"We need to give our best everyday for our neighbors, families and friends. They deserve nothing less."
~ Christine Wray, President, 06-05-12

P.1. Organizational Description Licensed for 89-beds, MedStar St. Mary's Hospital (MSMH) is a community hospital that delivers state-of-the-art emergency, acute inpatient and outpatient care, in Leonardtown, Maryland. With advanced technology and a dedication to excellence, the MSMH associates are committed to providing high quality, patient-centered care to patients through the hospital and extensive outreach programs, and leadership is engaged in many industry and community activities.

MSMH is a proud member of the MedStar Health System (MedStar, System, MSH) – combining the best aspects of academic medicine, research and innovation with a complete spectrum of clinical services to advance patient care. MedStar's patient-first philosophy combines care, compassion and clinical excellence with an emphasis on customer service. MSMH is the sole provider of hospital-based care in St. Mary's County (SMC). The hospital has key relationships with POCs, suppliers, partners and stakeholders as depicted in Figure (Fig) P.1-1. The hospital's patients come primarily from SMC and the southern portions of Calvert County and eastern portions of Charles County.

Fig P.1-1 Key Relationships

Dir/Ind	Service Areas	Pts	OC	Sup	Ptn	Stk
Direct	ICU, medical surgical units, pediatrics, obstetrics & gynecology unit, level I nursery, 6 operating rooms with post anesthesia care, an inpatient mental health unit, ED, Diagnostic & Rehabilitation Services, a Pulmonary & Cardiac Rehabilitation Center, outpatient Cancer & Infusion Service, Hospice & Hospice House, & a community outreach program, Health Connections (HC)	X	X	X	X	x
Indirect	HEZ, Wound Healing Center, inpatient dialysis, ancillary physician services, Express Care, & Eye Physicians of St. Mary's	X	X	X	X	x

Key: Pts=Patients; OC=Other Customers; Sup=Suppliers; Ptn=Partners; Stk= Stakeholders; Dir=Direct; Ind=Indirect; X=Yes

MSMH celebrated its 100th anniversary in 2012. Much has changed in the world of healthcare and technology over the past century, but MSMH still reflects the vision of its founders – a strong tradition of caring for the community. Over the years, we have embraced innovation and have expanded facilities, services and skills to provide appropriate high-quality healthcare to the residents in our market segments.

P.1.a Organizational Environment MSMH has a 125 total physical inpatient bed capacity within the hospital and the mechanisms for all of its healthcare delivery include direct and indirect service offerings. The key difference among the relations with the customers/other customers, etc. and the direct/indirect offerings are that the direct offerings are broader in scope, whereas indirect offerings are more specialized and a collaborator brings expertise. The volume of customers/other customers, etc. is also greater with the direct vs. the indirect service offerings.

The HEZ is a hybrid direct/indirect service collaborative initiated in 2013 in eastern SMC providing care to the underserved. While the historic success of MSMH was based on inpatient services, industry trends have increased the relative importance of outpatient services. Our main delivery mechanism, to provide healthcare services, is carried out in the hospital and outpatient facilities. MSMH's stated purpose is to provide healthcare in a community setting. The mission, vision and values (MVV) of MSMH are depicted in Fig P.1-2.

Fig P.1-2 MSMH Mission, Vision and Values

Mission	A community hospital that upholds its tradition of caring by continuously promoting, maintaining and improving health through education and services while assuring quality care, patient safety and fiscal integrity.
Vision	The Trusted Leader in Caring for People and Advancing Health. This vision provides the framework for our Strategic and Operating Plans as it is what we strive to be.
Values	***SPIRIT.*** Our **values** are best remembered through the acronym SPIRIT – Service, Patient First, Integrity, Respect, Innovation, and Teamwork. These values guide our daily conduct.
S	***Service.*** We strive to anticipate the needs of our patients, physicians and co-workers.
P	***Patient First.*** We strive to deliver the best to every patient, every day. The patient is the first priority in everything we do.
I	***Integrity.*** We communicate openly and honestly, build trust and conduct ourselves according to the highest possible ethical standards.
R	***Respect.*** We treat each individual, those we serve and those with whom we work, with the highest professionalism and dignity.
I	***Innovation.*** We embrace change and work to improve all we do in a fiscally responsible manner.
T	***Teamwork.*** System effectiveness is built on the collective strength and cultural diversity of everyone, working with open communication and mutual respect.

MSMH's **core competencies** include: ensuring safety and high quality, patient satisfaction, financial stewardship, innovation, transparency and continuous improvement. As a high reliability organization (HRO) these core competencies are the key characteristics of the MSMH Mission and culture. MSMH flourishes in providing the best of "high touch" patient care in a "high-tech" world.

The workforce profile is illustrated in Fig P.1-3. Key factors that motivate associates to engage in accomplishing the Mission are related to pride and loyalty. As the second largest private employer in SMC, MSMH is fortunate that more than 80% of associates live in SMC and are proud to work in MSMH where they give care to family, friends and neighbors. They are very interested in seeing that everyone receives the best possible healthcare. Other key factors for associates include fair and equitable treatment, opportunities for growth, ethical leadership, competitive benefits, teamwork, and personal safety. MSMH workforce groups/segments include employed physicians, associates, volunteers and students. Associate segments and job diversity are also shown in Fig P.1-3. At this time, there are no bargaining units in MSMH.

Fig P.1-3 Associate Segmentation FY13

Leadership	Management 4%, Non-management 96%
Education	Advanced Degree & Masters 10%, Baccalaureate 31%, Associates 38%, and high school diploma or less 21%
Job Category	Nurses 30%, Non-Nursing Professionals 22%, Technical 11%, Support 37%
Tenure	1 year 16%, 1-4 years 31%, 5-10 years 30%, 11-20 years 16%, >20 years 7%
Job Classification	Full Time 60%, Part Time 17%, PRN 23%
Shift	Day 55%, Evening 10%, Night 30%, Other 5%
Race/Ethnicity	Caucasian 78%, African American 14%, Hispanic 2%, Other 5%
Gender	Female 89%, Male 11%
Age	<20 years old 2%, 20-35 years old 36%, 36-50 years old 36%, 51-65 years old 24%, >65 years old 3%

All associates are required to receive specific training for special health and safety requirements. For those working with lasers, radioactive/nuclear materials, and chemo-toxic agents, specialized training is supported and regulated. Most segments of the associate population are also taught proper body mechanics/ergonomics, environmental safety, safe use of equipment and hand-washing. All associates who move patients are taught the use of safe lifting equipment. Since 2010, associates have been required to receive the influenza vaccination which is offered at no personal expense.

P.1 a (4) Assets MSMH consists of 4 major buildings – the acute hospital, the Outpatient Pavilion, the medical office building (St. Mary's Medical Center at Charlotte Hall) and the Hospice House. In all of these facilities, the Cerner EMR solution is actively used. The hospital and Medical Staff (MS) were early adopters of a fully integrated EMR. More than five years ago, MSMH was identified as having achieved a high degree of clinical automation incorporated into the delivered patient care services. This Stage 6 designation by the HIMSS Analytics EMR Adoption Model (top 1.6% in the United States) enables provision of the highest levels of patient safety and quality outcomes for the care provided to the patients. With the EMR, physicians and clinicians are able to access patient records at the click of a mouse from anywhere in the hospital, in physicians' offices/homes, or wherever they can connect to the internet. Care-Mobile, a handheld medication barcode reading device, together with Computerized Physician Order Entry (CPOE) ensures the utmost in patient medication safety.

Although MSMH has been in the community for over 100 years, the present building is a young and modern building that has been well maintained. This is a result of being ever mindful of the patient's experience and a conscious choice to be better able to serve the community. Physical growth such as modernization of the operating rooms (ORs), the addition of the 3rd floor and private rooms, the creation of a modern 12-bed intensive care unit (ICU), and the 2-story Outpatient Pavilion provide evidence of the commitment to safety and quality healthcare to the community. Other recent developments include a dedicated Education Center that includes a simulation lab and a dedicated Information Technology Center for associates.

In addition to the continued modernization of the hospital buildings over the years, the hospital has implemented significant advancements in services and advanced technology, including the latest in fully accredited imaging and interventional equipment. The hospital also provides Positron Emission Tomography (PET) and Computed Tomography (CT) services and digital Mammography.

In its quest to assure top quality and patient safety, MSMH has addressed recommendations from The Leapfrog Group that includes the use of evidence based protocols (EBPs), the use of Intensivists in ICU settings, in addition to the use of the EMR & CPOE. With the majority of the Leapfrog recommendations, MSMH has been innovative and an early adopter.

Healthcare in Maryland (MD) is a heavily regulated industry with strict specific requirements that must be met. Fig P.1-4 lists some, but not all, of the key oversight agencies and subject regulations with which MSMH must comply.

P.1.b Organizational Structure In October 2009, MSMH joined MedStar, the region's largest healthcare system. The merger created possibilities to expand services, advance technologies, recruit and retain quality physicians, and continue the strong financial performance of MSMH while proactively preparing for healthcare reform. MSH is governed by a parent BOD that is representative of the communities it serves. MSH's governance philosophy is to concentrate a broad range of "reserved powers" at the parent Board level, while allowing its entity hospital Boards to focus on safety and quality in a way that best meets the healthcare needs of the local communities they serve with guidance of MSH's best practices.

Ms. Christine Wray has served as President of MSMH since 1992 and has been a Senior Vice President (VP) with MedStar since 2011. As President of MSMH, she is responsible for the overall performance of the hospital, its successes and failures. She also focuses on building strong stakeholder relationships and serves as a representative to state and county healthcare and other external organizations. The Senior Leaders (SLs) of MSMH include the President; the VP, Medical Affairs (VPMA); the VP, Finance (VPF); the VP, Nursing (VPN); and a VP responsible for the remaining portion of operations.

