who has five years of vesting service can receive pension benefits while continuing to work for SSMHC, full- or part-time, and will also be eligible to receive any other benefit provided for the particular status.

SSMHC employee benefits are tailored to represent the diversity of the work force, specifically women who represent 82 percent of the workforce. This commitment to women prompted the implementation of PTO/EMTO, Family Medical Leave policies, day care benefits, and the cafeteria plan for employees. Eighteen percent of employees represent minority groups. The promotion and celebration of gender and ethnic diversity within SSMHC's culture has been one of several key organizational commitments since the system was organized in 1986. This commitment is reflected in SSMHC's 2002-2004 SFP, which includes four diversity goals:

- Increase the number of minorities in professional and managerial positions systemwide by 51 in 2002
 - All SSMHC entities support at least three community-based activities each year in partnership with organizations that rigorously pursue fairness and equality
 - All SSMHC entities provide annual diversity training to their employees and managers
 - Increase annual discretionary spending with minority business enterprises (MBE) to 10 percent in 2002.
- SSMHC created the position of corporate vice president-human resources & system diversity to assist SSMHC's networks and entities in achieving diversity initiatives and goals. All entities have action plans to support the systemwide diversity goals. SSMHC's diversity initiative was recognized as a national best practice in 2002 by the American Hospital Association.

The materials used for employee CRP training systemwide are available in both English and Spanish. Some SSMHC entities offer literacy and language programs for their employees. St. Mary's Hospital Medical Center and St. Marys Care Center in Madison, WI, for example, offer English-As-A-Second-Language classes for employees during work hours. An **SSM Diversity Forum**, composed of persons of color, different ethnicity or with disabilities holding professional and management positions within SSMHC in the St. Louis area, was piloted in St. Louis. During 2002, SSMHC will begin replicating the forums in other SSMHC regions.

5.3b(3) SSMHC assesses employee well-being, motivation, and satisfaction with the work environment systemwide and develops action plans for improvements. Corporate Risk Services collects, aggregates and analyzes systemwide data on employee health, safety and ergonomics. The corporate human resources staff collects, aggregates and analyzes systemwide data on diversity and harassment, grievances, harassment reports, work place violence, and labor activity. These data are integrated with other employee-related data, for example, employee satisfaction and turnover rates.

The annual **HR Solutions survey process** is the primary method used to determine staff well-being, satisfaction and motivation. Results can be analyzed by job groups

across an entity, network or the entire system. Follow-up feedback sessions are conducted with employee groups to clarify and validate survey results. The results from the survey and feedback sessions are compiled and integrated into reports on the system as a whole for System Management and the network/entity presidents. An interim written survey called "Short Form" is used to evaluate improvements made in the response to employee feedback.

Employee input also is solicited during exit interviews. This information helps trend why people leave and identify issues of concern. All of the results measured are analyzed and used by human resources executives and executives at the entity and network level to improve those factors that have been identified as drivers of staff well-being, satisfaction, and motivation. Figure 5.3-1 shows the key measures and indicators used to track staff safety, well-being, and satisfaction/motivation. Each SSMHC entity has an employee council with cross-functional employee representation that serves as a forum for discussion and resolution of issues of concern to employees.

5.3b(4) SSMHC's executives monitor key indicators of employee satisfaction and well-being along with other key organizations performance indicators through the PIRs and Quality Report (Item 1.1). Correlation analysis, root cause analysis, literature research and other quality tools are used to analyze the performance results and identify opportunities for improvement. Action plans at the system, network or entity level are implemented to make the necessary improvements. For example, SSMHC's executive leaders noted a correlation in 1999 between a drop in inpatient loyalty and dissatisfaction among a single group of SSMHC employees--nurses. Further analysis revealed that the early impact of a nursing shortage at some SSMHC hospitals was impacting not only labor costs but also nursing staff morale, SSMHC organized the two-day Nursing Recruitment and Retention Summit in January 2000. Since 1999, inpatient loyalty and nurse satisfaction have both increased. The nursing turnover rate declined in 2001 and is projected to decrease further in 2002 (Figure 7.3-3).

SSMHC implemented the HR Solutions Survey in 2002 on the recommendation of a systemwide team. The survey was piloted during 2001 at St. Francis Hospital & Health Center in Blue Island, IL. The new survey replaces a systemwide focus group survey instrument that the system had used since 1997. The HR Solutions Survey improves SSMHC's ability to correlate its employee and patient satisfaction; benchmark results with other organizations; and collect data related to special initiatives such as diversity.

CATEGORY 6- PROCESS MANAGEMENT

6.1 Health Care Service Processes

6.1a(1) Guided by the five SSMHC Quality Principles, teams design health care services and their related delivery processes using the **CQI Model - Process Design Approach** (Figure 6.1-1). The CQI Model incorporates the Plan-Do-Check-Act (PDCA) cycle and includes substeps or questions that serve as checkpoints to ensure process designers consider, at minimum, requirements such as customer expectations, best practices, potential design problems, measurement systems, etc. The model is intended to be used in its entirety when, for example, new complex health care service processes need to be designed, or in a streamlined PDCA cycle when the process is less complex or quick action is required. A **CQI Model-Process Improvement Approach**, similar to the Process Design Approach, is used to make improvements to existing processes.

6.1a(2) When network and entity leaders identify an opportunity to launch a new or modified health care service, they appoint a team to determine the feasibility of offering the new service. This team or a subsequent design team is appointed to design the new process(es) for the service. This team, composed of stakeholders in the process/service, including employees of all levels, physicians, and suppliers and customers, as appropriate, conducts an Analysis as part of the Plan phase of the CQI Model and makes a recommendation to the network/entity leadership group. The entity administrative council (AC) or network leadership group discusses the team's findings and decides whether or not to move forward to the next

step, Implement New Process, in the Do phase of the CQI Model. When a new process will impact the system as a whole, this decision is made in consultation with SSMHC's senior leaders.

Opportunities for a new service are generally discovered through the **Strategic, Financial & HR Planning Process (SFPP)**. As part of the SFPP, networks and entities identify needs for new services based on customer-focused studies, stakeholder input, community assessment data, and so forth. All new services are required under the CQI Model's Identify Opportunity step to link to the system/network/entity strategic goals. The need for a new or modified service may also stem from new regulatory issues, quality control (performance measurement data) for key processes, patient/customer input from tools described in Item 3.1, or an individual employee or employee team suggestion.

When the projected cost of a new service exceeds \$500K, the network or entity develops a strategic and financial analysis and submits the project to the **Capital Planning and Allocation Process (2.2a1)** for review and approval at the system level. A cost-benefit analysis is also conducted by the network or entity staff for those new or significantly modified health care services with a projected cost of less than \$500K.

6.1a(3) Customer requirements, expectations and priorities constantly change, with the advent of new technology and health care delivery systems. During the annual SFPP, the networks and entities review information about changing patient/customer and market requirements, such as changing demographics, the consumerism movement,

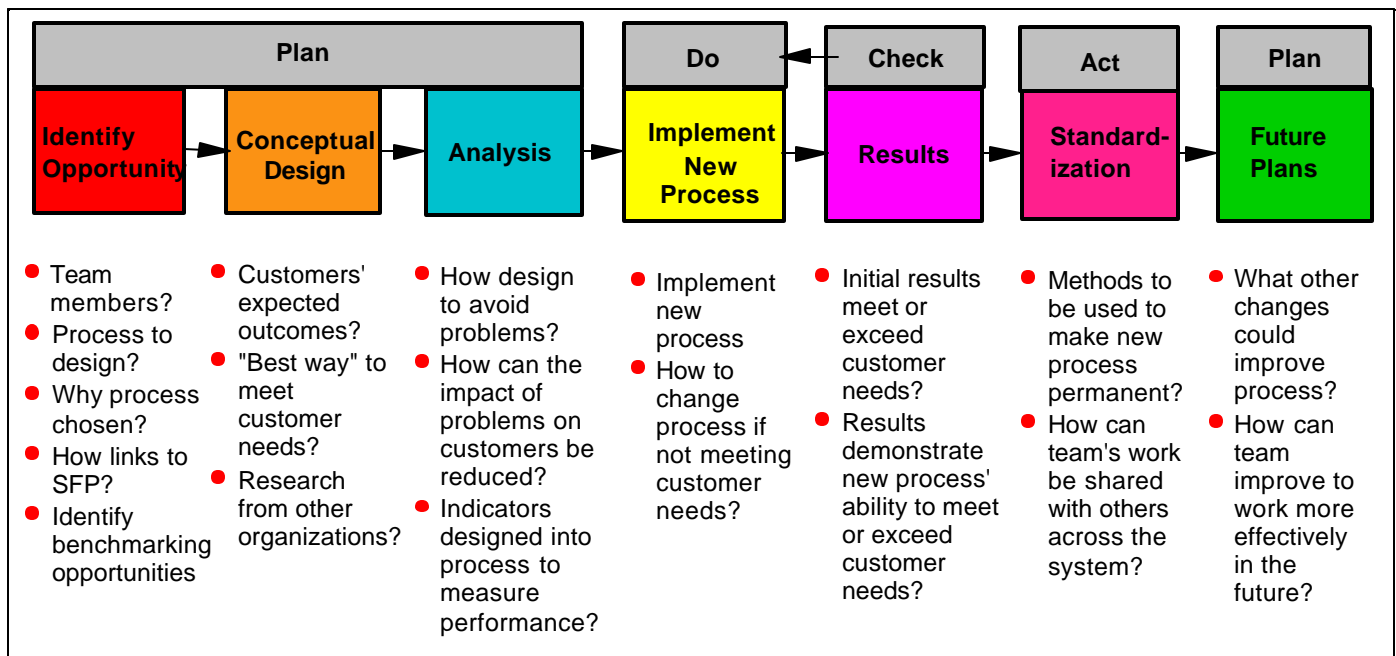


Figure 6.1-1 CQI Model: Process Design Approach

and available technology. Also analyzed are data from a variety of customer listening and learning methods described in Item 3.1. These data are also monitored by network and entity staff on an ongoing basis and by executives at least monthly.

During the Planning phase of the CQI Model, Conceptual Design step, the team addresses the question “What are the customers’ expected outcomes from the process?” to ensure that patient/customer requirements are incorporated into the new or modified service. This is accomplished by reviewing many sources of existing patient/customer feedback data, conducting specialized customer surveys or focus groups, and including customers on the design team. Customer needs are validated during the Check phase.

6.1a(4) Data on emerging medical and information technologies are collected, analyzed, and reviewed as part of the SFPP (Figure 2.1-2). The Information Management Council plan (Item 4.2) focuses on emerging information technologies. The networks and entities incorporate these learnings about new technology into health care service processes through process design teams. The teams do a technology assessment in the Planning phase, Conceptual Design step, to evaluate new technology, including e-technology capabilities, that will best support the ideal process design and achieve customer performance expectations. E-technology is considered for incorporation in any process involving education and communication with patients and the public, results reporting and communication with physicians, and supply chain management. Examples of e-technology applications within SSMHC are Web-enabled physician access to results of diagnostic testing and electronic collection and distribution of clinical quality data through the Quality Report. Technology options for the introduction of a new health care service often exceed \$500K and, therefore, are evaluated at the system level as part of the Capital Allocation Process. This ensures technology resources are aligned to support SSMHC’s strategic objectives.

6.1a(5) The CQI Model has a built-in focus on improving the design process, transfer of team learnings, and such factors as quality, cycle time, cost control, new technology, productivity, and efficiency/effectiveness.

Design teams build into new processes improved health care outcomes, reduced cost, new technology, enhanced productivity, and greater effectiveness through higher quality and reduced cycle time during all steps of the Planning phase. This is done by research and benchmarking, examining SSMHC’s strategic objectives and goals, reviewing customer expectations, establishing appropriate performance measures and goals, doing a cost-benefit analysis, and determining the impact on customers. Team

members evaluate the performance of the process in these areas during the Check phase, Results step, and ensure continued improvement in the Act phase, Standardization step.

Improvement of the design process occurs in the Future Plans step. Each team analyzes its use of the CQI Model and shares this and the team’s other learnings system-wide through methods shown in Figure 1.1-1. This improves future use of the CQI Model and assists SSMHC in evaluating and improving the overall organizational approach to the CQI Model. The CQI Model, introduced in 1990, is evaluated by the QRC staff on an ongoing basis to ensure design quality and timeliness. They provide guidance, oversight and education to teams using the CQI Model. The CQI Model and related education were improved in 1998 to enable teams to design and improve processes more rapidly. A team is currently revising CQI education to focus on ways to use the PDCA CQI Model to further shorten design cycle time and offer a greater variety of learning venues.

6.1a(6) Early in the Planning phase, the team ensures that the process being designed supports SSMHC’s (system/network/entity) strategic objectives. In the third step, Analysis, the team answers the question “What indicators are being designed into the process to measure its performance?” In designing the measurement system for the new process, the team researches key operational performance requirements, including regulatory and accreditation, and expected results.

6.1a(7) Implementation of the new process occurs with completion of an action plan assigning responsibility and goal dates for each step to optimize timely and successful implementation. Completion of an annual Failure Mode and Effects Analysis and incorporation of preventative measures in the process design, as described in 6.1a(5), provide a more error-free process and trouble-free implementation. In complex or critical processes, the recommendations from teams are tested, using pilot projects, for example, for a period of time to ensure the new process is working as designed. This gives customers and stakeholders of the proposed change the opportunity to learn the new process and to suggest modifications to enhance the chance of success. In the Check phase, Results step, the team confirms that the piloted process is meeting or exceeding established performance requirements. For key requirements not met or unintended problems, the team goes back to the Implement New Process step and continues the PDCA cycle, implementing necessary actions to achieve goals. In the Act phase, Standardization step, the team develops implementation and deployment plans. They establish written policies and procedures, guidelines, and orientation systems to ensure

the service or process continues to function as designed on an ongoing basis.

6.1b(1) As a health care delivery system with a variety of entities and care settings, the key or core health care service delivery processes relate to care provided to individual customers whose needs may vary. Despite the diversity in patient diagnoses and treatment needs, the key processes/functions in the delivery of patient care and services are the same at each entity throughout the system. Figure 6.1-2 depicts the four key delivery processes of admission/registration, assessment, care delivery/treatment, and discharge and the their related principal performance requirements.

6.1b(2) Patient expectations feed into the CQI Model (Figure 6.1-1) in Planning phase and are considered in Check phase in evaluating the results of the change in process. SSMHC uses a number of listening and learning tools (Figure 3.1-1) to understand patient expectations.

On a daily basis, during the health care service delivery experience, entities utilize a variety of methods to address patients' expectations and preferences, involve them in decision making, and explain likely outcomes:

- Each patient is informed of likely risks and outcomes to help establish realistic expectations through an informed consent process.
- The patient and family have input into the treatment plan and setting of goals.
- The initial and ongoing patient assessment includes determining patient preferences regarding spiritual, education, nutrition, and pain management needs, as well as needs relating to other aspects of care.
- CARE PATHWAYS, protocols, and guidelines “map” the plan of care based on practice standards for specific diagnoses, procedures, or patient types.
- Case Management coordinates patient care across the continuum of care. Case managers work closely with patients, families, payors, and each other to facilitate the timely delivery of appropriate services.