Fig P.1-4 Legal & Regulatory Agencies/Requisites	
DHMH	State Oversight, Patient Safety Professional Licensure
EEOC	Non-discriminatory practices
EMTALA	Patient transfers, appropriateness, patient rights
FLSA	Fair/equitable labor practices
NIOSH	Infection Control Standards
NRC	Radiation Safety
OCR, ADA	Office for Civil Rights, Americans with Disabilities Act
OIG	Privacy/security of health information
SMC HD	Food service inspection
Occupational Health and Safety and Environmental	
DLLR	Elevators & Boilers/Pressure Vessels
Fire Marshall	Workplace safety
NFPA	Fire Suppression
OSHA	Workplace safety/infections
Accreditation & Licensure	
AABB	Blood Bank Accreditation
CAP, CLIA	Laboratory Services Testing & Licensure
COP	CMS Conditions of Participation
MQSA	Mammography Standards
TJC	The Joint Commission
Financial & Environmental	
DHHS/CMS	Medicare/Medicaid
EPA	Environmental Protection Agency/Impact
HSCRC	Maryland State hospital rate setting
IRS	Not-for-profit status

Ms. Wray's reporting relationship is to the MSH Executive VP, Operations, Washington Region; the VPMA reports directly to the President of MSMH and has a matrix reporting to the Executive VP (EVP), Medical Affairs and CMO of MSH. He also is an employee of MSH. The VPF is directly responsible to the President of MSMH with a matrix relationship to the EVP, Chief Administrative and Financial Officer at MSH. Similarly, the VPN has a direct reporting relationship to the President of MSMH with a matrix reporting relationship to the Senior VP and CNO of MSH. The operational VP has a direct reporting relationship to the President of MSMH.

The hospital's MS develops its own by-laws, rules & regulations that are approved by the Hospital Board which has oversight for clinical quality at MSMH through MEC leadership.

MSMH's leadership system is comprised of governance and management which includes SLs, DLs, and MEC.

The key healthcare market segments of MSMH patients include those using the services of the inpatient, outpatient and ED settings. While the patients in these segments share similar expectations such as being informed, timing of the expectations is different. In the ED, patients expect to have their condition evaluated, their treatment started and their discharge within a few hours of arrival. In the outpatient setting (e.g. Ambulatory Surgery), the patients understand they will be in the hospital setting for a longer period of time; and in the inpatient setting, they understand their stay in MSMH may take a few days. One smaller but unique patient/community segment is the Amish/Mennonite who prefers limited technology interventions in care. Key **Stakeholder and Segment** groups and their requirements and expectations are found in Figs P.1-5 & P.1-6.

Due to the nature of the Maryland hospital rate setting system, individual insurers are less relevant and not considered key customers. The state sets the rates that all payers must pay.

Other Customers include prospective patients, competitors' patients and patients' families. The key requirements and expectations of these groups include those mentioned in Fig P.1-5 and also include quality

services sensitive to patient requirements as seen with patient satisfaction measurements.

Fig P.1-5 Key Stakeholders, Requirements & Expectations	
Patients & Patient's Families (Customers); MDs and other LIPs; Workforce; Students	Service, quality & safety; current technology; EBP; easy access
Community at Large	Service, quality & safety; value; current technology; EBP; easy access
External Governing Agencies; BOD	Compliance with regulations & statutes; high levels of quality & safety; financial stewardship

Fig P.1-6 Key Segments, Requirements & Expectations	
Inpatient (IP) Outpatient (OP) ED patients	Timeliness, keeping informed; communication; accessibility
Amish Donors Uninsured	Screenings; education; partnerships; high quality care & outcomes; communication; cultural respect
State Federal Voluntary	Meet/exceed requirements or standards

One of the more important **suppliers** is Cardinal Health providing medical, surgical and pharmaceutical items. Cardinal's presence at the MSMH VAT meetings ensures ongoing open and real-time communication. Other major suppliers include Up-To-Date Linen & Laundry and US Foods. Service suppliers include the Medical Waste Removal Company, KIWI-TEK (MR coding) and Transcend (transcription). The most important supply chain requirements include: order accuracy, timeliness, quality, value, reliability and safety, thus suppliers have a key role in assisting MSMH with its primary work system, the delivery of care to patients. In their partnership role with MSMH, the suppliers also allow the hospital to minimize inventory and personnel costs. Main suppliers contribute to the decision making processes by presenting alternative products that add value, improve competitive position, and reduce cost. Among the more important **partners** are contracted providers (e.g., Fresenius and HeaLogics), telemedicine & Maryland e-Care providers, Cerner, the local community college (CSM), and other higher education centers. These partners bring added expertise to aid in healthcare delivery that MSMH could not as efficiently provide on its own. CSM is not only a source of educational information but is also a source of personnel as newly graduated professionals seek job opportunities with MSMH. Other partners include the Foundations and Auxiliary so funds can provide scholarships for students pursing healthcare professions, Hospice Program support, capital funding and equipment that MSMH might not purchase as timely as they make possible.

The local Emergency Medical System (EMS), home health agencies, radiation oncology provider, skilled nursing facilities, and MedSTAR Transport are key **collaborators** who assist MSMH in implementing work systems and in actualizing the core competencies to provide patient safety, clinical excellence and patient satisfaction across the continuum. Seamless integration of patient care between MSMH and collaborators enhances quality and value to the patient thereby improving competitive position.

The chosen mechanisms for two-way communication and relationship management with suppliers, partners and collaborators are flexible based on their distance to our rural setting. Meetings and e-mails are the most commonly used tools for communication and relationship management with each of these groups and occur as needed and at pre-scheduled times, in person or by teleconference. Regularly scheduled meetings are most beneficial for key partners and collaborators. Although written correspondence including formal letters and memoranda is still a necessary component of doing business, communication now includes e-mails and text messaging.

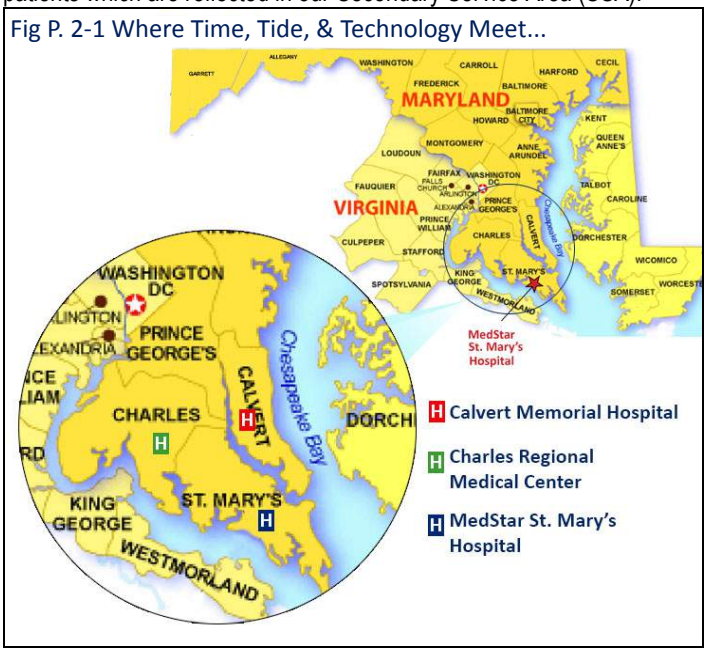
Key suppliers, partners and collaborators play an active role in MSMH's work processes. They provide expertise and share best practices, help identify future directions the hospital should take, assist in planning the designs of things such as new facilities and participate in the analysis of data to support PI. Of particular importance is the Cerner Corporation which has partnered with MSMH to develop an advanced fully integrated EMR and revenue cycle processes. In 2012, the local EMS system adopted a mechanism for communicating ECG tracings from the field to the ED for quicker identification/ confirmation of STEMI patients. This innovative technology assisted the safer and timelier handling of STEMI patients for appropriate care. These are just a few examples of the roles these groups may take.

P.2 Organizational Situation For FY 2013 MSMH held a dominant position in SMC and provided healthcare to 74% of the local market for inpatient admissions, 61% of ambulatory surgery center (ASC) outpatients, and 86% of the ED patients. In December 2011, a 2-room Surgi-Center opened within 2 miles of the hospital providing competition for the outpatient surgical business. Although surgical volume was lost to this Surgi-Center, there has been overall growth in outpatient services provided at MSMH. Consistent with national trends, ED utilization has been declining. At MSMH, part of this decline is the result of a deliberate attempt to reduce ED utilization through the expansion of operating hours at the Express Care facility and at our mobile clinic. In addition, we have collaborated with MSH affiliates to bring additional adult and pediatric primary care to SMC.

Competing community hospitals in the Southern Maryland region include one in Charles County and one in Calvert County, each about 31 miles away and similar in size (Fig P.2-1)

The Charles County hospital, University of Maryland Charles Regional Medical Center (CRMC), captures 4.4% of SMC residents while the Calvert County hospital, Calvert Memorial Hospital (CMH), captures 8.7%. These have been consistent figures for several years and are not growing significantly. MSMH captures some of the Charles and Calvert patients which are reflected in our Secondary Service Area (SSA).

Fig P. 2-1 Where Time, Tide, & Technology Meet...



There are several facilities in the region that represent competitors to MSMH and key collaborators for MSMH (Fig P.2-2). The two competing hospitals within the region compete for a broad portion of MSMH's total

business, while the Surgi-Centers, Urgent Care Centers, and Imaging Center compete for only a portion of MSMH's outpatient business.

Fig P.2-2 Competitors & Key Collaborators

Competitors		Key Collaborators	
Name	#	*Name*	#
Hospitals	2	Home Health Agencies	3
Surgi-Centers	5	EMS	1
Urgent Care Centers	2	MedSTAR Transport	1
Imaging Center	1	Radiation Oncology	1
		Skilled Nursing Facilities	4

A key change in MSMH's competitive situation occurred with the affiliation with MSH which provided new opportunities for collaboration and innovation. As the financial future for hospitals becomes increasingly more challenging, the security afforded by a large system assists in sustaining the competitive position of MSMH.

Through MSH, MSMH has access to a large research institute enriching research opportunities and MI2. MI2 was created to catalyze and create innovation that advances health.

Opportunities for collaboration exist in several areas: within the MS as the number of employed physicians increases; as other academic institutions come into the community to provide higher levels of education; as the EMS system grows in its comfort to manage additional patient conditions; and as specialty physicians increase through the MSH affiliation.

As a result of the strategic direction of MSH to be a Distributed Care Delivery Network (DCDN), the focus is to have care collaboration for patients among the various MSH facilities. Patients are cared for in the facility closest to their home and are referred to another MSH facility when higher-level expertise is needed. For example, many cardiac patients are transported to MedStar Washington Hospital Center (MWHC), a System hospital, when MSMH cannot provide the level of care that the condition requires such as open heart surgery. In this regard, MWHC is a key collaborator. Similarly, we collaborate with another System hospital, MedStar Georgetown University Hospital (MGUH), to develop needed physician specialties previously unavailable in the county, including transplant and other tertiary services.

Key sources of comparative and competitive data from within and outside the healthcare industry are shown in Fig P.2-3. Timing is among the limitations in MSMH's ability to obtain data. Often many months pass for data to stabilize and the most recent data is therefore not current when it becomes available (e.g., Hospital Compare, CMS HCAHPS). Other limitations include the willingness of other hospitals to share data for comparisons when the information is not publicly reported and the non-existent publicly reported data for the other competitors listed in P.2-2.

Fig P.2-3 Comparative & Competitive Data

Data	Inside Industry	Outside Industry
Patient Satisfaction	CMS, MHCC, NRC, HCAHPS	NRC
Mortality Rates	MHA, DHMH	Census Bureau
Salaries, Turnover, and Other Workforce Data	MacLeod, NDNQI, HHRA	BLS, Best Places to Work, Comp Analyst, OSHA
Associate Engagement	Towers Watson Morehead Assoc.	AWE, Towers Watson
Key Performance Indicators (KPI)	VHA, HSCRC	
Market	Sg2, The St. Paul Group	DECD
Quality & Patient Safety Measures	AHRQ, AHA, CDC, CMS, HSCRC, IHI, MHCC, MIEMSS, NDNQI, NQF, QAPI, TJC, HealthGrades	NIST ANSI

There are several key healthcare service challenges for MSMH. One example is the ED which has continued to experience high utilization over the last several years and currently is estimated at 52,750 visits/year. This is a high figure considering that SMC has about 109,000 residents. This fact strongly correlates that SMC lacks an adequate supply of primary care physicians. Similarly, there is a challenge to address ED patient satisfaction as high volumes are balanced with the need for additional staffing levels and associate turnover. When these two areas do not stay in equilibrium, ED patient satisfaction is compromised.

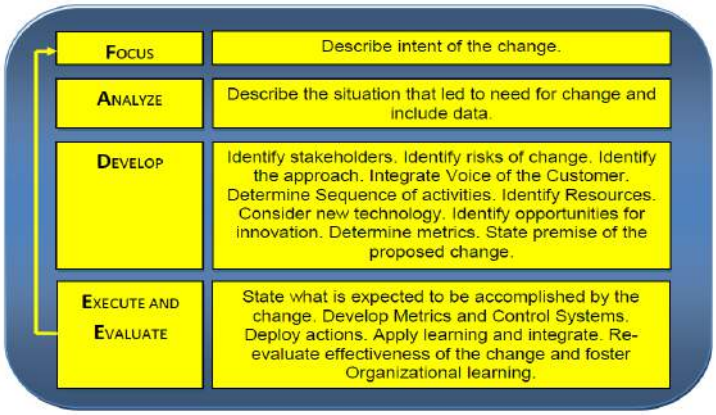
The key strategic advantages and challenges in the areas of healthcare services, operational, societal responsibilities and the workforce of MSMH are included in Fig P.2-4.

Fig P.2-4 Strategic Advantages & Challenges

Advantages	Challenges
Sustained high quality care (societal)	Physician shortage
Compassionate care	Changing reimbursement
Integrated EMR (HIMSS Stage 6)	Academic qualifications of associates
Community outreach (societal)	Specialty Care (HC services)
Sustained data driven PI	Inappropriate ED Utilization
MedStar affiliation/DCDN Vision	Engagement with consumers
Modern capital equipment, Technology	Paradigm shift to Population Health
Strong financial position	Workforce shortage (HR)
Local dedicated workforce	

Lastly, the key elements of the MSMH performance improvement system involve the acronym FADE (Focus, Analyze, Develop, Execute/Evaluate, Fig P.2-5), within which the Lean & 6-Sigma principles are incorporated. The design of the FADE process is to achieve organizational learning through a standardized management approach that is used to introduce new processes/services or improve existing ones. As one example, the FADE process is used for any major change management in the Organization.

Fig P.2-5 FADE



Several PI tools are used throughout MSMH as part of the Organizational PI Program. In addition to FADE, these PI tools include the following: Lean, FMEA, Root Cause Analysis, Adaptive Design and Peer Review. The use of these tools is explored further throughout Chapters 1 - 6. MSMH leaders are required to achieve yellow belt qualification in Lean & 6-Sigma (LSS) principles. Each tool assists SLs/DLs in engaging associates and physicians in improving processes and outcomes and in identifying innovative ideas. The PI Program uses cascading dashboards for all indicators and other PM tools such as monthly financials to evaluate current performance, predict future needs, monitor success and identify opportunities for mid-course corrections.

Innovation may occur at several stages of the FADE process (Develop & Execute) to optimize processes and outcomes. The Evaluation process at MSMH involves the collection and analysis of data with comparisons to competitor results and benchmarks from within and outside the healthcare industry and this feeds back into the Focus

process for another PI cycle. Organizational learning occurs in the Execute/Evaluation step fostering integration of fully vetted strategies.

Success in MSMH's PI Program is evident in the results chapters. These results demonstrate areas that are directly attributable to the work of the various councils, committees and cycles of improvement. Strong results are frequently the result of innovation. Continuous Improvement is a core competency and is the supporting framework to the disciplined approach that achieves high-level performance at MSMH. MSMH strives for top quartile performance and when achieved, sets its sights on top decile performance.

MSMH's organizational culture is predicated on the belief that diligence to continuously improve is the work of the organization and supports good stewardship of scarce resources. In all areas: strategic, clinical, operational, financial and support, policies and programs are developed and evaluated with continuous, systematic improvement as a foundation. This focus on continuous improvement enhances efficiency and reduces risk exposure. It is also through continuous improvement that the organization learns and moves closer to becoming an HRO. Leaders are expected to foster improvement through setting goals and priorities, planning, evaluation, education, providing time and resources, discipline and collaboration, taking risks, being innovative and empowering staff as appropriate. Leaders are expected to ensure that necessary processes and structures are in place to optimally manage business units. Accountability for quality and safety rests with the Board of Directors (BOD).

1. Leadership: Servant Leadership is the guiding principle at MSMH creating an environment for WF and POC engagement, innovation, risk taking and high performance built on effective two-way communication. Through transformational leadership, SLs engage stakeholders for the MSMH of the future with "one foot in today and one foot in tomorrow" as evidenced by the journey to move from an emphasis on episodic care to the strategic challenge of population health management.

1.1 Senior Leadership

1.1a(1) Vision and Values The synergy between the MVV of MSH and MSMH was one of the main reasons that the Hospital BOD chose to partner with MSH in 2009. SLs actively participate in the MSH Leadership and Senior Management Teams and therefore have high level input into setting the vision and values of MSH. The vision to be the Trusted Leader in Caring for People and Advancing Health is the foundation for SP/AOP development. SPIRIT values guide the MSMH LC, associates and MS in fulfilling the mission of being a community hospital upheld by a tradition of caring; continuously promoting, maintaining and improving health through education and service while assuring quality care, patient safety and fiscal integrity.

The AOP delineates goals, objectives and initiatives. The BSC (Fig 7.4-42) details performance, allowing the LC to spot trends, properly allocate resources and implement timely mid-course corrections. SLs meet weekly to address a specific AOP source of focus, monitor performance, address barriers & opportunities to ensure progress. The LC, comprised of SLs and DLs, meets monthly. These meetings keep the team informed of progress toward goals as well as continuing opportunities to reach identified objectives. The meetings are structured to focus on the MVV through the AOP. Subsequently, DLs hold monthly meetings with staff within one week of the LC. Additionally, SLs hold monthly 1:1 meetings with DLs to coach and share information. SLs also meet monthly with the MEC and quarterly with the MS departments & committees to similarly keep the MS informed of AOP performance and a focus on MVV.

SLs utilize many tools to disseminate information and inculcate the MVV. These include Town Hall meetings for the WF, publications including *The Pulse* for the WF and *Physicians Quarterly* for the MS, SL monthly departmental rounding and LC Retreats. Successful deployment of MVV to the workforce occurs when associates recommend each other for SPIRIT and Patient Safety Hero Awards. Semiannual self-assessment of SPIRIT values using an online performance management tool further demonstrates deployment.