Process	Key Requirements	Key Measures
Admit		
Admitting/Registration	Timeliness	<ul style="list-style-type: none"> ▪ Time to admit patients to the setting of care ▪ Timeliness in admitting/registration rate on patient sat. survey questions
Assess		
Patient assessment	Timeliness	<ul style="list-style-type: none"> ▪ % of histories & physicals charted within 24 hrs &/or prior to surgery ▪ Pain assessed at appropriate intervals, per hospital policy
Clinical laboratory & radiology services	Accuracy & Timeliness	<ul style="list-style-type: none"> ▪ Quality control results/Repeat rates ▪ Turnaround time (Fig. 7.4-5) ▪ Response rate on Medical Staff satisfaction survey
Care Delivery/Treatment		
Provision of clinical care	Nurse responsiveness Pain management Successful Clinical Outcomes	<ul style="list-style-type: none"> ▪ Response rate on patient satisfaction (Fig. 7.1-9) & medical staff survey questions (Fig. 7.3-8) ▪ Wait time for pain medications ▪ % CHF patients received med instructions/weighing (Fig. 7.1-2a,b,c) ▪ % Ischemic heart patients discharged on proven therapies (Fig. 7.1-3) ▪ Unplanned readmits>Returns to ER or Operating Room (Fig. 7.1-1) ▪ Mortality (Fig. 7.1-5)
Pharmacy /Medication Use	Accuracy	<ul style="list-style-type: none"> ▪ Use of dangerous abbreviations in medication orders (Fig. 7.1-4) ▪ Med error rate or adverse drug events resulting from med errors
Surgical Services/Anesthesia	Professional skill, competence/communication	<ul style="list-style-type: none"> ▪ Clear documentation of informed surgical and anesthesia consent ▪ Perioperative mortality ▪ Surgical site infection rates
Discharge		
Case Management	Appropriate utilization	<ul style="list-style-type: none"> ▪ Average Length of Stay (ALOS) (Fig. 7.4-2) ▪ Payment denials ▪ Unplanned readmits (Fig. 7.1-1)
Discharge from setting of care	Assistance & Clear directions	<ul style="list-style-type: none"> ▪ Discharge instructions documented and provided to patient (Fig. 7.1-11) ▪ Response rate on patient satisfaction survey

Figure 6.1-2 Key Health Care Delivery Processes in the Continuum of Care

6.1b(3) Key patient and applicable accreditation, regulatory and payor requirements are used by teams and departments or services within each entity to establish inprocess operational, quality control, and outcomes measures. Data are systematically collected for use in managing processes by: establishing a baseline when a process is designed, implemented or redesigned; describing process performance or stability; describing the dimensions of performance relevant to the functions, processes or outcomes; identifying areas for improvement; or determining whether designs/ changes in a process have met objectives. Dimensions of performance are evaluated, making changes as necessary to meet customer needs, regulatory requirements or advancing health care technologies.

6.1b(4) Performance assessments (daily, weekly, monthly or quarterly basis) provide an opportunity to review and manage process measures, as appropriate. Performance assessments occur at the department, entity and system level as outlined in Figure 1.1-2. On a day-to-day basis, these same measures enable caregivers to monitor and manage the delivery of patient care. Performance measures for health care service delivery processes are listed in Figure 6.1-2. Many of the department and entity-level measures used to monitor day-to-day operations include inprocess measures, such as computer edit checks, for both detecting and measuring potential errors before they impact the patient.

Real time patient/family and physician partner input is sought through continuous interaction between the patient/family, caregiver staff, and physician throughout the patient needs assessment, care planning and care delivery experience. Input is also obtained through comment cards, patient visits by nursing supervisors and executives, entity complaint processes, and patient and physician participation on CQI teams (Item 3.1).

6.1b(5) SSMHC believes that medical errors occur primarily because of a breakdown in processes. It is vital that design teams minimize errors and rework by implementing processes that prevent errors and problems from occurring. The CQI Model requires that design teams focus in the Planning phase, Analysis step, on designing a process that avoids problems and the need for rework. In 2001, SSMHC introduced a comprehensive systemwide Patient Safety Program, which aims to expand prevention-based processes and approaches. All entities have teams participating in the AES Clinical Collaborative, focused on implementing evidence-based processes to reduce medical errors and improve patient safety. Following are examples of existing patient safety prevention-based processes or mechanisms.

- In the Pharmacy, a computerized process flags duplicate medication therapies, medication allergies, drug

interactions, and high risk drug alerts to minimize adverse drug reactions.

- The Pyxis medication distribution system is interfaced with the Medication Administration Record (MAR) to prevent nurses from removing an incorrect drug, thereby preventing wrong drug errors, the highest risk error to patients.
- Computerized laboratory systems utilize a delta checking system to flag widely varying lab results and potential errors.
- Quality control testing in the laboratory and in Radiology detect potential problems prior to reporting results.
- Individualized patient assessment for falls and implementation of fall prevention practices for the fall-prone patient decreases the likelihood of patient injury.

6.1b(6) SSMHC employs a two-pronged approach to improving health care service delivery processes. One approach is proactive and draws from the creativity of our employees and physicians. It is based on our fifth Quality Principle, "Quality requires continuous improvement." A strong culture of continuous quality improvement, reinforced by our mission to deliver exceptional health care services, empowers SSMHC employees to proactively strive to improve their own work processes, individually or on teams. Suggestions for improvement come from employees who, for example, serve on Employee Councils or who have attended a Sharing Conference or simply see a better way of doing their work. In addition, the CQI Model is designed to uncover new opportunities for improvement as teams in the Future Plans step answer the question: "What other changes could be made to improve the process?"

The second approach responds to a demonstrated need for improvement and draws from various data monitoring processes. SSMHC evaluates health care service delivery systems and processes through the collection and analysis of process performance measures (Figure 6.1-2) and the **Quality Report** and **PIRs** described in Item 1.1 and Item 4.1. An intensive assessment, including a root cause analysis, is promptly initiated when adverse critical events occur or when statistical analysis detects undesirable variation in performance.

When either the proactive or responsive approach indicates that improvements are needed in system, network, or entity processes, teams are created that use the **CQI Model-Process Improvement Approach** to make the appropriate changes. This model is similar to the CQI Model-Process Design Approach, except for a Current Situation step in the Planning phase, which replaces Conceptual Design, and a Proposed Solutions step in the Do phase, which replaces Implement New Process. Transfer of team learning occurs using the same methods listed in Figure 1.1-1.

SSMHC's Clinical Collaborative process is a systemwide improvement approach using our CQI methodology that encourages rapid cycle improvement in clinical processes and the sharing of improvement ideas and results through learning sessions and monthly teleconference calls. For example, the Near Miss Team at St. Joseph Hospital West in Lake St. Louis, MO, participating in a patient safety Clinical Collaborative, developed a reporting process that includes a simple form and recognition of employees who report potential medical errors. The Near Miss reporting process, which led to 43 process improvements at the hospital within one year and no errors reported in any of the improved processes, was shared throughout the system and is one of 15 patient safety practices selected for replication throughout SSMHC within the next two years.

6.2 Business Processes

6.2a(1) SSMHC considers its **Physician Partnering** and **Supply Chain Management processes** to be most important to its business growth and achievement of strategies. Physicians are considered SSMHC's most important partners because they are critical to achieving exceptional health care outcomes and for growth through admissions. In addition, industry research has shown that physician orders account for the single largest usage of hospital resources. Reduction of expenses through control of supply costs, a key SSMHC action plan for 2002, is essential to offset decreasing reimbursement, rising labor costs caused by the shortage of nurses and other skilled health care professionals, and the growth of uninsured/underinsured patients.

6.2a(2) SSMHC's business relationships carry dual requirements. SSMHC's key requirements for these processes are determined primarily through the SFPP and business area planning. Input from customers of the processes is gathered during the internal and external assessment step of the SFPP (Item 2.1). A medical staff survey is the primary method of identifying the key requirements of physicians. Formal contracts and frequent business reviews define supplier requirements. These key business processes, their key requirements, and performance measures are provided in Figure 6.2-1.

6.2a(3) Business processes are designed by teams using the CQI Model.

Physician Partnering Process

The Physician Partnering Process consists of three primary steps:

- Recruitment and appointment to staff
- Integration into the organization
- Full participation as a partner in delivering exceptional health care outcomes

Recruitment. Before recruiting physicians, SSMHC's entities first identify their future needs for medical staff using the minimum data set within the annual SFPP and then develop a physician recruitment and retention plan. During the recruiting process, the entities seek to attract physicians who meet the entities' service line needs and are qualified to provide exceptional health care. All physicians undergo a rigorous application and appointment process, defined in the Medical Staff Bylaws, Rules and Regulations, that determines whether or not they are granted clinical privileges. To attract highly skilled physicians, SSMHC leverages its reputation for physician partnering and willingness to provide state-of-the-art clinical technology and information systems, updated facilities, and skilled and responsive staff that physicians require in order to give exceptional patient care. Physician liaisons on the entity staffs assist with physician recruitment and maintain ongoing contact with physicians to ensure that their requirements and needs are met.

Integration. SSMHC integrates physicians into the organization and its key processes through orientations, strategic communications (Figure 1.1-1), and the Medical Leadership Enrichment Program, and other education and development opportunities. Following are examples of key processes and programs in which physicians participate:

- Leadership System
- Leadership Development Process
- Regional Boards
- Strategic & Financial Planning Process & Governance Planning Retreat
- Ministry Effectiveness Analysis (MEA)
- Performance Improvement Process
- Development of mission & values
- Corporate Responsibility Process (CRP)
- Enterprise Resource Planning (ERP) process
- User groups giving input on supplies and technology purchases
- Physician Leadership Conference

Partner in Delivering Exceptional Health Care

Outcomes. Physicians have a key role within SSMHC in clinical improvement at the system, network and entity levels. In 1998, SSMHC began its own series of Clinical Collaboratives based on the National Institute for Healthcare Improvement (IHI) Breakthrough Series. These collaboratives are designed to make rapid improvements in clinical areas that result in better outcomes for patients and improved value and patient safety, while satisfying external agency regulatory requirements. Physicians work together with other caregivers, administrators, and staff, often as a team leader. SSMHC currently has four Clinical Collaboratives under way involving more than 75 improvement teams. Topics are secondary prevention of ischemic

heart disease, prescribing practices, patient safety, and congestive heart failure.

Since 1990, when CQI was first introduced systemwide, physicians have attended CQI courses and participated on teams to design and redesign health care delivery processes. Physicians receive just-in-time training before participating on teams or collaboratives. Physicians also participate in case management and in developing CARE PATHWAYS and protocols.

A medical staff reappointment process is used to ensure that physicians remain competent within their specialties to deliver high quality care. An ongoing peer review process ensures that physicians are performing to meet SSMHC's quality standards.

Supply Chain Management Process

SSMHC's materials management process is designed to achieve economies of scale and reduced prices by consolidating purchasing and contracting with preferred suppliers and partners. This supplier partnership enables SSMHC and its suppliers to align their strategic goals.

SSMHC is an owner and participating member of Premier, one of the two largest group purchasing organizations in the nation serving health care. Through this relationship, the system derives a significant economic benefit--6 to 15 percent savings over prevailing market prices.

SSMHC has chosen the following distribution partners: Cardinal Health (pharmacy & pharmacy automation); Allegiance, Burrows, Owen & Minors (regional medical/surgical); Alliant (food service); and Diagnostic Imaging (radiology).

6.2a(4) Key performance measures/indicators, including inprocess measures, monitored to manage the two key business processes are listed in Figure 6.2-1. Each medical staff member is required to reapply every two years, and data from peer review is considered in the recertification process. SSM Materials Management sets goals to support the system's strategic initiatives in an annual planning process. Systemwide user groups composed primarily of department directors have been

Key Business Process	Key Requirements	Key Measures
Physician Partnering		
Recruitment	Business Growth /Patient Referrals (SSM Requirement)	<ul style="list-style-type: none"> ▪ # Total Physicians on Staff ▪ #Pt. Referrals/Physician (Admits/physician) ▪ Admissions Growth (Figs. 7.2-9, 7.2-10, 7.2-11)
Medical Staff Integration & Partner in Health Care Delivery	Exceptional Patient Care/Outcomes (Shared Requirement)	<ul style="list-style-type: none"> ▪ # physicians in Clinical Collaboratives (Fig. 7.3-11) ▪ Clinical Outcome Results
	Resource Mgmt/ Mgmt of care delivery processes (SSM Requirement)	<ul style="list-style-type: none"> ▪ % Pathway use ▪ Supply & Total Expense Per AEA ▪ Aver. Length of Stay (ALOS) Reduction (Fig. 7.4-2)
	Exceptional Nursing: Responsiveness & Reduced Turnover (MD Requirement)	<ul style="list-style-type: none"> ▪ Nurse Turnover Rate (Fig. 7.3-3) ▪ Nurse responsiveness rate on satisfaction survey (Fig. 7.1-9) ▪ # Agency Hours ▪ Satisfaction w/Nursing Care rate on MD survey ▪ Overall Physician Satisfaction (Fig. 7.3-8)
	Administrative Responsiveness & Facility Improvements (MD Requirement)	<ul style="list-style-type: none"> ▪ Capital \$ Spent (Fig. 7.2-2) ▪ # Equipment Upgrades ▪ Satisfaction with Admin, facility & equipment rate on MD survey (Fig. 7.3-9b)
Supply Chain Management		
Distribution Management	Timely Inventory Availability	<ul style="list-style-type: none"> ▪ Fill Rate (Fig. 7.4-7) ▪ Zack – turn around time for EDI (PO to EDI vendor) ▪ Acknowledgement cycle (timeliness)
	Invoicing Accuracy	<ul style="list-style-type: none"> ▪ SAP Goods Receipt /Invoice Receipt Accuracy (GR/IR) ▪ Days Sales Outstanding (DSO) (Cash Flow) (Fig. 7.4-10)
	Cost Savings/Sales	<ul style="list-style-type: none"> ▪ Sales /Cost Savings (Fig. 7.4-9)

Figure 6.2-1 Key Business Processes, Requirements & Measures

formed to provide customer input on supply needs; consensus on preferred products; and clinical acceptability. Disciplines represented in key user groups include radiology, lab, dietary, operating room, and pharmacy.

The Supply Chain Management Processes is managed through a multilevel materials management organization that coordinates systemwide purchasing and maintains effective ongoing communication with internal customers as well as suppliers. Each SSMHC entity or network has a designated materials management office and staff. SSMHC's materials managers meet every two weeks by video/teleconferencing as a committee to brainstorm new ideas, discuss strategy, review contract offerings, participate in supplier presentations, discuss distribution issues, and review supplier performance. The meetings offer a collaborative process for supply chain discussions and decision making, ensuring a consistent approach and deployment of supplies throughout the system.

SSMHC has formal corporate agreements that define the partnerships with Cardinal Health, Burrows/Owen & Minors, Alliant, Fischer, and Diagnostic Imaging. These organizations represent the major sources of supplies. They have agreed to collaborate with SSMHC to develop innovative methods of enhancing the quality and cost-effectiveness of patient care services; to improve patient outcomes and satisfaction; and to enhance the financial success of both. Within Cardinal Health, the umbrella agreement covers the Cardinal Distribution, Pyxis, and Allegiance units. The contact persons meet quarterly with SSMHC to conduct formal business reviews and planning sessions. The purpose of these sessions is to review performance; discuss reciprocal goals, requests, and unresolved issues; and identify and present future business opportunities.

6.2a(5) The networks and entities have minimized costs and increased efficiency in the Physician Partnering process through a retention strategy based on integrating physicians into the organization and satisfying their requirements. In the Supply Chain Management Process, user groups give management support for standardization and product deployment, which controls consistency of the process. By standardizing and consolidating distribution, the system realizes the benefits of delivery according to user needs, including just in time, vendor managed inventory and, often, on consignment.

6.2a(6) Leaders at the system, network or entity level evaluate the Physician Partnering and Supply Chain Management processes by monitoring the PIR results and feedback from the patient, physician, employee and payor surveys and other listening and learning methods.

Premier provides SSMHC with an annual scorecard detailing its performance and comparing SSMHC's purchasing efforts against its peers within the group purchasing organization. A scorecard was developed in 2000 and 2001 by Cardinal and SSMHC with input from the system's internal customers to measure the performance of Cardinal Distribution, Pyxis, and Allegiance and SSMHC. Scorecards for each Cardinal unit are reviewed at each quarterly business review and planning session. SSMHC has extended the scorecards in 2002 to the other key suppliers. User group input is also considered in evaluating supplier performance.

When corrective actions are indicated by the PIRs, scorecards, or customer/partner input, SSMHC's leaders commission teams to improve the processes. The teams use the CQI Model: Process Improvement Approach. In the Act phase, teams consider how to best share their improvements across the system. Key communication methods are listed in Figure 1.1-1.

6.3 Support Processes

6.3a(1-2) SSMHC's key processes supporting daily operations and staff in the delivery of care and their customer and operational requirements are listed in Figure 6.3-1. When designing or improving key support processes SSMHC teams determine key requirements of internal and external customers in the Planning phase, Identify Opportunity step, of the CQI Model. Requirements may also derive from the SFPP and are determined through internal customer surveys, patient and physician satisfaction surveys, regulatory or accreditation requirements, and operational and financial requirements.