MSMH employs a systematic approach to communicating the MVV to suppliers and partners during the selection process when MSMH evaluates "fit" and alignment. Suppliers and partners that work on-site attend the same orientation as MSMH associates where MVV are introduced. MVV are reinforced during meetings or other contact with suppliers and partners. SLs evaluate alignment with MVV throughout the life of the relationship to ensure these groups are evolving along with MSH as the competitive and regulatory environment changes.

SLs deploy the MVV to POCs and other stakeholders at every service access point, during community presentations, through the MSMH website, social media, marketing publications and HC outreach programs. As community liaisons BOD members are kept abreast of developments and act as MVV ambassadors. BOD meeting agendas include an open forum for members to share community feedback.

SL actions reflect commitment to the values in day-to-day activities including: role modeling behaviors; displaying the MVV organization-wide, including the MVV on meeting agendas, identification badges and in community presentations; and patient stories to begin meetings. Improving health through education and service is a strong focus at MSMH. Perpetual learning is important for patients, associates, leaders, and MS. SLs/DLs employ many tools to accomplish this aspect of the mission. Continuing education and maintaining competencies are provided to associates via OLR. HC provides community education and training with a wide range of offerings. HC also delivers direct care and health education via a mobile van primarily to underserved areas. LC members are instructed in LSS and are Yellow Belt certified. MSMH has an accredited CME program leveraging MSH's educational, research and simulation resources for MS/WF. Opportunities exist throughout MSH, including: MHRI, MI2, onsite and video conference Grand Rounds with CME's at MGUH and participation with GME programs with MSH.

1.1a(2) Promoting Legal and Ethical Behavior SLs/MEC are committed to legal and ethical behaviors demonstrated by role model behaviors, sound ethical business decisions, participation on committees and boards, and advocacy of patient rights. Annually, SLs/MEC must sign a COI statement disclosing any potential conflicts. Semiannually, SLs also disclose political contributions made confirming no undue political influence.

SLs/MEC promote ethical and legal behaviors through several mechanisms. SLs attend new associate orientation and communicate the expectations and commitment required of associates to ethical and legal behaviors. During the on-boarding process, The Code of Conduct booklet is provided to associates, which they sign and agree to follow. MEC members establish criteria for membership to the MS including background checks, queries to regulatory reporting databases, and acceptance of a code of conduct. Associates/MS are taught about HIPAA and receive specific training about violations during orientation. Associates must participate in annual compliance training. A System-wide hotline exists for associates/MS to report potential legal and ethical issues. In addition, the Diversity Committee heightens awareness of cultural differences and their potential impact on care. The Bio-Ethics Committee is a forum to contemplate ethical and legal standards in patient care. Finally, SLs promote legal and ethical behavior. Legal and ethical violations, detailed in the Major Offense Policy, have a faster paced disciplinary tract than routine discipline.

1.1a(3) Creating a Sustainable Organization SLs/MEC achieve the Mission and create a sustainable organization by aligning SP/AOP processes including System-wide, regional and hospital specific plans, financial forecasts and budgets. In the initial stages of development, SLs/MEC evaluate factors impacting achievement of objectives in the SP/AOP including: industry trends/benchmarks; environmental and social responsibilities; community needs; regulatory environment; financial projections; engagement surveys; workforce capacity and capability; existing facilities and equipment; and innovative clinical and operational IT solutions for data collection and analysis to facilitate agility and flexibility in decision making. Sustainability is achieved through goals, established and cascaded through the PM process. AOP and APs with 90-day updates are used to make mid-course corrections to sustain progress and provide quarterly reporting to the BOD and throughout the organization. These efforts reflect how the SLs/MEC are committed to continuous PI and organizational sustainability.

SLs respond to stimuli in the competitive environment with agility through continual re-evaluation of MSMH's position and making timely changes accordingly. These considerations are reviewed at frequent intervals (e.g. 90 days), may require new decisions during the weekly SL meetings, or necessitate emergency huddles to discuss critical issues with LC (and likewise, DL huddles with their associates as appropriate), and new APs may be created. New APs address opportunities for innovation and intelligent risk-taking. These efforts in conjunction with a strong financial position contribute to high performance.

SLs create and promote a WF culture that delivers a consistently positive experience for POCs and fosters engagement by emphasizing

the SPIRIT values, holding WF accountable through performance goals and expectations, APs, and promoting transparency through information sharing. SLs set the expectations to recruit and retain a highly qualified WF (Chapter 5). SLs believe in the adage "happy staff makes happy patients" and communicate that every associate is responsible for POC satisfaction. Each associate has an established path to the patient demonstrating ways to improve satisfaction. Through the path to the patient, associates concentrate on what they must do to assist in patient satisfaction and engagement. In addition, associates are taught, via role play, appropriate customer interactions to provide a positive first impression and foster other customer engagement. The WF completes interdepartmental surveys so each department can evaluate each others' customer service. Results are shared with associates to celebrate and/or correct behaviors. In receiving feedback from peers, different perspectives are learned, fostering engagement (Fig 7.2-22).

Through the PM system, TM, SLs/DLs identify the highest achievers as role model associates, characterized by life-long learning, leadership skills and thinking. SLs ensure personal and organizational learning through a multi-pronged systematic process including: establishing OLR and an interdisciplinary LDC; conducting annual education needs assessments and planning WF and stakeholder education, using internal and external resources; requiring annual mandatory education and leadership training; assessing performance semiannually; providing CME, scholarships, tuition assistance and certification incentives; and developing career ladders (Chapter 5).

DLs involve associates in achieving the PI measures that are included in the goals and APs for their department. The initiation of a PI project, the systematic collection of the results/outcomes, the re-evaluation of those outcomes and course-corrections, promote a personal learning environment for the WF across MSMH. In addition, by encouraging advanced degrees with tuition reimbursement, career ladders growth, achievement of certifications with reimbursement awards, and allocating resources for continuing education, the SLs are also fostering an environment for personal WF learning. Likewise, SLs design and implement their own development plans, shared with the President to enhance personal learning and leadership skills.

SLs recognize that beyond core leadership skills, additional leadership knowledge and skills are needed for future organizational sustainability. Therefore, purposeful leadership development occurs at the System level for the MSH LT and MSMH SLs at quarterly meetings. Based on the SP/AOP and future forecasting, SLs identify and implement learning development for SLs/DLs through monthly leadership book discussions and through quarterly EBP presentations. Additional measures for leadership development include LSS training, support to achieve other professional certifications such as FACHE, funds to attend state/national Baldrige training, professional organization seminars and annual meetings. Other recent MSH leadership development includes evaluation process training, coaching and mentoring to enhance two-way communication. TM allows associates and leaders to document all year to capture a more robust picture of performance.

MS leaders include patient satisfaction data on departmental dashboards. MS members receive frequent feedback on physician oriented patient satisfaction metrics including education on key drivers to help guide best practice performance. Patient satisfaction metrics for each provider is evaluated during the reappointment process.

SLs/DLs create an environment for innovation and intelligent risk-taking to achieve the strategic objectives and maintain organizational agility. The discipline of PI and change management processes, during the Develop phase of FADE, where innovation and risk taking are addressed, increases the likelihood that agility and performance objectives are achieved.

SLs/MEC participate in succession planning in several ways. During evaluation periods, SLs provide performance input about DLs within and outside their Divisions. SLs openly communicate about observed strengths of each DL and the potential for additional responsibilities/growth. When organizational restructuring is entertained, SLs discuss DLs' abilities to absorb additional responsibilities and potential for promotion. Some DLs are provided executive coaching to enhance leadership abilities. Future leaders are identified, groomed and developed. Progressive responsibility for MS members develops leadership skills and prepares next generation leaders.

MSMH has a PSC, recognized in 2007 TJC literature as a stellar example for associate involvement in patient safety. The PSC is comprised of representatives from each area in the hospital. These representatives communicate safety information and concerns between the council and the area they represent. As a result of their work 188 safety concerns over the past 4 years have been identified and corrected based on associate input. The President mandated that safety is the first item for discussion on all staff meeting agenda. Improvements in associate's perceptions of safety are in Secs 7.3 and 7.4.

During Administrative Rounds, SLs ask specific questions of the associates to reaffirm focus on safety. As a result of these deployed efforts and others, MSMH was recently recognized by HealthGrades with the 2012 and 2013 Patient Safety Excellence Award.

The MS contributes to patient safety through departmental peer review and the interdepartmental Peer Review Council, which reports to the MEC. MS members participate in patient safety initiatives and are recognized as Patient Safety Heroes.

1.1b(1) Senior Leadership Communication SLs effectively communicate with and engage associates emphasizing transparency and building trust. Generational and personal preferences for communication are evident in the vehicles used for communication including face-to-face, website, Facebook, hospital-wide meetings, department meetings, etc. These vehicles evolved through feedback from associate surveys, advances in IT and internal marketing.

Key to AOP accomplishment is effective communication so all associates understand their roles within the plan. SLs developed a standard approach to setting expectations and methods of communication across reporting relationships, e.g. a staff meeting standardized agenda was created to ensure coverage of cascaded information and focus on the work of the SP/AOP.

SLs engage associates through Questions and Answers at Town Hall meetings and by offering opportunities to volunteer in hospital sponsored community activities such as Relay for Life Team, Christmas in April, Hospice Run/Walk and many others.

MSMH assesses the effectiveness of two-way communication through the biennial associate survey with subsequent APs. After each survey, SLs/DLs analyze and share hospital and departmental data, including facilitated discussion leading to the development of APs which have resulted in refinements to communication. Examples include: initiation of an internal newsletter; associate suggestion line, box and online database; quarterly Breakfasts with the President and Town Hall meetings; use of intranet and other social media. SL Rounding and Breakfast with the President are particularly focused on ensuring two-way dialogue on matters of the day. This systematic survey was adopted to address the current and ongoing strategic challenge of WF shortages improving retention. Sections 7.3 & 7.4 demonstrate results.