6.3a(3) Because SSMHC understands that the effective functioning of support processes is critical to the effective delivery of health care services processes, key support processes are designed using the CQI Model: Process Design Approach. The design team ensures that the process supports SSMHC's strategic initiatives early in the Planning phase. It next determines customer requirements and benchmarks within SSMHC or outside, if appropriate. In the Analysis step, the team designs a measurement system to track fulfillment of key customer requirements. Inprocess measures are included to facilitate rapid identification and correction of potential problems.

6.3a(4-5) Performance measures include both outcome and inprocess measures that are used by process owners to manage day-to-day process performance and to assess results. Performance measures used to determine if support processes meet the key customer and operational requirements are listed in Figure 6.3-1. Internal customer feedback from daily interactions and employee

satisfaction survey results are also used by process owners to manage and improve support processes.

Benchmarking data and employee suggestions are other activators for improving support services.

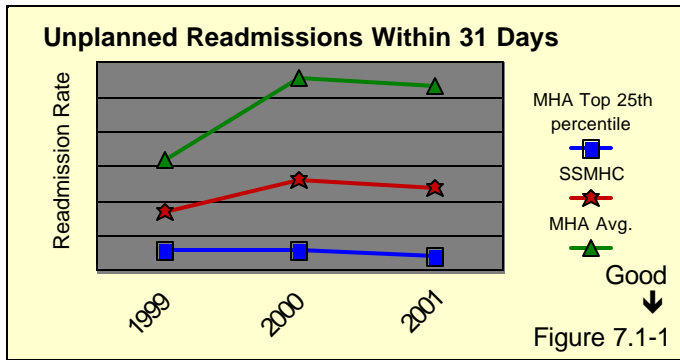
6.3a(6) Prevention-based methods are used within SSMHC to minimize costs associated with inspections, errors and rework in key support processes. Methods include computerized edit and validation checks for billing, accounting, and human resources; extensive preventive maintenance for clinical equipment; and proactive safety programs.

When an opportunity for improvement is identified in the performance of a key support process, entities use the CQI Model Process Improvement Approach (Figure 6.1-1). Results are shared with staff, through storyboards and entity/system newsletters and are also communicated through the transfer of learning methods depicted in Figure 1.1-1.

6.3a(7) SSMHC evaluates and improves support processes in a proactive way as a result of its CQI culture and supporting tools and in response to performance measurement data or to keep current with changing organizational or industry needs. The PIRs contain established thresholds for performance for 16 indicators at the system, network and entity level. At the department level, in-process measures are monitored based on established performance thresholds. A negative variance from these thresholds activates the formation of teams and corrective action plans to make process redesign/improvements.

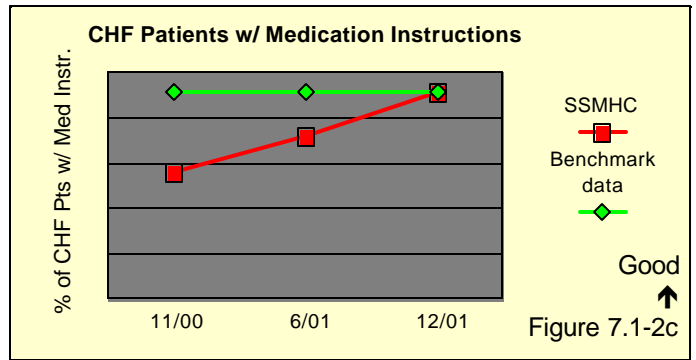
Support Process	Key Customer & Operational Requirements	Key Measures
Finance		
Finance/Patient Accts/Collections	Exceptional financial performance Accurate billing Timeliness of billing/cash flow	<ul style="list-style-type: none"> ▪ Revenue & Expense/APD (Fig. 7.2-4) ▪ Admissions (Figs. 7.2-9 to 7.2-11) ▪ Operating margin % (Fig. 7.2-3) ▪ Bad debts % ▪ Insurance cash collections (Fig. 7.4-15) ▪ Suspense days (days to billing) ▪ Net days accounts receivable (Fig. 7.4-16)
Human Resources		
Human Resources	Recruitment and retention Employee Satisfaction	<ul style="list-style-type: none"> ▪ % separated employees w/exit interview ▪ Results of internal customer manager surveys/manager training hours ▪ Turnover (Fig. 7.3-3) ▪ Employee Satisfaction (Fig. 7.3-1)
Facilities Management		
Housekeeping	Facility cleanliness	<ul style="list-style-type: none"> ▪ Results of Quality inspection rounds ▪ Response rate to satisfaction surveys
Maintenance /Clinical Engineering Services	Appropriate physical condition & proactive maintenance	<ul style="list-style-type: none"> ▪ % of preventive maintenance (PM) completed within established time frame ▪ Response rate to satisfaction surveys ▪ Deficiencies from state health department or JCAHO (Fig. 7.4-17)
Information Systems Management		
Information Systems	Timeliness, Efficiency of information	<ul style="list-style-type: none"> ▪ Issue Resolution Time ▪ User satisfaction scores (Fig. 7.4-13)
HIM (medical records)	Timely & accurate medical record completion	<ul style="list-style-type: none"> ▪ Transcription turnaround time & error rate ▪ Medical record delinquency rate ▪ Response rate on medical staff surveys
Figure 6.3-1 Key Support Processes, Requirements, & Measures		

CATEGORY 7 - ORGANIZATIONAL PERFORMANCE RESULTS

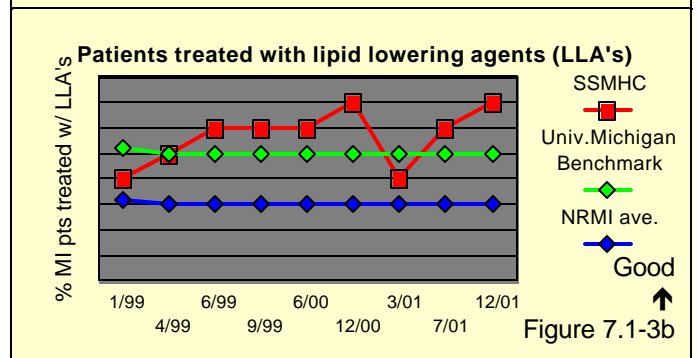
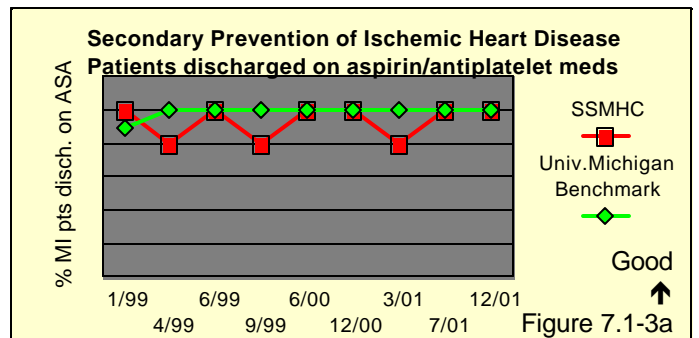
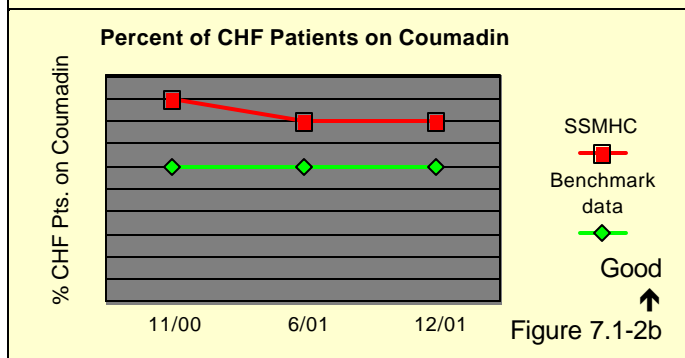
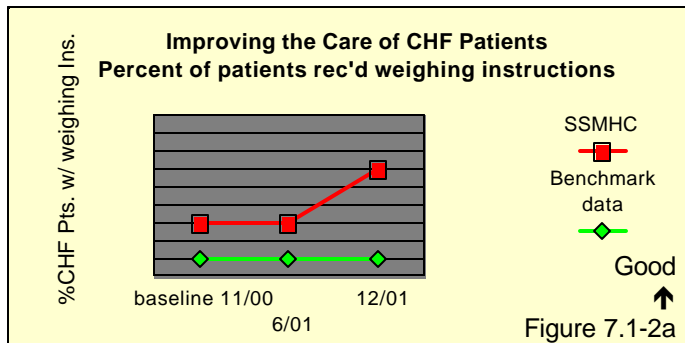


7.1 Patient and Other Customer-Focused Results

7.1-1 Unplanned readmissions within 31 days is a system level indicator for health care outcomes. Review of this indicator helps SSMHC prioritize process improvement opportunities in order to address the drivers of readmissions and variations in care delivery. A systemwide team is working to identify best practices by standardizing data collection and assisting entities in implementing improvements. Causal factors contributing to readmissions can be DRG-specific (patients that have illnesses which are likely to recur, such as congestive heart failure (CHF) and ischemic heart disease), as well as process-specific (i.e., consistent discharge instructions to improve post-discharge compliance).

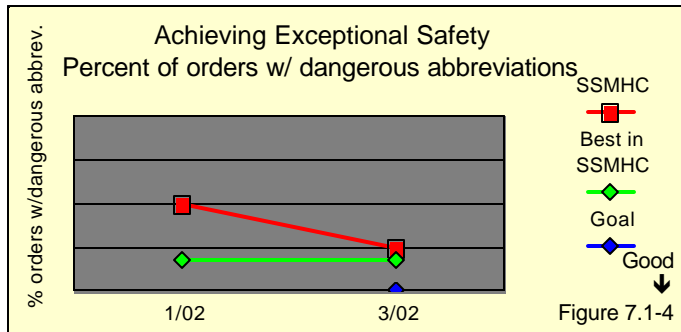


7.1-2 CHF is a primary driver of SSMHC readmissions. SSMHC launched a Clinical Collaborative for CHF patient care in November, 2000 to enable patients to benefit from the best evidenced-based interventions possible. SSMHC hospitals are performing at or above national benchmarks based on studies published by the American Heart Journal, The Journal of the American Medical Association, and The Quality Management and Health Care Journal. Research has shown that behavioral drivers (such as weighing and/or medication instructions) and therapy-based drivers (such as Coumadin use) are primary factors that contribute to unplanned readmissions. SSMHC's efforts to focus on these drivers of readmission will contribute to reducing unplanned readmissions. Participating physicians and employees recognize that these collaborative efforts are a unique benefit of being part of SSM Health Care.

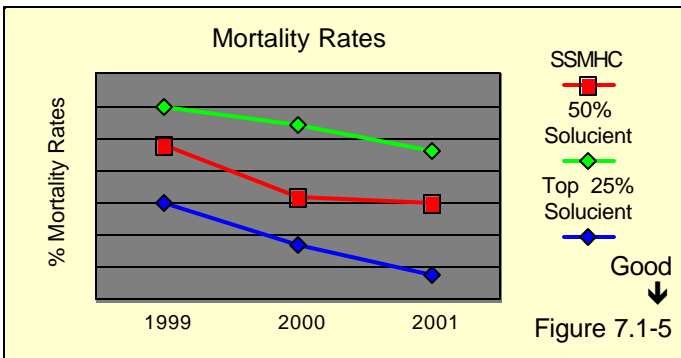


7.1-3 SSMHC launched another Clinical Collaborative to reduce the incidence of secondary ischemic heart disease (likelihood of a second heart attack). National studies have shown that daily aspirin use, lipid lowering agents (LLA's) and other therapies reduce the incidence of second heart

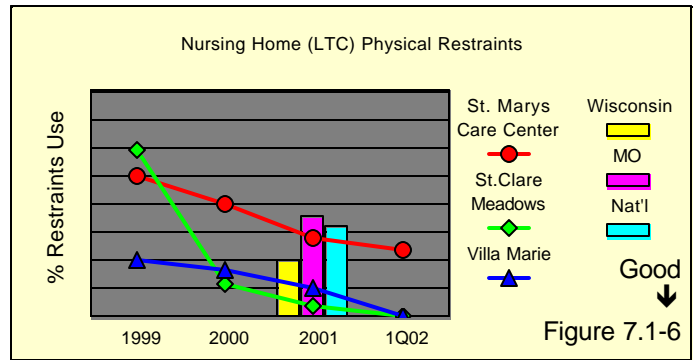
attacks and the development of CHF. SSMHC's Clinical Collaborative to reduce the incidence of second heart attacks promotes the increasing use of proven therapies. SSMHC's process improvements have resulted in reduced variation through the application of evidence-based treatment protocols. Based on benchmark studies by the University of Michigan and the National Registry for Myocardial Infarctions, SSMHC entities are performing at or above national benchmark levels.



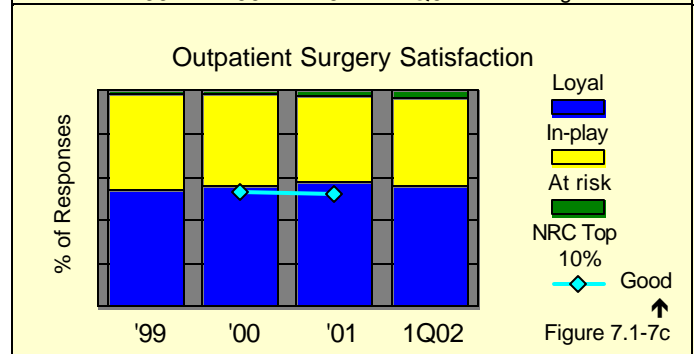
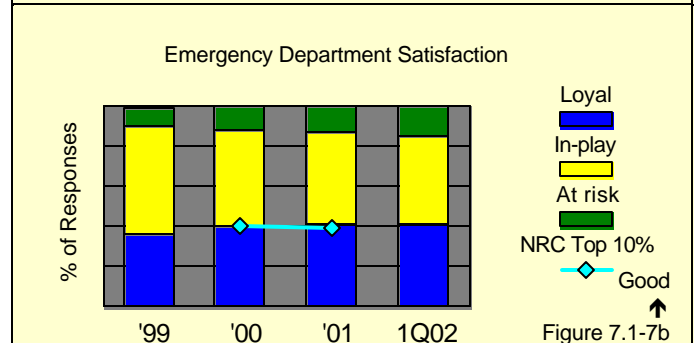
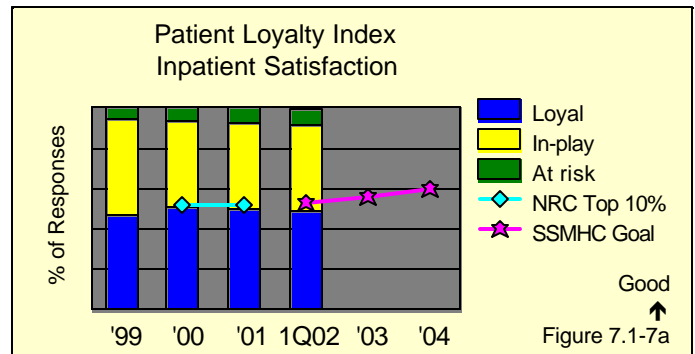
7.1-4 Patient safety is a primary focus of SSMHC's improvement activity. A three-year Clinical Collaborative is under way, titled Achieving Exceptional Safety in Health Care, to address this issue. This collaborative is designed to have all SSMHC entities adopt and implement 16 safety practices that are recommended by national safety authorities. The collaborative started in January, 2002 with an initial focus to eliminate dangerous abbreviations used in prescribing medications. A review of the medical literature failed to identify appropriate benchmark data, so we are comparing ourselves to best practices internally.

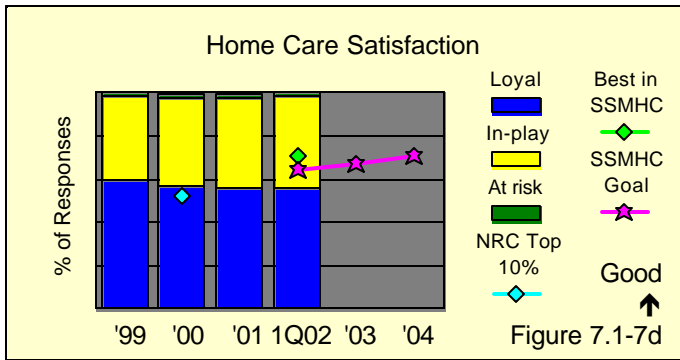


7.1-5 Mortality rate is an overall indicator of quality of care and services provided and can be stratified to adjust for severity of illness and to identify select groups of patients for improvement opportunities. SSMHC tracks its overall mortality rate compared to Solucient's top 25th quartile to assess performance on a relative basis and to prioritize improvement initiatives. The overall goal is 0% mortality, and we continue to make progress toward this goal. SSMHC intends to continue its emphasis on Clinical Collaborations, concentrating on high risk and/or high volume disease states, to reduce variation and increase the use of proven therapies to ultimately impact mortality.