A standardized process ensures SLs' successful communication with the MS, via cascading goals, formal and informal dialog. Each MS department and committee has a designated SL and DL to facilitate communication and follow up on action items. Additionally, SLs meet regularly with the COS. Information and decision making flows in both

directions between the BOD and MS via the COS. A physician satisfaction and engagement survey was implemented with subsequent APs developed to address areas for improvement that included the VPMA position, Physician Liaison, Physician Satisfaction Committee, improved TAT for radiology and laboratory, and enhanced CME.

Throughout the decision making process, SLs communicate with associates, MS and other stakeholders to solicit input and achieve engagement. Key decisions are communicated through numerous formats: direct mailing to associates' homes, *The Pulse, Physician Quarterly,* department meetings, Town Halls, SL/DL Rounding, e-mail, social media, and huddles. For most communications about decisions, manager tool kits are provided which include FAQs, Talking Points and handout materials. For more complicated topics, Meeting-in-a-Box training sessions are used for role play and real-time practice for DLs, capturing associate reaction to better plan for future communications. When communicating decisions, the information is shared within the context of the AOP and the impact on associates or MS to facilitate understanding and progress on the journey.

MSMH's reward and recognition programs are based on the SPIRIT values. Recognizing high performance and effectively addressing poor performance was an area of opportunity identified in the associate survey. Behaviors demonstrating SPIRIT values are evaluated annually within TM, making up 40% of the assessment. SLs hold monthly celebrations recognizing associates who continually role model SPIRIT values. From these awardees, the Associate of the Year is chosen. SL Rounding is also utilized to recognize associates amongst peers. Patient Safety Heroes are celebrated quarterly and represent the many unsung heroes who practice safely every day.

Based upon associate survey results, managers' tool kits were developed to provide timely access to congratulatory notes, candy bars and other small tokens of recognition and appreciation to make a real time impact on the associate.

MS and associates' recognition by patients is celebrated within department meetings, in letters to the individuals from the President and other SLs/DLs. The Salute Your Care Giver program and The Daisy Award were also instituted to recognize the outstanding work of associates and MS.

1.1b(2) Focus on Action A core competency of MSMH is continuous improvement built on the principles of LSS – the community deserves nothing less. This is clear in the MVV and is evident in the data driven focus measuring all aspects of performance. With transparency in reporting, SLs/MEC share the same information with the BOD, MS and WF. The SP/AOP have associated APs with quarterly status reports and intervention as needed. APs and strategies are developed using internal and external benchmarks to assess performance. These data are shared with stakeholders by the SLs and input from stakeholders is used to develop the APs. SLs are assigned as ELs to every AP and project, and through the FADE process are accountable for intelligent risk taking, pace, innovation, needed actions, results and celebration of work accomplished. SLs help stakeholders focus on creating and balancing value for POCs. Interdisciplinary teams ensure many perspectives are considered during problem solving.

SLs/MEC deploy the overarching policy for Organizational PI and a complimentary PM policy. SLs/MEC use data to assure there is a balance between value for patients and other stakeholders and performance expectations. For example, to create value for patients and stakeholders, SLs/MEC, working with the OR DL, took the calculated risk of restructuring the work process of OR scheduling to allow utilization of 2 ORs for a high volume ophthalmologist, adopting the efficiency of an ambulatory surgery center approach.

1.2 Governance and Societal Responsibilities.

1.2a(1) Governance System Governance sets the tone for continuous improvement for itself, leadership and the organization. There is a 17-member MSH BOD and a local MSMH 17-member BOD, the majority being independent community members. Approximately one-third are physicians who bring clinical expertise to the BOD and address the unique needs of this key stakeholder group. Both BODs include business leaders, MS and other key stakeholders.

While the System BOD is ultimately responsible for governance of MSMH, the MSMH President reports to the EVP, Washington Region, who evaluates her performance against established goals monthly, and annually with input from the MSMH BOD. MSMH VPs report to the MSMH President and are also evaluated based upon established goals.

The MSMH BOD is responsible for MS credentialing and privileging. MEC accountability to the BOD is fulfilled through the peer review process, OPPE/FPPE process and credentialing/re-credentialing.

Final fiscal accountability rests with the MSH BOD and is established between SLs and MSH leadership through the annual budget process and monthly review of financial results. The review includes a call between the VPF and MSH finance, a detailed narrative and quality of earnings analysis, and a high level review between the MSMH President and the MSH EVP. In addition to an annual independent financial audit, MSH employs an Internal Audit function and Corporate Integrity Program accountable to the MSH BOD, to assess and improve operational effectiveness and ensure legal and regulatory compliance (Figs 7.4-17 & 7.4-18).

With the financial, audit and compliance functions of governance resting with the MSH BOD, the MSMH BOD meets 4 times per year to review and assess the hospital's performance in quality, patient safety, and community benefits, holding SLs & MEC accountable for the results.

Potential BOD members are vetted through a transparent nomination process. To ensure needed expertise and diversity, the BOD Governance Committee, composed of community and physician members, analyzes the current board profile and identifies gaps in expertise or demographics against areas of influence that are important in executing the SP/AOP. Necessary traits for new members are then identified. Community members who express interest are considered as are other community members identified by current BOD members. Potential candidates are interviewed and vetted. In order to ensure transparency, the Governance Committee reports regularly to the full BOD during the nomination process, making recommendations to MSMH BOD who submits candidates for approval by the MSH BOD. Per policy BOD members complete an annual COI statement disclosing any business relationships with the System or its entities. BOD agendas begin with the requirement to identify potential conflicts of interest.

Per policy, the results of external organizations' audit/ assessment/investigation/survey/regulatory compliance review of MSMH must be transparently reported to the BOD. Follow-up APs are reported to the BOD on a routine basis until such time as issues are resolved.

Transparency among SLs/DLs, BOD, MS and the WF provide efficient transfer of information and protection of stakeholder interests. For example, SLs post operational data in advance of BOD meetings on the BOD portal for meeting preparation. The BOD's agenda purposefully starts with a patient safety story, positive or negative for full operational transparency. The agenda focuses on PI, MS development and QSPAC quality data, which with financial data is presented in a BSC.

BOD members are from the community and have a strong sense of accountability to protect the interests of the community, and drive continuous improvement, evidenced by the community health assessment, patient and MS engagement surveys, and the BOD's self-evaluation, detailed in Chapter 7.

MSMH has a primary strategy to promote from within and as such develops career advancement opportunities. DLs are provided leadership development programs and project responsibilities to prepare them for senior leadership advancement. Should a need arise due to the departure of a current leader or because of a new requirement identified in the SP/AOP and viable internal candidates are not evident, candidates are sought out and as a last resort an external search conducted. MS departmental vice chairs are identified in order to develop future MS leadership, committee chairs, and MEC members. MS leadership development is provided by MSH and MSMH, and is a specific focus of the new MSH Leader of the Future program.

1.2a(2) Performance Evaluation With the development of the SP/AOP, EL responsibilities for each component are assigned to SLs. Assignments are incorporated into performance expectations for the year as both team and individual goals; that, along with the assessment of leadership competencies and SPIRIT values, constitute the annual performance evaluation. Performance expectations include opportunities for improvement gleaned from POCs, WF and MS surveys. Thus there is full alignment and focus on organizational improvement. There is a complete BSC which forms the basis for President/SLs performance evaluation and executive compensation incentive awards. Team and Individual performance goals are agreed upon at the beginning of each year with relative weights assigned to determine the incentive award achieved. Executive compensation is reviewed annually and adjusted in accordance with the MSH BOD policy and nonprofit EBP. SP/AOP and budget performance is reported quarterly to the BOD and is also reviewed by the President with each SL. Input for SLs with matrix reporting, sought from System colleagues, is incorporated into evaluations. OFIs are identified, including education/professional development and incorporated into the next year's goals.

The SLs use their performance reviews to advance their development and improve leadership effectiveness by developing an annual learning plan, maintaining professional certifications, reading daily industry clipping services and through the use of executive mentoring.

The BOD appoints MS members for a 2 year term. At reappointment, a thorough review of clinical activity, citizenship, and adherence to quality, safety & patient satisfaction measures through the OPPE process occurs and is evaluated by the Department, MEC and BOD.

BOD members participate in a biennial self-evaluation utilizing the AHA survey (Fig 7.4-16). These results identify opportunities for individual member and full BOD development and are discussed at an annual BOD retreat. Educational programs are incorporated into future meetings and/or retreats to improve personal and BOD effectiveness. The BOD or committee chair mentors members about attendance and participation and this input is considered by the Governance Committee in reappointment recommendations. These efforts improve the effectiveness of the SLs, MEC, the BOD, and the leadership system.

1.2b(1) Legal and Regulatory Behavior and Accreditation SLs' approach to legal and regulatory compliance is to be early adopters of best practices, assimilating compliance mandates into operations at least a year before the mandates begin.

SLs/DLs assess the potential adverse impacts of operations and develop strategies to address them. For example, the EOC Committee develops policies and plans and guides implementation to minimize the environmental impact from hospital operations. Some of these include: the Hazardous Materials subcommittee initiative to reduce regulated medical waste disposal (Fig 7.4-38); the establishment of a "Green Team" (recycling programs); utilization of the Maryland Department of the Environment review of major construction projects and campus development; community forums for input on campus development plans; leadership of community-wide disaster preparedness efforts; and resource stewardship through energy conservation and effective supply chain management. Fig 1.2-1 demonstrates other opportunities to mitigate potential adverse impacts on stakeholders.