7.1-6 Prevalence of physical restraints is a systemwide indicator of patient safety and preservation of patient dignity. There are times when the use of physical restraints is necessary to protect the patient from harming themselves or others. To reduce the use of restraints, SSMHC has commissioned CQI teams to ensure appropriateness of restraint use and has adopted restraint use protocols which outline progressive alternatives to restraint use. As a result, use of restraints has significantly declined from 1999-1Q2002.





7.1-7 The systemwide patient satisfaction and loyalty survey process provides in-depth insight into the needs and requirements of SSMHC's patients. Loyalty is a key measure for SSMHC because it indicates a patient's willingness to recommend our services. Inpatient loyalty is a system level indicator of exceptional patient satisfaction.

A word-of-mouth referral from a friend or neighbor is a key factor in a person's selection of a health care provider. Loyalty is calculated monthly from patient satisfaction survey responses for inpatients, emergency department patients, outpatient surgery patients, and home care patients. Long term care (nursing home) satisfaction is assessed annually. The loyalty indices are calculated from key summary questions in the surveys addressing the respondents' overall satisfaction, willingness to recommend to others, and overall performance relative to their expectations. Respondents are placed into one of three categories, "loyal", "in-play", and "at risk". SSMHC uses impact analysis to engage in process improvements to increase "loyal" and decrease "at risk" and "inplay" respondents.

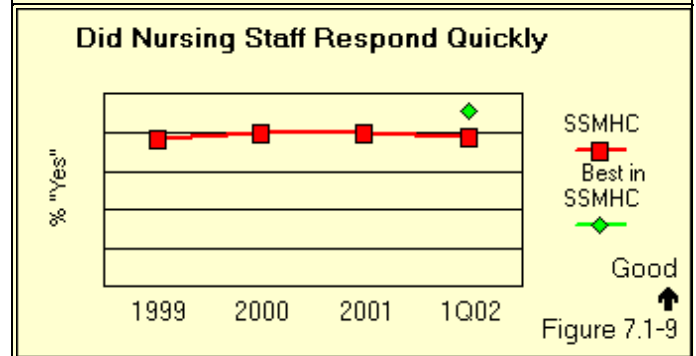
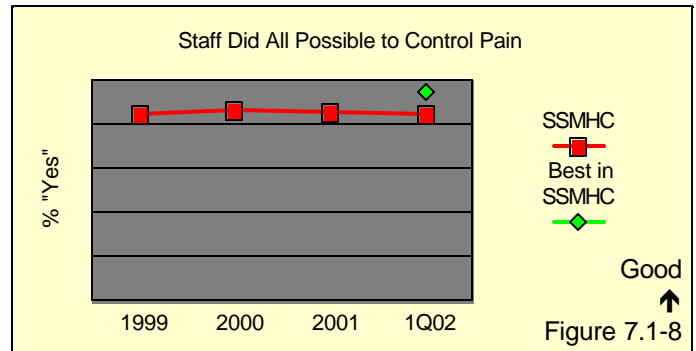
Loyal - Respondents who are very highly satisfied, very willing to recommend, and found the service to be more than they expected.

In-play - Respondents give inconsistent ratings--neither high or low--to the summary questions.

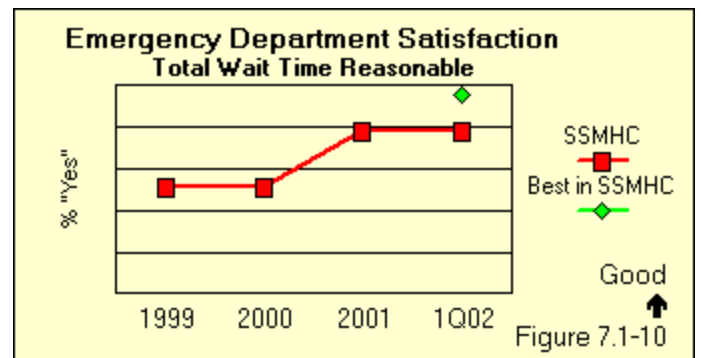
At-risk - Respondents who were dissatisfied, not willing to recommend, and found the service to be less than expected.

National benchmarks for patient loyalty are taken from the NRC *Health Care Market Guide*. SSMHC uses the scores of hospitals performing in NRC's top 10% (best in class).

SSMHC inpatient loyalty increased from 47.5% in 1999 to 50.0% in 2001, nearing NRC's top 10% national benchmark of 51.6%. In 2000 and 2001, SSMHC ranked above the national benchmarks for patient loyalty in emergency department services, outpatient surgery, and home care.

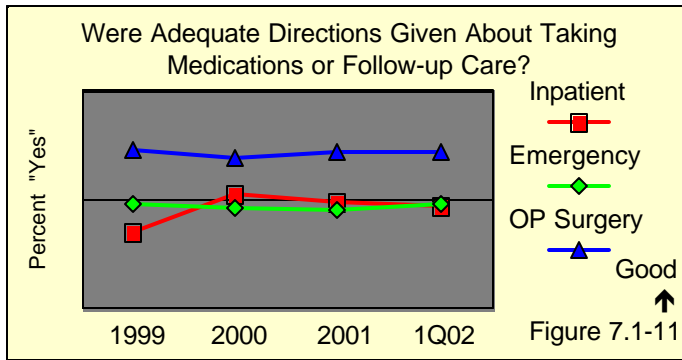


7.1-8 & 7.1-9 Pain management and nurse responsiveness are two key customer requirements for SSMHC patients in the inpatient care setting. Research supports the correlation of these key patient requirements with patient loyalty. Data from patient satisfaction surveys show high levels of patient satisfaction with pain management and nurse responsiveness for SSMHC. The SSMHC internal benchmark (highest scoring hospital in 2002) is 97.3% for Pain and 95.9% for Responsiveness.



7.1-10 First quarter 2001 Emergency Department (ED) Satisfaction results are the highest to date. The increase is a result of entity-specific focus on the key patient requirements of responsiveness and wait times. For example, two hospitals in the St. Louis region introduced a guarantee that all patients, regardless of the severity of their illness or injury, will be seen by a physician within 30 minutes of their arrival in the ED. This 30-minute guarantee has resulted in consistent improvement in patient satisfaction at the entity and system level. SSMHC's internal benchmark (highest scoring hospital in 2002) is 97.9%. Our 2003 goal is to replicate these

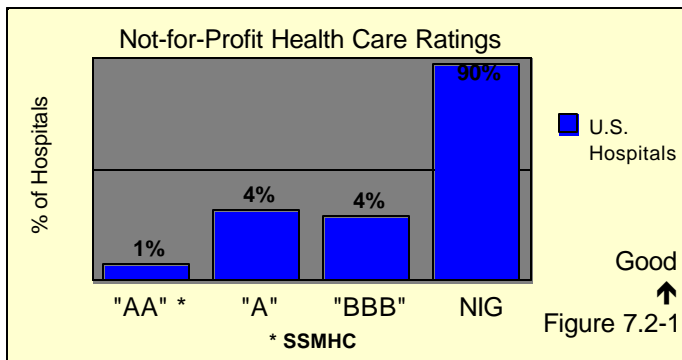
improvement efforts systemwide through best practice sharing and required benchmarking.



7.1-11 Good communication is another key patient requirement. Inpatients, emergency, and outpatient surgery patients are asked this question on the satisfaction survey. This indicator demonstrates SSMHC's ability to maintain good hospital-based communication and patient education across all patient segments. The SSMHC internal comparisons (highest scoring hospitals in 2002) average 99% for inpatient, 100% for the emergency department, and 100% for outpatient surgery. Communication is also assessed for home care and long term care patients using questions specific to the needs of these patient groups.

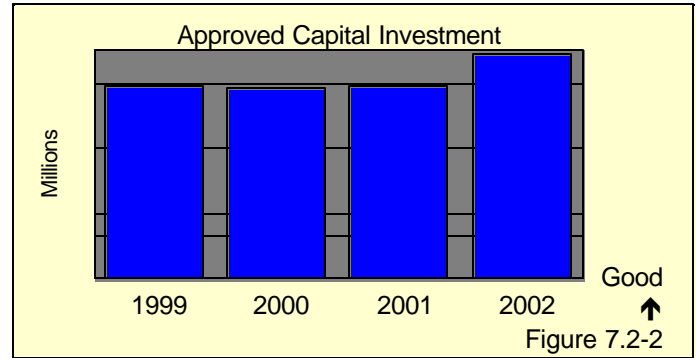
7.2 Financial and Market Results

As a result of its commitment to CQI, SSMHC was one of only a small number of health care systems across the country to be able to report a substantial financial improvement, enabling the system to pursue continued investment and growth opportunities.

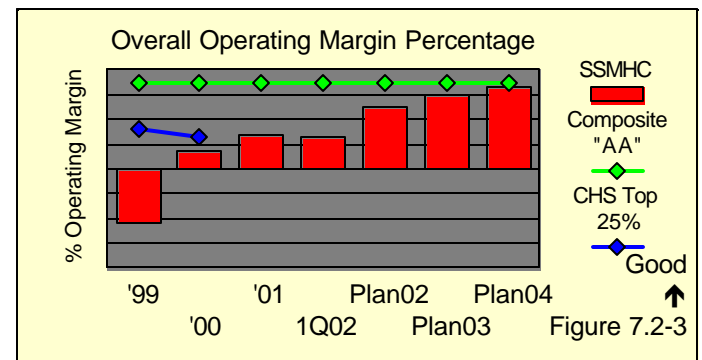


7.2-1 For the fourth consecutive year, two of the major national credit rating agencies have placed SSMHC in the "AA" credit rating category. The "AA" category is the highest rating given to health care providers. Less than 2 percent of all U.S. hospitals and only 13% of those rated by S&P carry this exceptional rating. The rest are considered non-investment grade (NIG). SSMHC was rated by both Fitch IBCA and Standard and Poor's in early 2001 and has maintained its high rating in 2002. This strong positioning

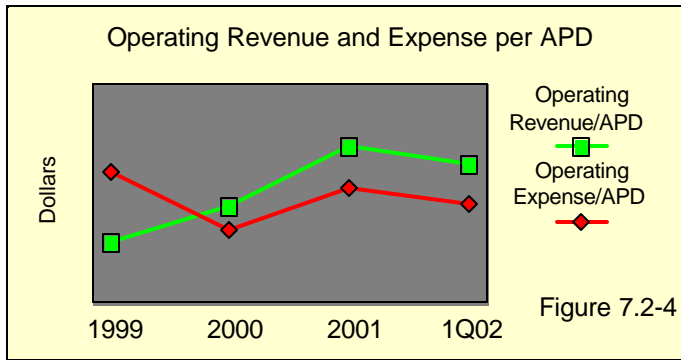
has facilitated investing in facilities through access to inexpensive debt financing.



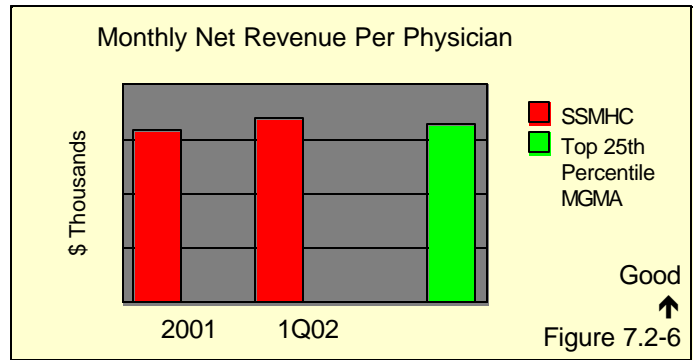
7.2-2 SSMHC's core business is hospitals. In the last four years, SSMHC has approved increasing capital investments in its institutions, facilities and services. SSMHC approved to spend \$173 million in 2002 on several large capital projects to support the system's strategic initiatives. This includes improvements to add capacity for the provision of product/service line enhancements in cardiology in Oklahoma and Illinois and expanded medical and intensive care in Wisconsin and St. Louis.



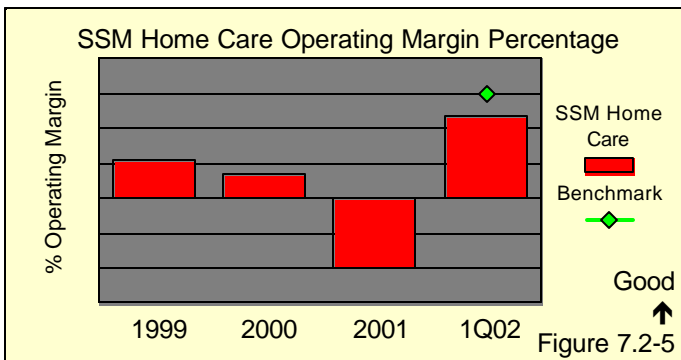
7.2-3 Operating margin for SSMHC, its nursing homes and home care are system level indicators. SSMHC used its MEA process in a multi-year turnaround plan between 1999-2001 that resulted in a \$56 million dollar improvement. The MEA process uncovered strategic and operational improvements necessary to address performance shortfalls in 1999 resulting from capitated managed care arrangements, high physician practice acquisition & operational costs, and declining reimbursement from Medicare. SSMHC process improvements led to improved volume, decreased physician practice losses, enhanced reimbursement, and improved operational efficiencies.



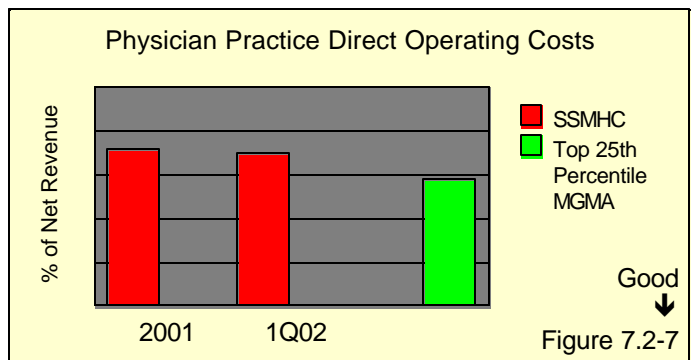
7.2-4 Revenue and expense per adjusted patient day (APD) is an indicator of patient service volume and is a predictor of operating margin. As a result of CQI and process improvements related to revenue enhancement and expense reduction, SSMHC began exiting unprofitable insurance contracts and renegotiating with key payors. In addition, SSMHC's public advocacy efforts influenced an increase in Medicare reimbursement (BIPA). These initiatives led to the overall improvement in revenue per patient day in 2000 and 2001. Labor-related expenses represent over 50% of our operating costs and compensation has increased 4% to 6% annually for many years. Despite this financial pressure, SSMHC has effectively managed the revenue/cost implications of providing health care to its patients.



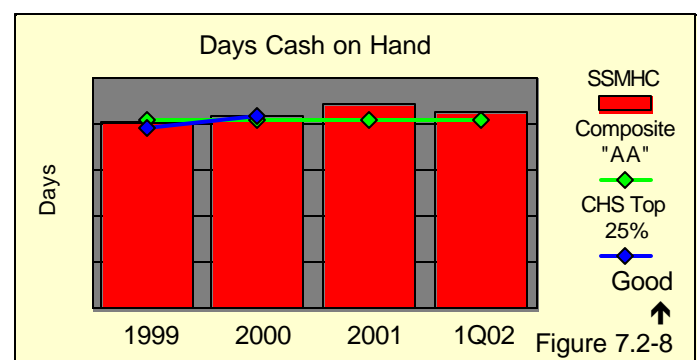
7.2-6 Net revenue per physician is a system level productivity indicator. SSMHC works in partnership with its physicians to effectively deliver health care services. As such, it has restructured many of its physician compensation agreements to be productivity based, and has assisted physicians in increasing net revenue and reducing expenses at the practice level through accounts receivable improvements resulting from billing cycle time enhancements.