Fig 1.2-1 Examples of Minimizing Adverse Impacts

Opportunity to Address	Strategy/Process to Minimize Impact
Environmental	• Policies for Regulated Medical Waste Disposal Development and reduction initiatives • Development of Hospital "Green Team" • Use of biodegradable cleaning & paper products • MDE review of construction projects • Energy conservation with vendor partnerships
Community	• BOD members representative of Community participate in development of strategic plans • SL in local Chamber of Commerce, SMC Community Health Advisory Council's Community Health Assessment Teams • Community Benefits tracking systems
Disaster Preparedness	• EOP drills practiced (e.g., RACE, Code Red) • MSMH Emergency Management Team includes external representatives from the community • Pandemic Influenza preparedness
Supply Chain	• Utilization of MedStar Supply Chain processes, including use of MedStar Vendor Compliance Policy • Administrative Contract Policy with addenda to assure regulatory compliance
Patient Safety	• PSC comprised of front line associates to identify and reduce potential patient safety issues • Fully integrated EMR assures patient safety through forcing functions and EBPs • FMEA to mitigate potential future safety events • Incorporation of TJC SEA and state alerts

SLs/DLs anticipate and respond to public concerns in the following proactive ways:

- Developing organizational services and operations based on a formal community health assessment
- Tracking government/regulatory measures through risk assessments conducted with MSH legal, including use of Enterprise Risk Assessment and Management discipline
- Coordinating disaster preparedness with public health agencies, emergency responders and civic organizations
- Coordinating energy conservation initiatives with suppliers, e.g. Southern Maryland Electric Co-op reducing use at peak load times
- Leveraging vendor contracts assuring 96 hours of inventory
- Assuring confidentiality of patient records and respect for privacy: password protected computer access; computers in the patient care areas time-out after short periods of inactivity; mandatory HIPAA training in orientation and annually thereafter; VIP audits; and a structured process for patients to access their health information.
- Assuring patients are aware of their rights by providing a pamphlet upon admission and publicly posting them.

Fig 1.2-2 lists key compliance processes, measures and goals that allow MSMH to achieve and surpass regulatory, legal accreditation and risk requirements (Figs 7.4-21 through 7.4-24).

1.2b(2) Ethical Behaviors SLs promote and ensure ethical behavior in all interactions. Leaders live the SPIRIT values and lead by example in everyday work. The BOD, SLs, MS leadership and compensated MS members, are required to divulge any potential COI through a formal statement and are required to pass Medicare fraud screenings (Figs 7.4-13 & 7.4-27).

Associates are obligated to report situations they believe to be unethical and/or illegal to their supervisor or through the MSH Integrity Hotline, a confidential hotline monitored by a third party. Associates or

MS may also refer concerns to the Bioethics Council, the formal structure to address ethical dilemmas.

Fig 1.2-2 Key Processes, Measures & Goals for Compliance & Addressing Risks

Requirement	Process	Measure	Goal
Regulatory	State & Staff Licensure	DHMH Certification	Full
	OSHA Compliance	Number of unresolved complaints	0
Legal	Audits	Adjustments/Weaknesses	None
	Legal review	Number of Physician & Professional Service Contracts reviewed	100%
Accreditation	TJC/CMS, ACS, CAP, CLIA, AABB, ACR, MQSA, DHHS, DHMH, FDA, MIEMSS Stoke Certification	Compliance with standards	Full
Risk Management & Mitigation	ERM	Action Plan Completion	100%
	Regulatory Risk Assessment	Action Plan Completion	100%
	Safe Patient Care	Patient Safety Event Reporting	100% reviewed & investigated
		CLABSI	0
		SSE	0

MSMH has a process to credential vendors assuring they conduct business with integrity and respect patient confidentiality. Vendors are also required to disclose gifts or benefits given to any affiliate or associate. The vendor credentialing process also delineates appropriate procedures for accessing restricted patient care areas.

Key processes and measures for enabling and monitoring ethical behavior in the MSMH governance structure and in interactions with POCs, partners, and suppliers are listed in Fig 1.2-3. Ethical breaches are investigated thoroughly and are subject to remediation and/or performance management strategies up to and including termination.

1.2c(1) Social Well-Being Integral to the community economic system, MSMH promotes, maintains and improves health through education and service, so the citizens of SMC can enjoy optimal quality of life. SLs/DLs consider societal well-being during the SPP and plan for community benefit programming. This assures overall benefit to society as part of strategy and daily operations in the following ways:

- Completes a triennial community health assessment, guiding organizational strategy based on community needs and disease prevalence
- Works with the Fit and Healthy St. Mary's Coalition to address obesity
- Sponsors community and WF smoking cessation programs providing free smoking cessation medications to staff
- Provides Diabetes and nutrition counseling
- Provided over $10 million in community benefit and uncompensated care in FY13 (Fig 7.4-29 through 7.4-31 & 7.4-41)
- Recruits primary and specialty care physicians to reduce transfers and ED utilization (Figs 7.4-33 through 7.4-35)
- Contributes to a quality of life that facilitates other organizations' ability to recruit potential workforce
- Develops Emergency Management Plans with community agencies, including the county Emergency Operations Center, the Department of Health, the Department of Public Safety and the NAS Patuxent River (NASPR)
- Facilitates State Region V Emergency Operations Planning
- Conducts community forums to ensure appropriateness of care to special populations, e.g. the Amish community
- Provides scholarships in the medical sciences
- Assures environmental sustainability via a "Green Team" (Figs 7.4-38 & 7.4-39)
- Evaluating the feasibility of solar panels for cleaner energy

Finally, over 80% of associates live in the county, contributing to the economic strength of SMC.

Fig 1.2-3 Key Processes for Monitoring Ethical Behavior

Category	Key Process	Measure	Response to Breach
Board, SLs, MS Leaders	Conflict of Interest Statement	100%	Analysis & conflict resolution or removal
	Background check & Medicare Fraud Screen	100%	Non-selection or removal
	BOD Biennial Self-Assessment	Exceed National Average	Ethics/conduct policy education
	Immunizations	100%	Suspension in flu season; SL termination
Associates & Volunteers	Sign & adhere to Code of Conduct Statement	100%	Analysis & conflict resolution or Progressive disciplinary action
	Participation in periodic training on legal & ethical compliance standards	100%	Remediation or progressive disciplinary action
	Immunizations	100%	Termination
Medical Staff	Sign & adhere to Code of Conduct Statement	100%	Analysis & conflict resolution or corrective action
	Participation in periodic training on legal & ethical compliance standards	100%	Remediation or corrective action
	Immunizations	100%	Suspension during Flu Season
Suppliers	Sign Code of Conduct Statement	100%	Loss of Access
	Immunizations	100%	Loss of Access during Flu Season
Stakeholders	Complaint Evaluation	100%	Resolution

1.2c(2) Community Support In concert with the WF, SLs/DLs support and strengthen key communities served as identified during the SPP (Fig 1.2-4). The hospital provides: on-line resources to facilitate the patient's understanding of a variety of diseases; personalized health assessments; medication education; proactive health management; and the ability to locate physicians.

Fig 1.2-4 Identified Key Communities & Supporting Organizational Involvement

Key Community Identified	Supporting Organizational Involvement
Cancer Patients	Cancer Survivor's Picnic; Look Good, Feel Better
Obese	Bariatric Support Group
Expecting Families	Childbirth and Lactation Classes
Cardiac Patients	Classes on living well with a Cardiac Condition
Geriatric population	Early signs of Alzheimer's Disease Classes, Yoga Fit and Healthy Lifestyle Classes
Underserved and Underinsured	Get Connected To Health (mobile healthcare van/ clinic); HEZ
Grief Support Groups	Camp Sunrise, Traumatic Support, Through My Eyes, Sunrise Group, Good Grief

HC programs include community health education, immunizations, health screenings, disease specific community case management, workplace wellness, community safety programs and primary care for the uninsured and underinsured.

MSMH received a state grant in 2013 to provide services in an area with health disparities designated as an HEZ. This grant facilitated hiring community health workers and added a transportation route to improve access to care in eastern SMC. Additional grant funding allowed the expansion of services provided by our mobile health clinic "Get Connected to Health".

SLs/DLs are also represented in the community through the SMC Housing Authority, the SMC Community Health Advisory Council, the Chamber of Commerce, Southern Maryland Navy Alliance, United Way,

Health Share of St. Mary's, and Christmas in April for underprivileged families that need home repairs.

Finally, SLs are influencing the HC industry through service on statewide decision-making bodies including the MHQCC, MBON, MHA (Clinical and Legislative Councils), HSCRC work groups and serving as national and state Baldrige examiner.

2. Strategic Planning: In 2008, the MSMH Board recognized the significance of its strategic challenges (physician/specialty shortages, access to capital/purchasing power, healthcare reform and changing reimbursement) and made the bold decision to seek a merger with MSH, from a position of strength with its strategic advantages, and secured long term sustainability. Full integration into MSH now exists, thus strategic planning is done at the system level with extensive participation by MSMH stakeholders who drive development of tactics at the regional and local level.

2.1 Strategy Development

2.1a(1) Strategic Planning (SP) Process MSH began its current SP cycle by establishing a broad statement of action which connects the vision to the SP. This was developed by a team from across the System covering the healthcare continuum, including MSMH SLs/DLs. The result of this work was a strategic direction - MedStar 2020 – the journey to a Distributed Care Delivery Network which states, "*MedStar Health will evolve by expanding access and resources across the region; creating new business models with more focus on post-acute and primary care; and evolving our focus from episodic care for sick patients to a coordinated, bundled network of care across the continuum for all patients."* This strategic direction serves as the target for the development of the SP.

The SP development process is conducted in five phases: Identify Strategic Issues, Develop Goals and Strategies, Quantify Long Range Utilization and Financial Forecasts, Prioritize Major Multi-year Tactics/Priorities for Execution/Measures of Success, and Plan Approval. The 5 year timeframe (2013-2017) was selected in part to better integrate the SPP with the long range financial forecast, and annual review/modifications allow organizational agility based upon changing market dynamics.

In Phase 1, strategic issues are identified using a SWOT Analysis from which core competencies are validated, and blind spots and critical issues recognized. A situation analysis is created (internal and external metrics analysis) and is used to identify the critical issues (strategic challenges, opportunities and advantages). These include changing utilization and reimbursement, improving quality/safety/service, and implementing population health management. These issues determine the questions addressed by the SP. They are formulated based on analysis of the organization, the environment, possible future scenarios, evolving market assumptions and how success can be achieved while maintaining organizational flexibility. Stakeholder input is garnered minimizing blind spots not otherwise evident.

During Phase 2, goals describe the Vision toward which the organization will direct its efforts over the SP timeframe. Strategies specify the "how" of achieving the vision and goals. They are broad courses of action providing the framework for developing a tactical plan (serving as the basis for the AOP).

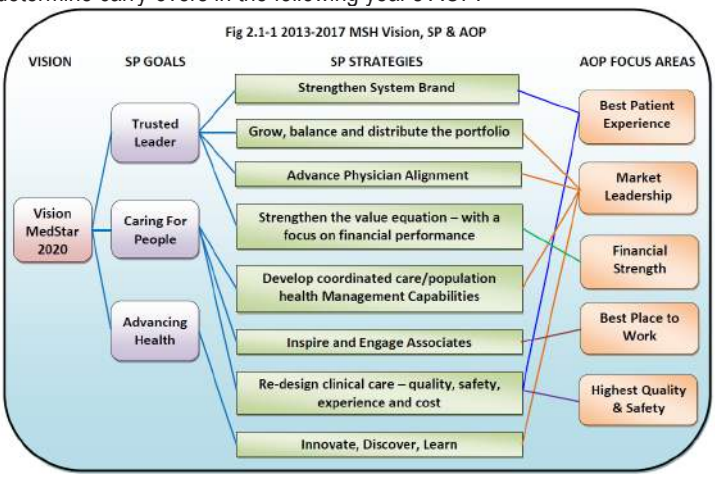
With the depth and breadth of MSH, regional market SPs are developed within the context of the SP to engage more stakeholders and develop specificity around implementation. In this context, stakeholders include the BOD, MS, MSH LT, SLs, DLs, associates, the community, partners and key suppliers. Service line focused teams develop the details.

Phase 3 includes long range utilization projections and the resources to execute the SP. They are incorporated into the priorities for funding in the Long Range Financial Forecast.

The fourth phase, Tactical Planning, includes developing multi-year tactics, determining metrics to assess success, identifying resources, establishing accountability and timing, and setting priorities for execution in year one. Near term and out year targets are set for metrics. Because tactics often address multiple strategies, the SP work is streamlined into 5 areas of focus (objectives) for the current year's work (AOP).

Throughout all phases of development, draft plan documents are vetted with BODs, LT, SLs/DLs, and MS. The final SP phase includes securing the MSMH BOD recommendation to the MSH BOD for final approval. To address the need to be flexible and agile, the SP is refreshed annually to determine new and updated measures, identify new targets, determine carry-over and new tactics to develop the next AOP and achieve the SP. The SP is implemented through AOPs, budgets and APs. The AOP's 5 areas of focus/strategic objectives are achieving world class performance in Highest Quality and Safety; Best Place to Work; Best Patient Experience; Market Leadership; and Financial Strength. The approach to moving MSMH from G2G requires the WF to understand and embrace their individual roles in context of the SP/AOP and in improving performance. A crosswalk of SP goals and strategies to the AOP (Fig 2.1-1) was developed to frame this work. There is accountability for the System AOP at the MSH LT level via cascading responsibilities throughout the System. There is accountability for the MSMH AOP at the SL/DL level, cascading responsibilities to the WF (Fig 2.1-2). SLs/DLs implement the AOP and based on organizational learning from prior year's performance, review it to determine new and updated measures, new timelines and tactics and determine carry-overs in the following year's AOP.

Fig 2.1-1 2013-2017 MSH Vision, SP & AOP



2.1a(2) Innovation Innovation, research and learning are so key to future success that it is identified as a specific SP strategy with delineated tactics, with MI2, including Human Factors Engineering, and MHRI as key resources. Further, integration within MSH allows innovation to flourish. SLs/DLs/MS/WF meet with colleagues to learn, brainstorm and share best practices across MSH. This approach identifies strategic opportunities for service line development, use of technology and consolidation of operational infrastructure. Intelligent risks are identified and result in developing and implementing SP/AOP tactics (Fig 2.1-4).

Key strategic opportunities include: expansion of telemedicine to meet physician shortages and access to specialty care, reducing readmissions with community partners using new processes to respond to changing reimbursement, partnering with institutions of higher learning to advance associate academic qualifications, development of

HEZ programming to reduce inappropriate ED utilization and shift the paradigm to population health management, incorporating the VOC directly to SLs/DLs to engage with consumers, and creating engagement oriented APs to address WF shortages.

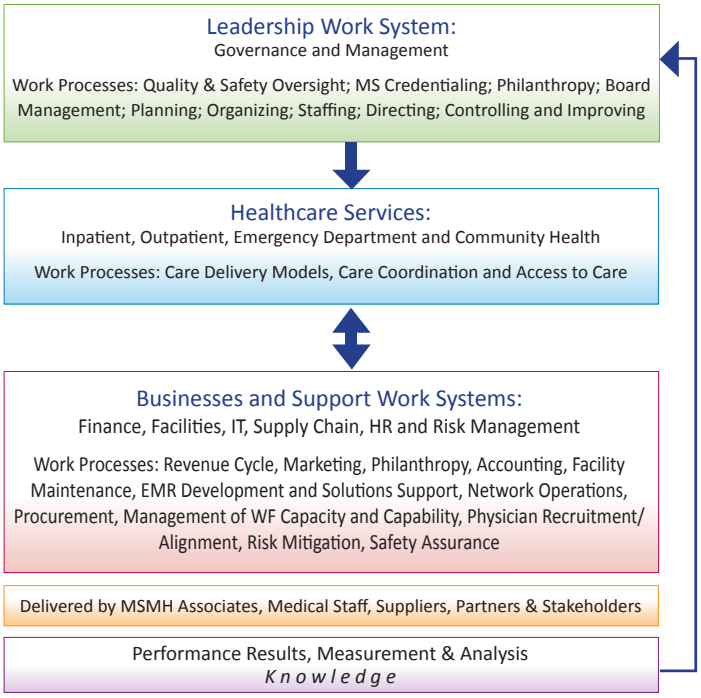
Fig 2.1-2 The Road Map to MedStar 2020

2.1a(3) Strategy Considerations The SPP addresses strategic advantages and challenges, sustainability, potential blind spots and barriers to execution through information collected which are analyzed using a data driven approach with reassessment at routine intervals. SLs identify and collect data on these key elements by leveraging the EMR, researching industry databases, surveying VOC and WF. Analysis techniques include comparatives to industry benchmarks, internal and competitor performance execution, regression and market forecasting. This analysis provides information used to identify and validate risks, strategic advantages and challenges. The analysis helps identify blind spots such as evolving competitors' services, e.g. wound healing which may lead to an SP update or the uncertainties of population health management where the goal is to keep people healthy and out of the hospital, clearly challenging organizational sustainability.

2.1a(4) Work Systems and Core Competencies MSMH key work systems are those required to carry out the Mission (Fig 2.1-3). The BOD and SLs/MEC make all organizational decisions within the context of the MVV and SP/AOP using data to add value to POCs and optimize scarce resources.

Outsourcing key work processes, external or within MSH, is considered when MSMH benefits from economies of scale, lacks expertise or when resources are limited, e.g. remote hosting of the EMR by Cerner (Fig 7.1-27). These decisions are based upon who has the better core competencies that provide the best value – quality, service, outcomes and cost effectiveness.

Fig 2.1-3 Key Healthcare Services, Work Systems & Work Processes



As the SP/AOP evolve, competencies are identified as essential for future sustainability and if lacking, tactics include competency development. Two current examples are the need for different leadership competencies and population health management infrastructure development.

2.1b(1) Key Strategic Objectives Key strategic objectives are detailed in Fig 2.1-4, with initiatives for implementation. While the timeframe to accomplish this work is generally 1 year, some initiatives/tactics may be multi-year. Those identified as most important are included in the quarterly report to the BOD (Fig 7.4-42). Changes planned include the integration and expansion of key service lines; improve access to primary care; pursue higher education partnerships to develop WF capability; the development of a structured Leader of the Future development program and Education and Simulation Center; expansion of telemedicine applications; IMSP solutions to advance the analytics of the EMR and to further educate and engage the POCs with MSMH; and evaluation of MSH and external resources/suppliers/partners' capabilities to replace internal work processes.

2.1b(2) Strategic Objective Considerations Key initiatives (incorporating strategic opportunities) within each strategic objective are developed and implemented to address the needs of POCs and the WF, and to minimize risk of strategic challenges. Fig 2.1-4 cross references each strategic objective, the strategic advantages and core competencies used as foundation, the strategic challenges to be addressed by key initiatives, with aligned metrics, outcomes and longer term targets.