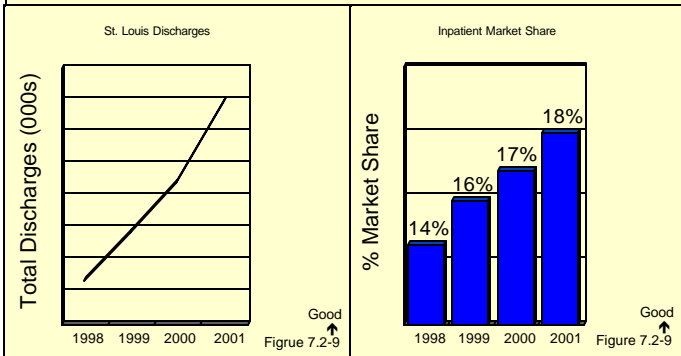
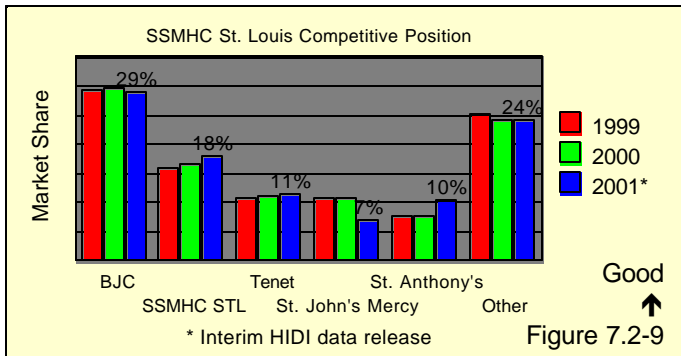
7.2-5 The home care industry has gone through tremendous consolidation and reimbursement changes in the last few years. In addition to changes in the industry, SSM Home Care underwent a change from decentralized, hospital-owned agencies to a centrally managed structure. SSM Home Care also changed clinical and patient financial information systems during this same time period and recorded significant accounts receivable reserve adjustments during the latter part of 2001. Operational issues which led to this adjustment have been corrected and SSM Home Care has returned to a strong financial position through the 1st quarter of 2002.



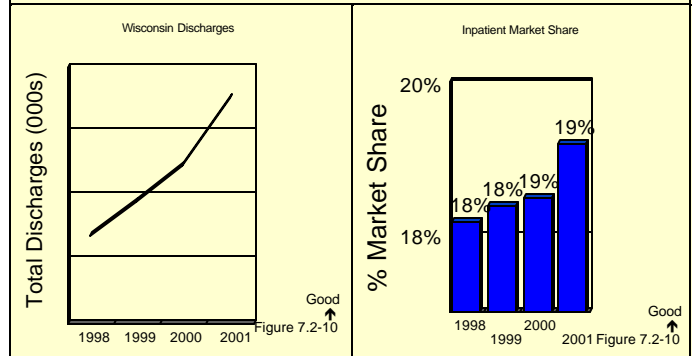
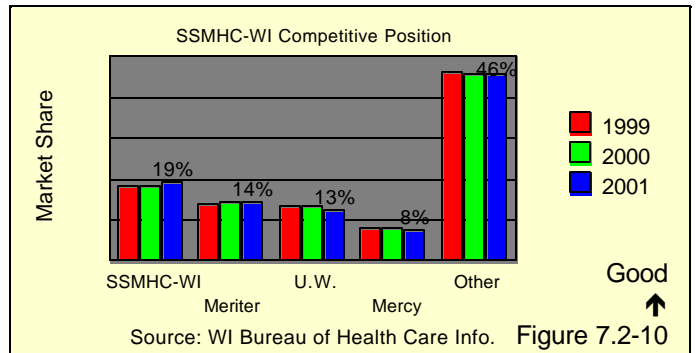
7.2-7 Physician practice direct operating costs as a percent of net revenue is a system level efficiency indicator. SSMHC assists its employed physicians with practice management strategies to reduce direct operating costs to improve efficiency. Initiatives include restructured group purchasing arrangements to reduce supply costs and consolidation of physician practice locations to reduce overhead expenses. SSMHC's performance stretch goal is to reach the top 25th percentile of MGMA, which is currently at 58.6%.



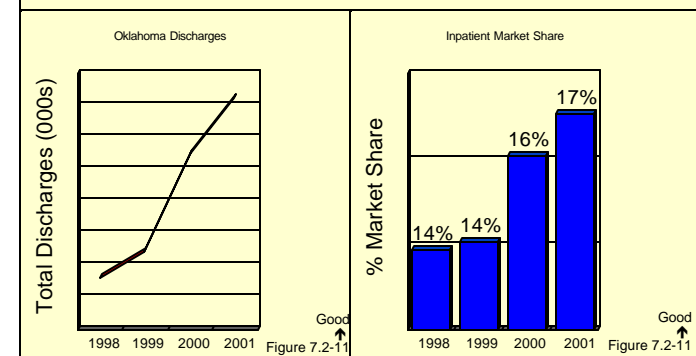
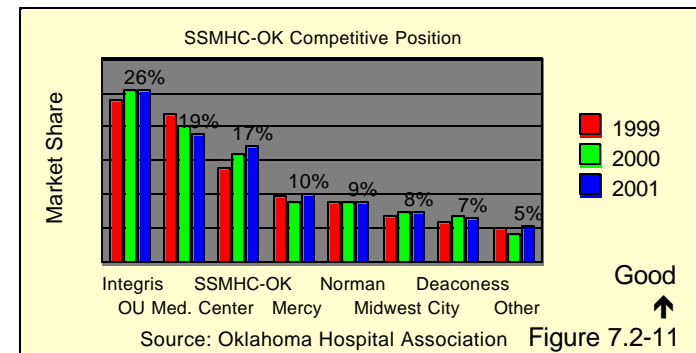
7.2-8 SSMHC has maintained an average of 211 days cash on hand while increasing capital spending throughout the system. The reliance on government payors greatly reduces SSMHC's ability to effectively manage the timing of payments. The reduction of 9 days in accounts receivable in 2001 represents \$36 million in additional cash on hand. Not-for-profit health care providers are dependent upon their own financial outcomes to fund their capital needs since the stock markets are unavailable to them. SSMHC is the industry benchmark for AA-rated health systems.



7.2-9 SSMHC-St. Louis is the fastest growing network in St. Louis, with a market share of 18%. Discharges jumped 13% in 2001 which also marked the fourth consecutive year of growth for the network. These results are largely attributable to the effective use of Physician Partnering, resulting in an increase in total discharges.



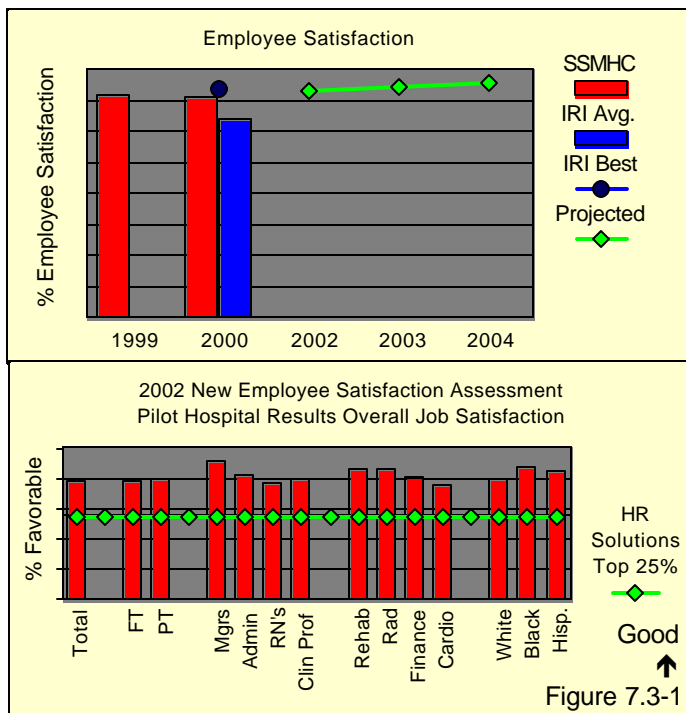
7.2-10 SSMHC-WI has the top market share in its 15-county service area due to growth in discharges for the fourth straight year. Market share in 2001 was 19.2%, up from 18.5%. In its primary service area of Dane County, St. Marys has a 35.5% market share. In Sauk County, St. Clare's primary service area, the hospital has a 50.0% market share. SSMHC-WI is well-positioned to continue as the market leader. The network's successful physician partnerships are clearly demonstrated by a strong physician and rural hospital referral network.



7.2-11 SSMHC of Oklahoma's successful use of the Physician Partnership Process has facilitated St. Anthony's recruitment of oncologists and orthopedic surgeons from competitors. In addition, sustained implementation of SFPP growth initiatives and restructuring of key contracts have resulted in 4 straight years of increasing discharges leading to market share growth.

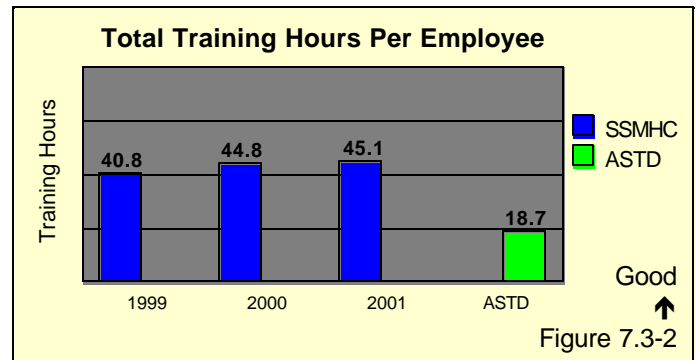
7.3 Staff and Work System Results

Employee satisfaction is a system level indicator. SSMHC strives to be the employer of choice to ensure employee satisfaction and well-being and is one of only 49 hospitals across the country to be named by AHA as an exemplary employer. SSMHC has analyzed the drivers to employee satisfaction and the data indicate that the work itself, teamwork, the role of managers, opportunities for advancement/growth and work-life balance are primary factors contributing to employee satisfaction. The ability to segment the employee data and stratify by function, department or national origin allows us the flexibility to provide more in-depth analysis to identify improvements needed in any of these critical drivers of satisfaction and dissatisfaction.

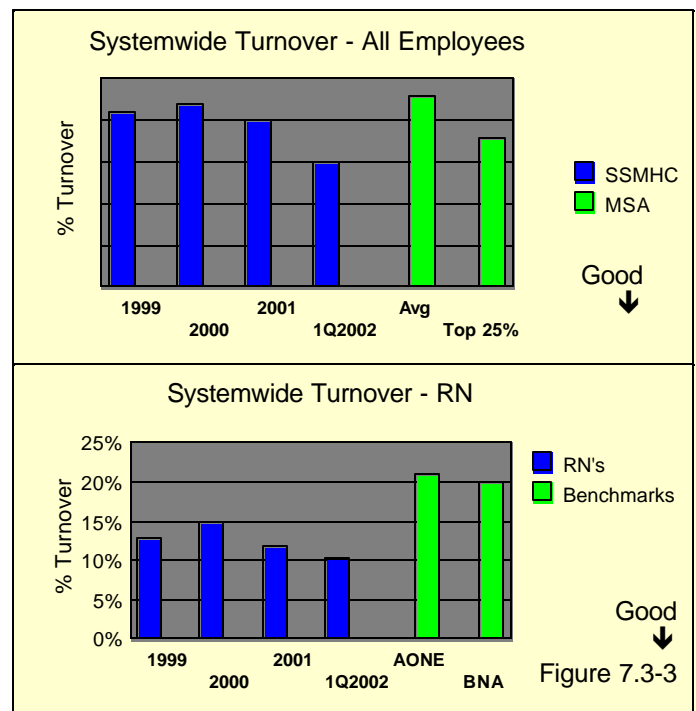


7.3-1 Employee satisfaction is extremely important in recruitment and retention efforts. Systemwide focus groups, since 1997, have provided feedback to prompt changes in areas such as employee benefits. In 2000 the total average system score was 71%, comparing favorably to the IRI average of 64% and best in class at 74%. Focus groups were done every 18 months with interim progress evaluations to assess the effectiveness of the action plans generated from the focus group information. SSMHC

recognized the importance of stratification of data and the ability to review data by employee populations, thus prompting a change away from the focus groups to a written survey with a new surveying vendor in 2001. Due to the vendor change, pilot results are shown for one hospital; entire system results are expected in summer of 2002. Results can be stratified by function, department, ethnicity, tenure, gender and employee classification. SSMHC goal for 2004 at 75.8% is well above the 69% national normative data.

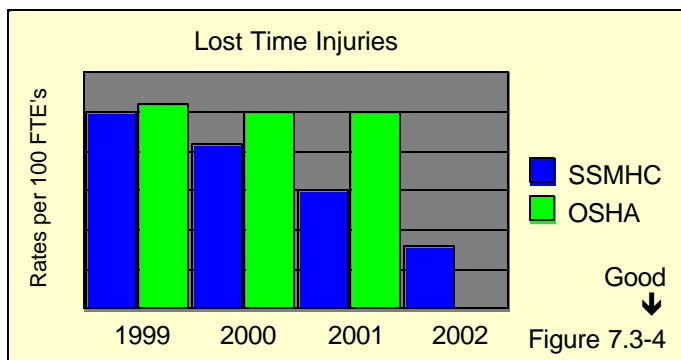


7.3-2 Employee education plays an important role in our ability to deliver exceptional health care services, meet accrediting agency criteria, maintain a safe work environment, enhance employee satisfaction, and continually develop employees. This graph represents internal training hours by employees and excludes tuition reimbursement hours/dollars sought outside SSMHC. As such, SSMHC's training investment is significantly above the health care benchmark (18.7) provided by the 2002 ASTD State of the Industry.

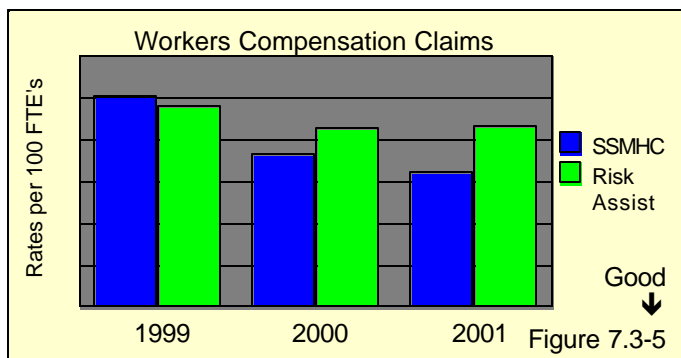


7.3-3 With a nationwide shortage of nurses and other health care workers, retention of employees is critical for SSMHC. With the increased focus on retention in 2001, including changes to enhance the benefit package (tuition reimbursement, legally domiciled adult coverage, LTC insurance) and more focused efforts in recruitment, turnover decreased to 20%, which is close to the top 25% of reported turnover rates from Management Science Associates (MSA). Annualizing the current turnover to date (5.05% as of April, 2002), SSMHC anticipates further improvement in turnover by year end.

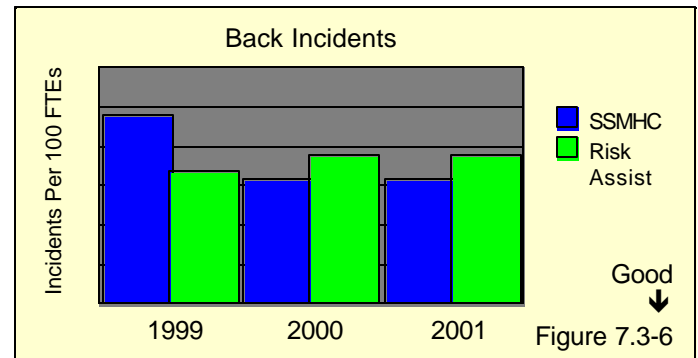
Nursing Turnover: With the increasing shortage of nurses, SSMHC has made special efforts to decrease RN turnover. These efforts include expanding the deployment of Shared Accountability systemwide and development of a Nursing Recruitment and Retention Team to address nursing concerns that impact our ability to implement current and future strategies. For example, the team is evaluating a centralized approach for the use of nurse technology by SSMHC's Nursing Informatics Team. SSMHC has successfully maintained lower reported RN turnover rates than benchmark comparisons. Annualizing the current year-to-date turnover (3.45% as of April, 2002), SSMHC should also see a positive decline in turnover results by year end.



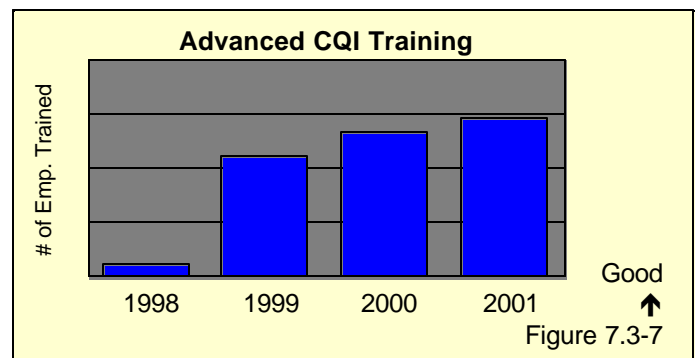
7.3-4 The occurrence of employee injuries resulting in lost work time is a key measure of environment of care and safety management processes and is critical to work system performance. Transitional duty programs have been implemented to reduce the number of lost time claims, resulting in less discomfort and disruption to the injured worker while realizing reduced costs. Lost-time injury rates compare favorably to OSHA rates.



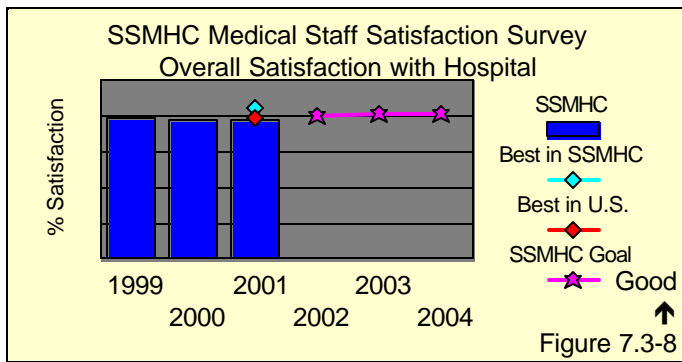
7.3-5 The frequency of workers' compensation claims is another key measure of environment of care and safety management processes. Safety training and focused patient handling initiatives have been implemented to reduce the number of workers' compensation claims. Systemwide data reflect improvement in work-related injuries. Current performance compares favorably with rates for other health care organizations according to Risk Assist, Inc.



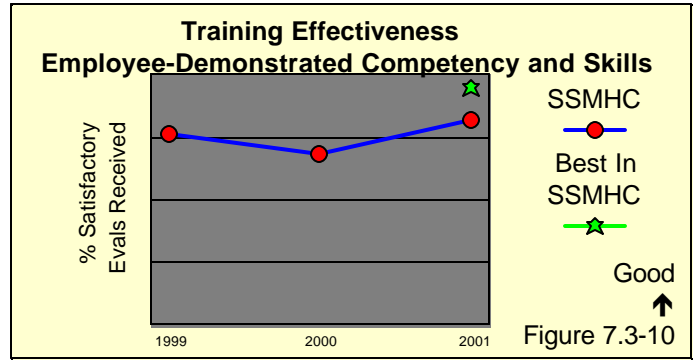
7.3-6 Back injuries are a primary area of risk in the health care environment. Focused patient lifting initiatives have been implemented to reduce the number of back injuries. Systemwide data show sustained performance which compares favorably to other health care organizations, as reported by Risk Assist, Inc.



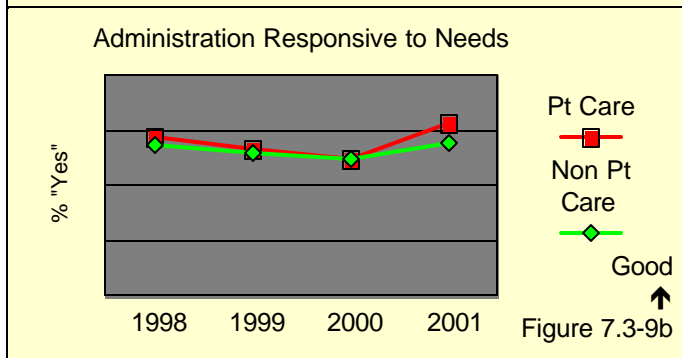
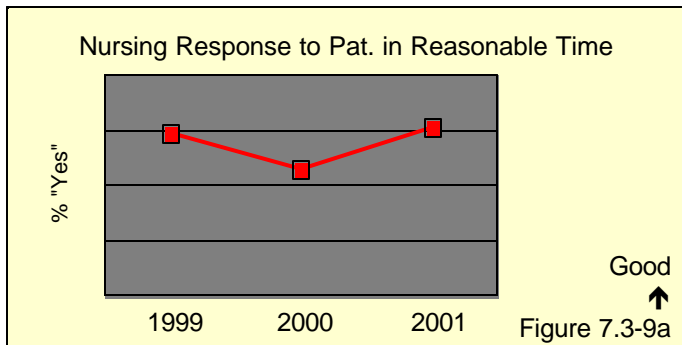
7.3-7 SSMHC's commitment to continuous quality improvement is supported by the requirement that each employee receive an introduction to CQI during their orientation session. This requirement applies to all 20,000+ employees to teach them how to innovate and achieve work system improvement. In addition, advanced CQI training is available for all administrative council members and all employees who are involved in or interested in team participation. This graph illustrates cumulative employee training in advanced courses such as team member, team leader, and team facilitator classes. In 1998 an automated systemwide tracking system was implemented to better monitor participation in CQI training. The data shows that advanced CQI coursework continues to increase each year.



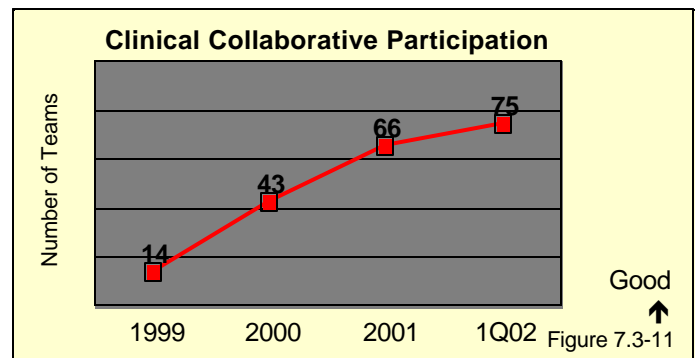
7.3-8 Physicians are an essential partner in the delivery of health care and in addressing and caring for patient needs. They also have a very influential role in directing a patient to a particular hospital. Physician satisfaction is a key system level indicator and is measured through an annual written survey. The SSMHC internal comparison (highest scoring hospital) in 2001 is 84.6%. According to the AARP the "best hospital in America" is Northshore University Hospital in Manhasset, NY, with an overall satisfaction score of 93%.



7.3-10 SSMHC believes that education and training are key essentials to employee demonstrated skills and competency. A strong emphasis is placed on continuous training and development for all employees. This includes job-specific and industry training needs and assessments. Each spring, hospitals compile a summary report for the Board of Directors which demonstrates the previous years employee competency and satisfactory evaluations. The results are tabulated and used to assess, modify, and adjust training needs. Of the performance evaluations received in 2001, 93% demonstrated competency and adequate training. Many of those not assessed as satisfactory received additional training and coaching or were terminated. Bone and Joint Hospital provided the internal benchmark for best overall percentage within SSMHC.

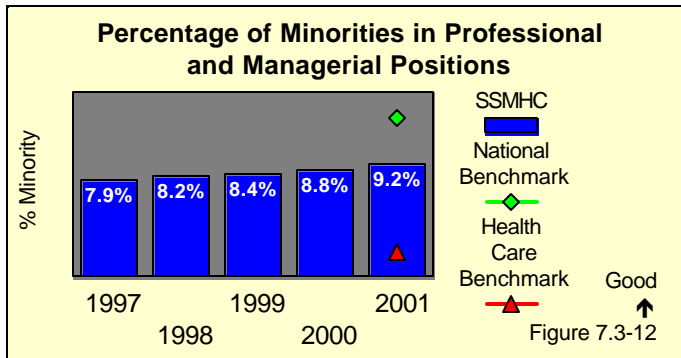


7.3-9 Key drivers of physician satisfaction include nursing and administrative responsiveness. Impact analysis indicates that addressing these primary influencing factors will positively impact satisfaction ratings. As such, SSMHC is engaging in initiatives such as monitoring nurse call light response time and reducing agency use to increase physician satisfaction with nursing. In addition, hospitals are increasing efforts to engage physicians in Clinical Collaboratives and facility enhancement projects to proactively address administrative responsiveness concerns.



7.3-11 In 1999, SSMHC began a Clinical Collaborative series to achieve rapid improvement in key clinical areas based on evidenced-based medicine, study of internal improvement efforts, and best practices identified in literature resources. In early 2002, four Collaboratives with 75 teams were in progress. All entities have participated in at least one collaborative, with 80% of the teams achieving their goals. This indicates progress in achieving innovation in our work system design. Comparatively, the Institute for Healthcare Improvement's Breakthrough Series Collaboratives show approximately 65% of their teams reach their goals. Teams participating in the SSMHC Clinical Collaboratives accelerate patient care improvements and improve outcomes by working together. For SSMHC, this creates a network of experts on specific clinical topics that serve as valuable resources for the system. Participating physicians and employees recognize these collaborative efforts as a unique benefit of

being part of SSM Health Care. The collaboratives are continuously open to new teams joining. SSMHC is the forefront of health care systems engaging in clinical collaboratives in partnership with physicians to facilitate improvements in health care delivery and to improve health care outcomes.

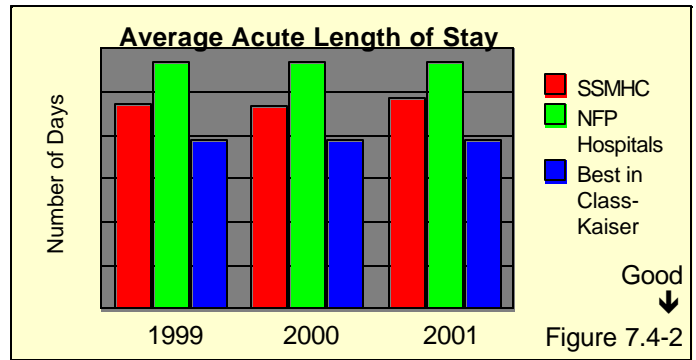


7.3-12 SSMHC has achieved a 26.7% increase in minority representation in management and professional positions in the past 5 years. This demonstrates results of the system's focus on increasing workforce diversity. Minorities in professional and managerial positions increased from 7.9% to 9.2% from 1997 to 2001. These results are better than the health care industry benchmark of 2% and moving positively toward the National Benchmark of 13.2%

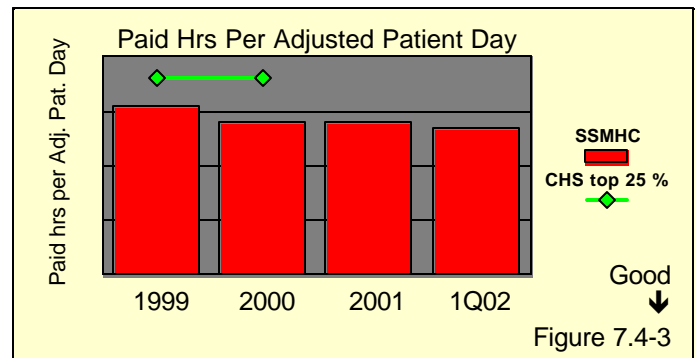
7.4 Organizational Effectiveness Results

	Admits	ED Visits	OP Visits	HC Admits
1999	123,292	358,671	1,047,176	15,232
2000	131,375	375,517	1,099,281	14,638
2001	145,784	413,952	1,248,217	14,407
1Q02	151,456	423,132	1,218,844	14,708

7.4-1 From 1998 to annualized 2002, acute admissions, a system level indicator, has grown 32%. SSMHC experienced a growth in admissions in 2001 largely due to increases in ED volume and service utilization. This significant increase in inpatient and outpatient utilization drove part of the financial turnaround in 2000 and 2001 as SSMHC was able to cover fixed costs more effectively. This trend has continued into the first quarter 2002. SSMHC's admission growth on an annual basis has been greater than the top 25% of performers from HBSI.



7.4-2 Average acute length of stay (ALOS), a hospital, network and operations performance indicator, has remained consistently below the comparison data for the average of the top 26 not-for-profit hospital systems. ALOS is important since most payors reimburse hospitals/providers on a per case (per admission) basis, not per day. Reducing the length of stay reduces expenses per case/admission and positively influences operating margin. The "best in class" is provided by Kaiser Permanente.



7.4-3 Despite significant growth in volume, SSMHC has engaged in a disciplined approach to staffing and, as a result, has been able to successfully manage paid hours per adjusted patient day at a slower rate of increase than the increase in patient volume. This has resulted in efficiencies in staffing while accommodating volume growth without compromising patient care. Productivity is managed daily at SSMHC at the department level to better predict and anticipate volume changes which impact staffing needs. Improved daily management resulting from more stringent monitoring has contributed to SSMHC's ability to manage this critical component of expense management.

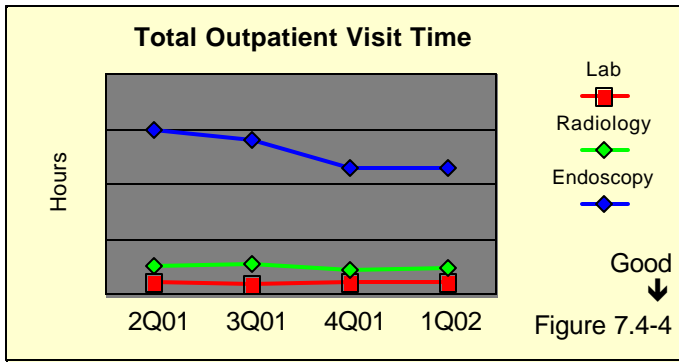


Figure 7.4-4

7.4-4 The satisfaction survey for outpatients was implemented in October 2001. Total outpatient visit time is a component of overall wait time, which is a key requirement of outpatients. Wait times has been validated through research to positively influence patient satisfaction. While the length of a visit is clearly impacted by many factors, SSMHC designs its processes to be as efficient as possible in completing the primary care or treatment for which the visit was scheduled.

and in fostering loyalty with our physicians. SSM Connect enables more effective and timely communication with physicians using internet, pager, fax, or PDA's, based on each physician's preference. Physician input is routinely sought regarding enhancements or new solutions. Connected physicians allow SSMHC to deploy information regarding patient care more quickly, thereby satisfying physicians and enhancing process efficiencies.

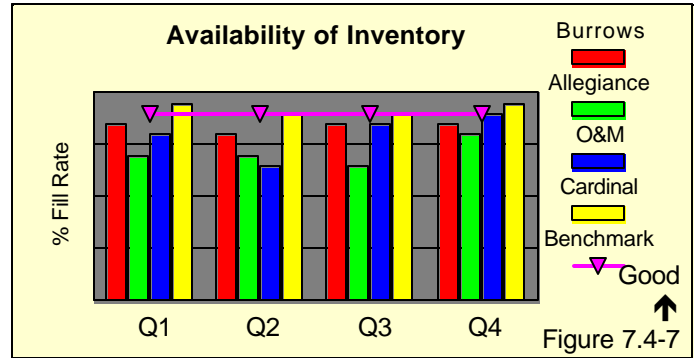


Figure 7.4-7

7.4-7 SSMHC works collaboratively with suppliers to address key requirements of availability of inventory, invoice accuracy, and cost savings. Through the cooperation of Burrows, Allegiance, Cardinal and O&M, SSMHC has been able to keep an increasing demand for inventory available in the warehouse for nearly on-demand shipment. The internal benchmark is 98%.

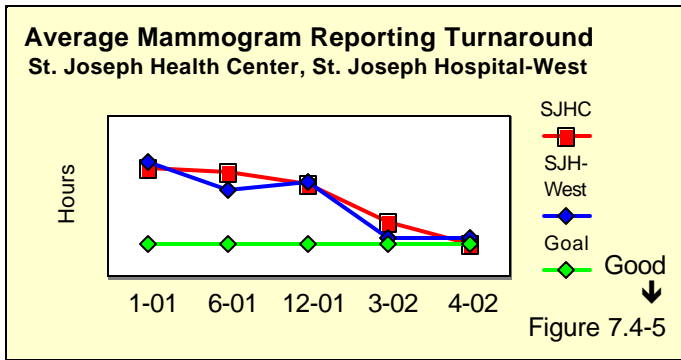


Figure 7.4-5

7.4-5 In response to physician satisfaction survey results, SSMHC radiology departments have initiated efforts to reduce turnaround time (patient check-in to report release) for mammogram reports. The pilot hospitals of this project, St. Joseph Health Center in St. Charles and St. Joseph Hospital-West, Lake St. Louis, MO were able to reduce turnaround time from more than four days to just over their goal of one day by changing a computer interface and the report release process when waiting for comparative films.

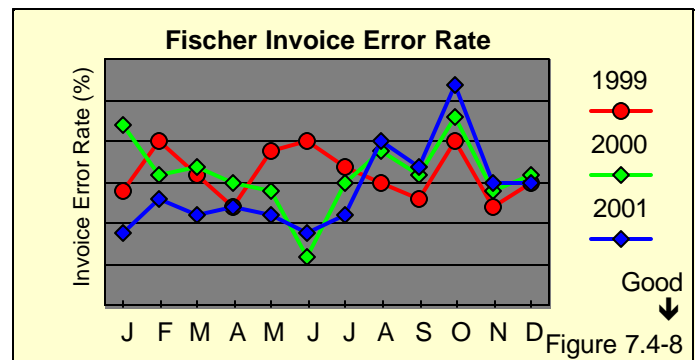


Figure 7.4-8

7.4-8 Through continued cooperation between SSMHC and its vendors, SSMHC has been able to decrease the invoice error rate by adhering to strict standards with respect to the placement and filling of orders.

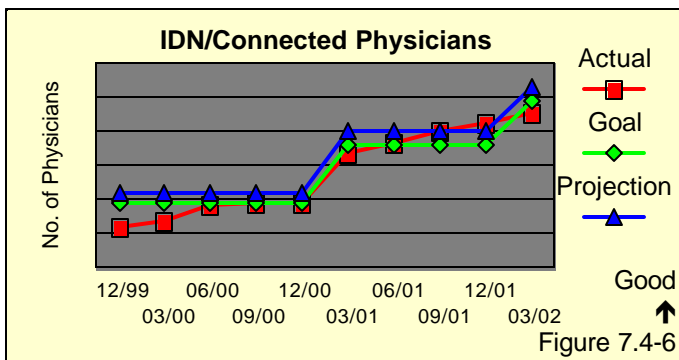


Figure 7.4-6

7.4-6 Physician connectivity is an important element in improving the timeliness of diagnostic test results reporting

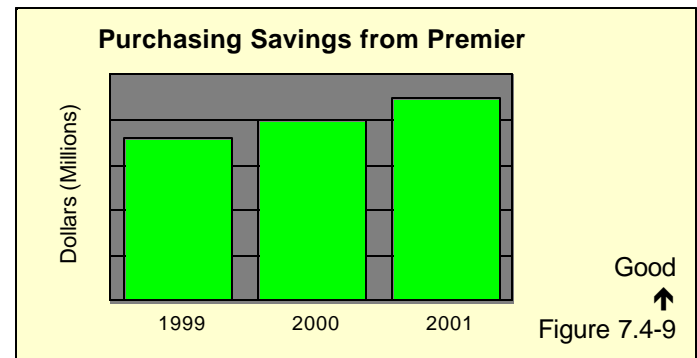
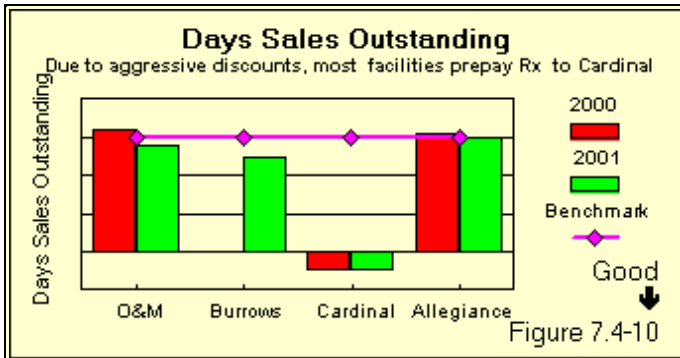


Figure 7.4-9

7.4-9 SSMHC has achieved significant savings through its affiliation with Premier. Premier is a Group Purchasing Organization (GPO), which provides access to pre-negotiated discount arrangements with distributors and supply vendors. Through aggressively negotiated contracts, SSMHC and Premier have been able to increase the standardized use of key purchased items, which, in turn, channels volume and decreases cost per unit and increases cost savings.



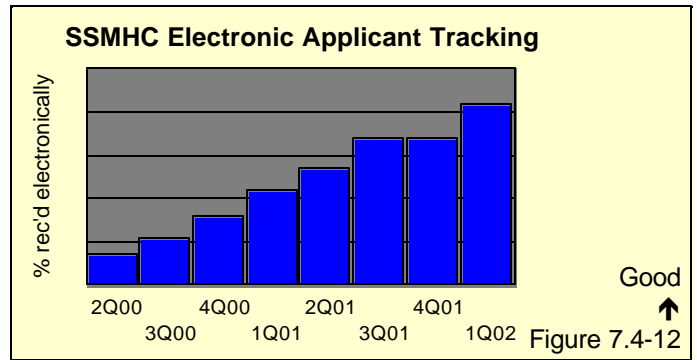
7.4-10 The key requirement of SSMHC by its key suppliers is fast payment of invoices, as reflected by days sales outstanding. This graph demonstrates the measure used to track the key requirement of fast payment for SSMHC's four top suppliers. The performance goal is based on payment terms of the contract (30 days or less). Prompt payment (paying more frequently) gives SSMHC access to discounted rates, which benefits SSMHC by reducing total costs. This also helps the vendor by reducing its administrative costs by lowering accounts receivable (days sales outstanding). Scorecards reflect current benchmarks.

Catholic Audit Health Network
Identified Cost Savings & Revenue Enhancement as of 6/30/01

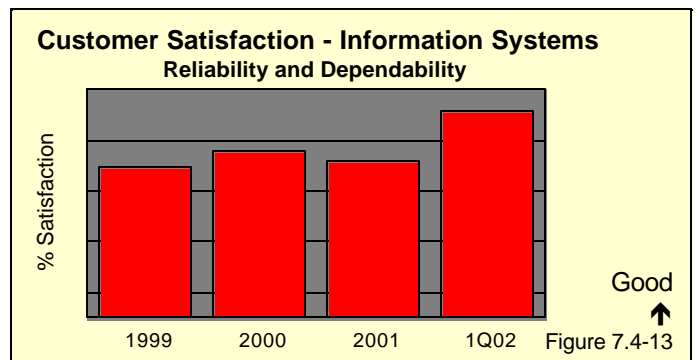
	CY Sav.	Real. Sav	Pot. Sav
Mgd Care	\$1,917,780	\$497,682	\$1,891,550
Rev Chrg	\$379,578	\$281,111	\$285,773
Other Oper.	\$235,321	\$161,959	\$137,821
Clinics/Phy.	\$7,133	\$5,545	
Compliance		\$62,578	\$18,422
Total	\$2,539,812	\$1,008,875	\$2,333,566

Figure 7.4-11

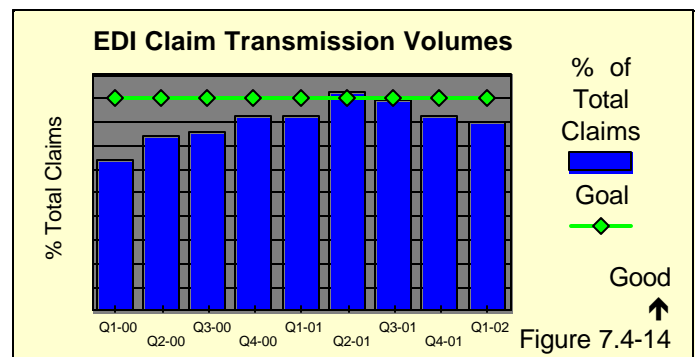
7.4-11 SSMHC's internal auditor, Catholic Health Audit Network (CHAN), helps SSMHC generate significant cost savings and revenue enhancements. During the year ended June 30, 2001, CHAN identified potential revenue enhancements and cost savings in SSMHC's key operational areas of focus including managed care, revenue charge capture, physician practice billing and other areas of operational improvement. Continued realization of savings will be recovered in the next 12 to 18 months.



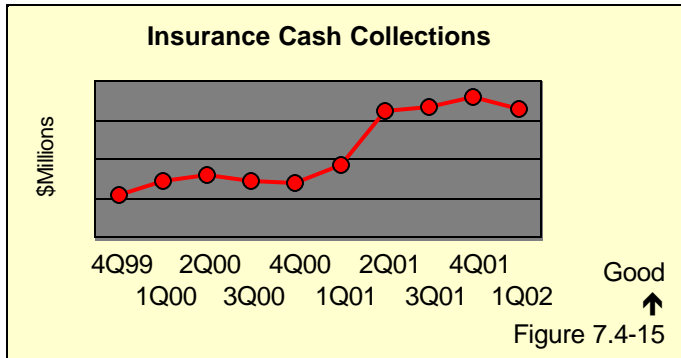
7.4-12 Employment applications received via the intranet streamline the process internally by automatically processing applicants through our applicant tracking system. Applications submitted electronically have increased 500% since the second quarter of 2000.



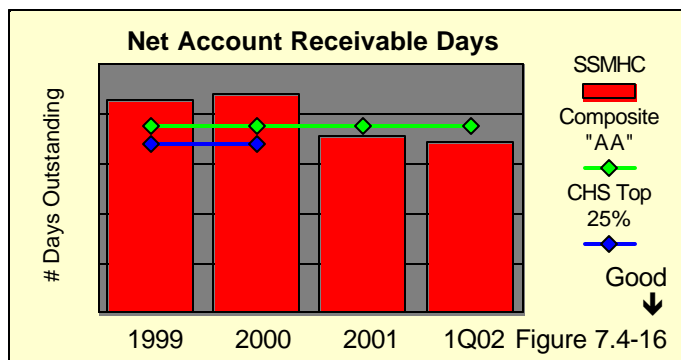
7.4-13 Through a disciplined customer relationship management program and the IS Planning and Management Process displayed in Figure 4.2-1, SSMHC assures that IS systems and infrastructure are kept up-to-date and provide a high level of reliability and dependability. In the 3rd quarter 2001, SSMHC's network performance was severely impacted by viruses which affected many organizations' information technology operations. These problems were corrected in the 4th quarter of 2001 and 1st quarter 2002 results reflect the trend of increasing satisfaction. A key inprocess measurement of dependability is wide area network availability, which has an availability rate exceeding 99.5% since 1999.



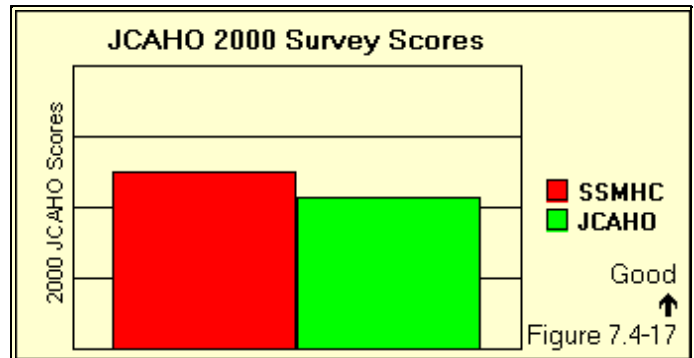
7.4-14 The SSMHC electronic claims vendor, SSI, was installed in 1999 and 2000. Electronic transmission of claims speeds cash flow. Payors increasingly require electronic claim transmission to reduce their cost of processing claims. However, some of our more complex managed care payors have recently reduced the number of claims which can be sent electronically by requiring increasing numbers of rebills and attachments. SSMHC continues to work with key payors to identify alternative ways to transmit required information rapidly.



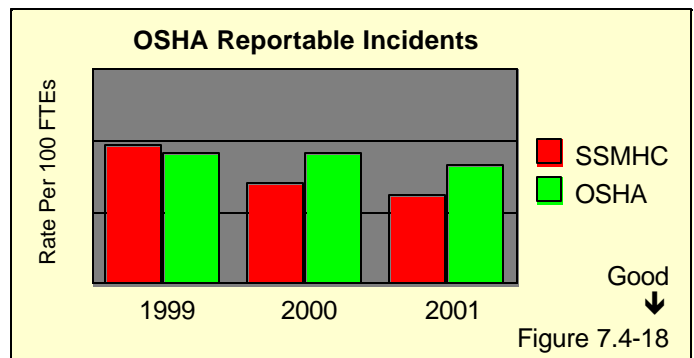
7.4-15 To improve rate of reimbursement which positively impacts cash on hand, SSMHC improved the quality of information sent to third-party payors. SSMHC installed an advanced claim editing and transmission system. This graph demonstrates the improved insurance cash collections after SSI was implemented in 1999-2000. After a year of significant improvement in third party payments, the level of improvement has slowed. The next major increase will come after further EDI transactions (Claim Status Inquiry) are implemented late in 2002.



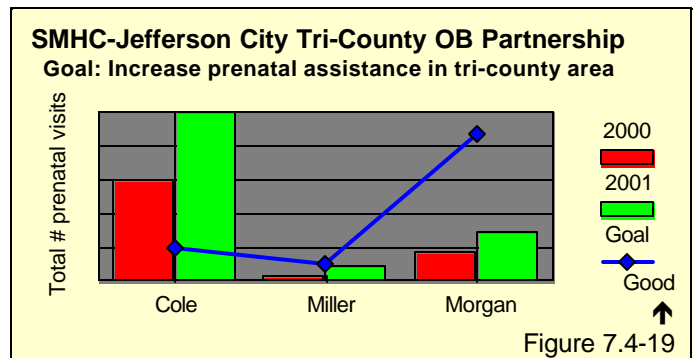
7.4-16 While the industry benchmarks have been rising on average, SSMHC's net days in accounts receivable have been decreasing. A systemwide Revenue Cycle CQI team has been implementing process changes to achieve this improvement.



7.4-17 All SSMHC hospitals are JCAHO accredited and are surveyed every three years. This graph demonstrates that the survey scores are above the JCAHO average score of all hospitals. SSMHC hospitals have consistently performed better than the JCAHO average. In the 2000 survey, the JCAHO recognized eight SSMHC hospitals for best practices. SSMHC will be surveyed again in 2003.

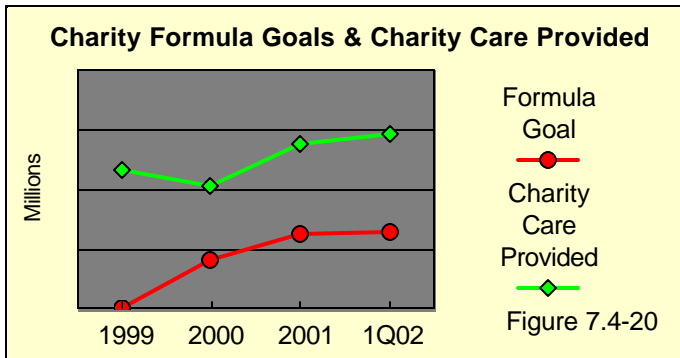


7.4-18 Safety training and focused patient handling initiatives have been implemented to reduce the number of OSHA reportable incidents. Reportable incident rates have declined by more than 40% since 1999 and compare favorably to OSHA hospital rates.



7.4-19 All SSMHC entities engage in activities to improve community health and measure effectiveness of their initiatives. Since results are project-specific, these results represent one example of SSMHC's Healthy Communities initiatives. St. Marys Health Center in Jefferson City, MO developed prenatal partnerships with three county health departments beginning with Cole County in 1996, and Miller and Morgan Counties in 2000. Success is measured

by increases in prenatal visits, indicating the counties' improved rate of prenatal care. In Cole County, the risk for not receiving adequate prenatal care decreased from 12.3% to 9.8% in 1999. Annual goals through 2003 have been established for each county.



7.4-20 Over 20,000 SSMHC physicians and staff are committed to participating in the healing ministry of Jesus Christ, delivering health care services to our community, especially the economically, physically and socially marginalized. SSMHC provides a significant amount of charity care in order to improve the health of the communities it serves. SSMHC's commitment is evidenced by a \$29 million-dollar investment in the provision of charity care. A minimum of 25% of net operating margin (before deductions) is spent annually on charity care. No one in need is turned away from our doors.

GLOSSARY OF TERMS AND ABBREVIATIONS

360 Degree Evaluation - tool used to conduct individual performance evaluations of executive leaders

AA Composite - combined ratings from top financial rating agencies including S&P, Fitch, Moodys, top 25% of CHIPs, and top 25% of CHS to form best in class comparisons

AA system - an organization rated "AA" by bond-rating agencies (AA is the highest rating for not-for-profit health care organizations)

AARP - American Association of Retired Persons

AC / Administrative Council - entity leadership group composed of the entity president, vice presidents as well as the controller and some directors from the operational areas of each entity. Some entities call this body their "Leadership Team."

ACHE - American College of Healthcare Executives

Acuity - severity of patient illness

AEA--Adjusted Equivalent Admissions, a growth indicator of the full range of patient services, with an adjustment for acuity; It uses average gross revenue per acute admission, adjusted by the acute Case Mix Index (CMI) to convert nonacute and outpatient services into acute inpatient equivalent units.

AES - Achieving Exceptional Safety

AONE - American Organization of Nurse Executives

APS - Enhancing Patient Safety

APD--Adjusted Patient Days, a measure of patient service volume; It uses average gross revenue per acute inpatient day to convert nonacute and outpatient services revenue into units equivalent to acute patient days.

Acute care--services provided to inpatients of a hospital unit certified and licensed by state and/or federal regulatory agencies to provide diagnostic and nursing services to patients, based on the orders of the patients' physicians, during an acute episode of illness.

Advisory Board - group of community representatives that assist SSMHC entities in an advisory capacity. Each entity has such a group although a few may be called by a different name.

AHA - American Hospital Association

ALOS / Average Length of Stay - average number of days patients are in the hospital; ALOS is used to analyze populations of patients with common characteristics.

Ambulatory Services / Care - care or service rendered in an outpatient setting without an overnight stay; not an inpatient

ASTD- American Society of Training & Development

Behavioral Medicine - psychiatric, mental health, chemical dependency, mental retardation, developmental disabilities, and cognitive rehabilitation services

Board of Directors - parent board of SSM Health Care

BJH - Bone & Joint Hospital, Oklahoma City, OK, a member of SSMHC

BNDD - Bureau of Narcotics and Dangerous Drugs

CGCH - SSM Cardinal Glennon Children's Hospital, St. Louis, MO, a member of SSMHC

Caliper Profiles - tools to assess personality characteristics of potential managers

Campus - grouping of all SSMHC services and sites associated with an acute care entity

Capital Allocation Council - SSM Committee that prioritizes projects based on strategic and financial benefit to the system as a whole

CAG - SSM Information Center's Compliance Administrative Group which is responsible for system confidentiality, privacy and security

Capital Planning and Allocation Process (CAP) - the systemwide process by which SSMHC entities submit proposals for funding of capital projects costing more than \$500,000

CARE PATHWAYS® - practice guidelines; descriptive tools for care of the typical individual in the typical situation, developed through a formal process that incorporates the best scientific evidence of effectiveness and expert opinion

CARF- Commission on Accreditation of Rehabilitation Facilities

Case Management - coordination of patient care to facilitate the timely delivery of appropriate services in the most effective manner

Case Mix Index - the comparison of a hospital's cost for its type of patients to the national or regional average hospital cost for a similar type of patient

CDC - Centers for Disease Control

CHAN - Catholic Healthcare Audit Network

CHF - Congestive Heart Failure

CHIPS - Center for Healthcare Industry Performance Studies

CHS - Catholic Healthcare Systems ratio analysis from Arthur Andersen, LLP

Clinical Collaboratives--a series of teams, based on the National Institute for Healthcare Improvement (IHI) Breakthrough Series, that SSMHC has established to make breakthrough improvements in clinical areas

CMS - Centers for Medicare and Medicaid Services

COBRA - Consolidated Omnibus Budget Reconciliation Act of 1985.

Continuum of Care - matching an individual's ongoing needs with the appropriate level and type of medical, psychological, health or social care or service within an organization or across multiple organizations; care provided over an extended time, in various settings, spanning the illness-wellness continuum

COO - Chief Operating Officer

CPAF - Capital Project Application Form

CQI / Continuous Quality Improvement - a management tool used throughout SSMHC to involve all employees in monitoring, managing and improving processes and outcomes

CRC - Client Response Center

CRP - Corporate Responsibility Process, a systemwide SSMHC process to manage regulatory, legal and ethical compliance

Dean Health System - Physician joint venture partner in SSM Healthcare of Wisconsin

Di-Diver/Web-Diver - Software system that provides detailed segmentation of patient satisfaction data

DPHC - SSM DePaul Health Center, Bridgeton, MO, a member of SSMHC

DRG / Diagnostic-Related Group - a classification for patients based on diagnosis, length of hospital stay and therapy received; Adopted by Medicare as a mechanism for paying hospitals, changing from a cost-based, retrospective-reimbursement system to a prospective payment system giving hospitals a financial incentive for reducing health care costs

DSO - Days Sales Outstanding

EAP/Employee Assistance Program - programs that provide counseling, alcohol and substance abuse and often mental health services to employees

ED - emergency department, sometimes called "ER"

EEOC - Equal Employment Opportunity Commission

EIT - Entity Implementation Team

Employee Council - a council made up of a variety of employee representatives who investigate and address a wide range of issues

Entity - an operating unit within SSM Health Care; May refer to an individual hospital, nursing home, etc.

ePMI - Electronic Performance Monitoring Improvement

EPA - Environmental Protection Agency

ERP - Enterprise-wide Resource Planning to analyze SSMHC's business practices and requirements associated with finance, materials management, and HR/payroll operations

Executive leader - SSMHC employee who is a member of System Management, the Innsbrook Group, network leadership, entity administrative council, or is a corporate vice president

FDA - Food and Drug Administration

Fee-for-Service - an insurance plan that reimburses the hospital based on total billed charges with or without percentage discounts (see also Indemnity Plans).

FMEA - Failure Mode and Effect Analysis. Analytical process in which potential problems are identified and evaluated for severity so that design modifications can be made.

FSM - Franciscan Sisters of Mary congregational initials

FTE / Full-Time Equivalent - the amount of time worked by the combined full- and part-time staff, divided by the time worked by a full-time employee (40 hours)

GSRHC - Good Samaritan Regional Health Center, Mt. Vernon, IL, a member of SSMHC

HBOC - Patient-level software system providing clinical, financial and decision support information

HBSI - Healthcare Benchmarking Systems International. Provides external operational and clinical data used to benchmark departmental operations and isolate performance improvement opportunities.

HIPAA - Health Insurance Portability and Accountability Act of 1996

HCAB - Health Care Advisory Board

HCFA - Health Care Finance Administration

HCMG - National Research Corporation's Health Care Market Guide is a comparative database containing consumer-reported assessments of hospitals, health systems and health plans representing data on more than 2,500 hospitals and 600 health plans.

HMO / Health Maintenance Organization - managed care business that organizes health care services for its members. HMOs have three distinct features: (1) they use primary care providers to coordinate patient care; (2) they have specific providers and facilities members must use; and (3) they have a fixed fee structures

HR Solutions Survey - annual SSM employee satisfaction survey

HME/IV- Home medical equipment/intravenous

Healthy Communities - an SSMHC systemwide initiative to improve the health of people who live in the communities served by SSMHC entities. Each entity has at least one Healthy Communities project.

Home Health Care - refers to services provided to patients in their own homes.

IHI - National Institute for Healthcare Improvement

IMC - Information Management Council

Indemnity Insurance Plans - an insurance plan that pays for the cost of services after the services have been given, as long as the service is in the benefit package. See also Fee-for-service.

Innsbrook Group - a leadership group within SSMHC consisting of the members of System Management, all hospital presidents, plus representative physician

organization, network, home care, and information systems executives.

Inpatient (IP) - inpatient acute services, in a suitably equipped setting to provide services to persons who require 24-hour care (overnight) treatment or rehabilitation

International Benchmarking Clearinghouse - a division of the American Productivity & Quality Center (APQC) which provides information on benchmarking, knowledge management, measurement, customer satisfaction, productivity and quality

IRI- a management consulting firm specializing in human resources, customer satisfaction and labor relations
ISM - Information Services Manager

JCAHO / Joint Commission on Accreditation of Healthcare Organizations; an independent, not-for-profit national organization dedicated to improving the quality of care in organized health care settings. Major functions include developing accreditation standards, awarding accreditation decisions, and providing education and consultation. Also called "Joint Commission."

JOA - joint operating agreement

KPMG - SSMHC's auditor

LANS - local area network of information systems

LDA - Legally Domiciled Adult

LLA - Lipid Lowering Agent

LOS - Length of Stay; the number of days a patient is in the hospital.

LTC - Long Term Care

Managed Care - an organized system of health care services characterized by a primary care provider that manages and coordinates the patient's access to services; the doctor's approval prior to admitting a patient to the hospital or performing a surgical procedure is frequently required.

MAR - Medication Administration Record

MAT - Mission Awareness Team

MCO - Managed Care Organization

MEA - Ministry Effectiveness Analysis; Process used by SSMHC to evaluate market potential and make improvements

Medical Staff - a body that has overall responsibility for the quality of the professional services provided by individuals with clinical privileges and responsibility of accounting to the governing body. The medical staff includes fully licensed physicians and may include other licensed individuals permitted by law and by the organization to provide patient care independently (without clinical direction or supervision within the hospital). Members have delineated clinical privileges that allow them to provide care within the scope of their clinical privileges.

MGMA- Medical Group Management Association

MHA - Maryland Hospital Association; Group which maintains a national comparative database of health care outcomes representing more than 1,000 hospitals as part of its QI Project. SSMHC uses the top 25% for benchmarking.

Mission Think Tank - SSMHC employees and entity/network mission awareness representatives that provide input on mission and values deployment throughout SSMHC.

MTI - A master trust indenture ("MTI") is the legal platform for coordinating external borrowing, primarily the proceeds for tax exempt revenue bonds. The MTI provides (i) a mechanism for linking separate organizations into a single credit, (ii) a uniform set of covenants to which all participants will adhere, and (iii) a structure for reporting results to the external creditors.

Mortality Rate - measures the death rate based on past statistical measures. Mortality is usually measured by sex or age, among other factors.

MSA - Management Science Associates, an organization that monitors health care compensation and other numerics for over 370 organizations and 733,500 employees.

Multidisciplinary Team - a group of clinical staff members composed of representatives of a range of professions, disciplines or services areas.

Network - grouping of SSMHC entities within a community

Network Leadership - Network president/CEO and his/her direct reports

NRC -Nuclear Regulatory Commission

NRC - National Research Corporation

OIG - Office of the Inspector General

OP / Outpatient - program that provides services to persons who generally do not need the level of care

associated with the more structured environment of an inpatient or residential program

Operations Council - subset of System Management senior leaders who review and address the system's operational performance

Operations Performance Indicators--a set of 49 systemwide performance indicators for hospitals that are rolled up for review by SSMHC's Operations Council. Home Health, Long-term Care and the Physician Practices also each have a set of operations performance indicators. These indicators are aggregated into the Performance Indicator Report, a color coded report.

OSHA - Occupational Safety & Health Act

Passport - a card carried by SSMHC employees that includes the mission and values of SSMHC and other information to provide "line of sight" from personal goals to organizational goals

Payors - third parties who make all or partial payment of charges on behalf of the patient. Includes indemnity plans, HMOs, PPOs, Medicare, Medicaid, Champus, etc.

PDA - Personal Digital Assistant (handheld device)

PDCA - Plan, Do, Check, Act; a cycle for monitoring and improving processes, functions and outcomes. Some times called Plan, Do, Study, Act (PDSA)

PI - performance improvement

PIR - Performance Indicator Report containing key performance indicators; also known as the PI Report, PIR and Stoplight Report

Physician--a person legally qualified to practice medicine.

Physician Portal - access to reliable, updated medical information

PO - Physician Organization

PPC - Post Process Change

PPO / Preferred Provider Organization - a health plan that gives patients lower rates if they use physicians in the preferred group of providers. Patients may still use doctors outside that list, but usually pay more to do so.

PRC - Professional Research Consultants

Premier - the nation's largest group purchasing organization

Premier Insurance Company - one of Wisconsin's largest HMOs, in which SSMHC owns an interest

Preservation of the Earth Committee - SSMHC entities have a committee of employees devoted to environmental protection

Primary Care Providers - physicians who practice in the areas of pediatrics, family practice, internal medicine who treat primary care needs of patients.

PRN - As needed

PTO/EMTO - Paid Time Off/Extended Medical Time Off

QI Project[®] - External health care database provided by the Maryland Hospital Association. Data are supplied by individual facilities and aggregated by the QI Project. Aggregate QI Project data represent the averages of all rates and are intended for the internal use of Project participants.

QRC / Quality Resource Center - department located at SSMC's Corporate Office providing support to entities throughout the system

Readmission - patient returns to the hospital within 31 days, for the same or related condition as previous admission.

Regional Board - the Board of Directors responsible for reviewing medical staff credentialing and quality review activities. A Board of Directors may be responsible for an Individual entity, or a group of entities within a geographic area

REMEDY - complaint tracking software

RN - registered nurse

SAPP-Define - SSMHC Intranet based application that includes Standard Accounting Policies and Procedures

SAH - St. Anthony Hospital, Oklahoma City, OK, a member of SSMHC

S&P - Standard & Poors Index

SAP--cutting edge software selected by SSMHC for its Enterprise Resource Planning (ERP) project. SAP integrates finance, materials management and HR/Payroll information systems to provide real-time access and sharing of data across the organization

SCH - St. Clare Hospital and Health Services, Baraboo, WI, a member of SSMHC

SFHHC - St. Francis Hospital & Health Center, Blue Island, IL, a member of SSMHC

SFHHS- St. Francis Hospital & Health Services, Maryville, MO, a member of SSMHC

SFP - Strategic, Financial and HR Plan

SFPP - Strategic, Financial and HR Planning Process used by SSMHC

Shared Accountability - an organizational structure that gives nurses greater decision-making authority as part of overall accountability for nursing practice

Shared Governance - a model of Shared Accountability

SJHC/HW - SSM St. Joseph Health Center, St. Charles, MO, and SSM St. Joseph Hospital West, Lake Saint Louis, MO, members of SSMHC

SJHK - SSM St. Joseph Hospital of Kirkwood, Kirkwood, MO, a member of SSMHC

SMH - St. Michael Hospital, Oklahoma City, OK, a member of SSMHC

SMCC - St. Marys Care Center, Madison, WI, a member of SSMHC

SMHC-JC - St. Marys Health Center, Jefferson City, MO, a member of SSMHC

Solucient - clinical information system

SMHC-STL - SSM St. Mary's Health Center, St. Louis, MO, a member of SSMHC

SSMHC - SSM Health Care; also called "system" throughout this application

SSMIC - SSM Information Center

SSM Health Care St. Louis - network of SSMHC entities in the greater St. Louis, Missouri metropolitan area

SSM Health Care of Oklahoma- network of SSMHC entities in the Oklahoma City area

SSM Health Care of Wisconsin - network of SSMHC entities in the southern Wisconsin area

SSM Policy Institute - an SSMHC 501(c)(4) organization whose mission is to enhance the public awareness of those matters relevant to the design and delivery of health services that provide best quality, access and overall best practices. Also, to work toward improving community health status in a variety of venues.

SWOT - Strengths, Weaknesses, Opportunities and Threats

System Management - a group of 11 senior leaders that provides direction to entity and network leaders throughout SSMHC

System Level Indicators - a set of 16 performance measures selected by SSMHC to be reviewed systemwide and by System Management & the Operations Council

VMSNF - Villa Marie Skilled Nursing Facility, Jefferson City, MO, a member of SSMHC

WANS- wide area network information system

WAHSA - Wisconsin Association of Homes and Services for the Aging

WIITTS - Wisconsin regional integrated information technology and telemedicine system