2.2 Strategy Implementation

2.2a(1) Action Plan Development With the BOD approval of the AOP, the President assigns ELs to each initiative. ELs engage DLs to develop APs to implement key initiatives. APs with metrics are developed by teams of WF, suppliers and partners based on the systematic approach, of the FADE process, using DMAIC methodology. Key short and long term plans (initiatives) are identified in Fig 2.1-4.

Fig 2.1-4 MSMH FY 14 Annual Operating Plan Summary

	Strategic Advantages (SA) & Core Competency (CC)	Key Initiatives (Strategic Challenge)	EL	Sample Key Measures	Figure	FY 12 Actual	FY 13 Actual	FY 14 Proj.	FY 15 Target
Highest Quality & Safety Strategic Objective: Redesign clinical care-quality, safety, experience	SA: Sustained Highest Quality; Integrated EMR; Sustained Data Driven PI CC: Safety & High Quality; Innovation; Transparency; Continuous Improvement	- Participate in the Development of a system wide patient safety program to include the AHRQ Survey. (SC6-8)	VP	# serious events	7.4-42	5	6	1	0
				# of ICU CLABSI	7.1-18	0	0	0	0
		- Implement systematic approach to redesign the clinical care model to support population health management including the reduction of the readmission rate. (SC7)	VP	↓ 30 day readmissions rate (HSCRC)	7.1-8	8.22	7.8	7.6	<7.6
				Delmarva Composite > 96%	7.1-23	98.44%	98.70%	98.70%	> 96%
				QBR Top Quartile	7.1-3	7th	7th	Top 5	Top 5
		- Develop systematic approach to HAI management (SC7)	VP	HAI Top Quartile (MHAC)	7.1-15	2nd	2nd	2nd	Top 5
		- Implement next phases of IMSP; meet MU requirements (SC6-7)	VPF	↑ MU criteria: VO percent (<20%)	7.4-12	6.84	6.03	<6	<6
				↑ MU criteria: Meds Rec rate (>.5)	7.1-25	N/A	0.87	0.89	>.90
Best Place to Work Strategic Objective: Inspire and engage Associates	SA: Local dedicated WF CC: Transparency; Innovation; Continuous Improvement	- Complete 2013 Associate Survey Aps; Pulse Check (SC8)	VP	↑ Increase 2013 EEI by 2	7.3-20	76	79	81	82
				>80% participation rate	7.3-18	>80%	>80%	>80%	>80%
		- Leadership Development Program to include MedStar Leader of the Future (SC1-8)	Pres, VP	↑ Role Model retention rate	7.3-3	96%	97%	97%	98%
		- Implement Capacity & Capability WF Plans to include more higher educ. partnerships (SC3) & improved HR processes.(SC8)	VP	Average Time to Fill	7.3-4	38.1	29.5	29.0	28.0
		- Pursue Magnet Journey (SC1, SC3, SC8)	VPN	↑ % BSNs	7.3-10	36%	42%	46%	50%
Best Patient Experience Strategic Objectives: Strengthen system brand and re-design clinical care-quality, safety, experience and cost	SA: Compassionate Care CC: Patient Satisfaction; Continuous Improvement; Transparency	- Improve patient and staff relationship through SPIRIT Inside Training and setting expectations (SC6)	VPN	Overal Inpatient	7.2-1	75.0%	74.3%	75.0%	75.0%
				Overal Ambulatory Surgery	7.2-11	81.4%	85.3%	85.5%	86.0%
				Overal ED	7.2-13	52.0%	50.7%	52.0%	53.0%
				Communication with Nurses	7.2-2	86.3%	83.9%	84.0%	84.5%
				Communication with Doctors	7.2-6	80.5%	81.3%	81.9%	82.5%
				Pain Management	7.1-21	78.8%	75.5%	76.0%	77.0%
				Communication about Medication	7.2-6	71.4%	70.6%	72.4%	74.0%
		- Expand patient and community involvement in patient experience (SC6)	VPN	Willingness to Recommend (IP)	7.2-25	75.5%	75.3%	79.1%	80.0%
				Discharge Information	7.2-3	87.2%	90.6%	91.0%	91.5%
		- Expand hospitality focus of services (SC6)	VPN	Responsiveness of Staff	7.2-4	71.2%	70.7%	71.0%	71.5%
				Cleanliness	7.2-5	76.6%	77.3%	79.1%	80.0%
				Quietness	7.2-5	67.6%	67.5%	69.9%	71.5%
		- Develop new strategies to address HCAHPS questions. (SC6)	VPN	MedStar Way: Hourly Rounding	7.2-7	94.1%	N/A	>95%	>95%
Market Leadership Strategic Objectives: Grow, balance and distribute the portfolio; physician alignment; and innovate, discover & learn	SA:Community Outreach; MSH Affiliation & DCDN Vision CC: Safety & High Quality; Innovation; Transparency; Continuous Improvement	- Expand primary care access (SC1, SC5)	VPMA, VP	Market Share (IP)	7.5-10	72.2%	73.7%	74.0%	75.0%
				Admissions/Observations	7.4-42	10,578	10,713	10,828	10,757
				Market Share (ED)	7.5-15	85.9%	86.0%	86.0%	86.0%
				ED Visits	7.5-15	54,028	56,482	52,772	51,189
				Community Benefit $	7.4-29	$10.9m	$11.9m	>$11.9	>$11.9
		- Maximize system cardiology service lin integration (SC4)	VPMA, VP	↑ Cardiac Market Share (IP only)	7.5-12	77.8%	78.9%	79.2%	79.5%
		- Expand access to specialty care via advancement of regional service lines in colo-rectal, neurosciences, vascular, oncology and orthopedics. (SC1,SC4)	VPMA	↑ Orthopedic Market Share (IP only)	7.5-14	61.3%	57.6%	58.1%	59.0%
				↑ Oncology Market Share (IP only)	7.5-13	72.0%	69.8%	70.0%	70.5%
				# physicians recruited	7.4-33	3	4	6	6
				↑ Physican survey participation rate	7.4-8	57%	N/A	63%	N/A
				Market Share (ASC)	7.5-11	62.7%	60.9%	61.5%	63.0%
				ASC Cases	7.4-42	5461	4674	5151	5344
Financial Strength Strategic Objective: Strengthen the value equation-with a focus on financial performance	SA: Strong Financial Position; Modern equipment, technology CC: Financial Stewardship; Innovation	- Implement LSS projects to reduce waste & achieve cost savings & other evaluations of alternatives to internal work processes, demonstrating ROI where feasible (SC2, SC6-7)	VPF, VP	Total Exp/EIPA < $6,335	7.5-4	$6,235	$6,375	$6,268	$6,319
				FTE/1000 EIPD ≤ 14.51	7.4-42	15.45	15.15	14.58	14.45
		- Assess impact of changes to Maryland reimbursement system & respond to reduce cost and maximize revenue. (SC2, SC6)	VPF	Operating margin ≥ 5.3%	7.5-1	7.30%	6.8%	8.76%	6.0%
				Operating revenue ≥ $139 million	7.5-3	$138m	$134m	$142m	$143m
				Total Donations	7.4-40	$912k	$1.1m	$1.4m	$1.5m
				Operating income	7.5-2	$9.9m	$12.3m	$11.3m	$8.6m
		-Implement renovations; initiate design for next phase. (SC4, sC6)	VPF	Age of Plant < 8yrs	7.5-6	6.84	7.94	7.95	7.75

Key for Strategic Challenges: **SC1** = Physician shortage; **SC2** = Changing reimbursement; **SC3** = Academic qualifications of associates; **SC4** = Specialty Care Access; **SC5** = Inappropriate ED Utilization; **SC6** = Engagement with consumers; **SC7** = Paradigm shift to Population Health; **SC8** = Workforce shortage

2.2a(2) Action Plan Implementation APs are systematically deployed throughout MSMH to the WF, key suppliers, partners and collaborators using a variety of methodologies. Each AP is assigned to SLs/DLs who have accountability and lead interdisciplinary teams that may include WF, POCs, suppliers, partners, collaborators, using business planning templates and education/communication tools. Plans are incorporated into SL/DLs' mutually agreed upon annual goals as part of the evaluation process. DLs share 90-day APs so SLs can help eliminate barriers to success, facilitate agility and ensure outcomes are sustained. DLs deploy APs to associates via departmental staff meetings and committees where feedback is used to modify plans. For example, the Laboratory associates engaged in a project improving

physician satisfaction, optimizing phlebotomy staffing plans (Fig 4.1-1) and designing efficient construction schematics. MSMH AP updates to WF are also provided through rounding, Town Hall Meetings and formal written communications. Metrics are determined for each plan and become part of quarterly dashboard updates to BOD committees, MS, SLs/DLs and WF to demonstrate outcomes are being met, midcourse corrections are being made and performance is sustained.

2.2a(3) Resource Allocation SLs ensure financial, IT, HR and other resources are available to support accomplishing APs while meeting ongoing obligations. Forecasting resource requirements is accomplished based on data from prior years, trended market data, new service projections and state rate regulations. ROI is calculated for APs based on medical necessity, cost savings and/or cost avoidance. Finance associates are incorporated into AP teams. AP resource requirements are incorporated in to annual operating and capital budgets. HR needs calculated during the budget process include paid hours for staff, away from their primary duties, to participate in team activities related to AP implementation or other performance initiatives.

DLs are accountable for budgets which are analyzed at least monthly and reviewed with SLs for course corrections. Achieving budget targets is part of each DL's annual goals and monitored with SLs via standardized budget reports and analysis tools. Budgets may be reprioritized and resources reallocated as required for AP modifications.

Financial and other risks are assessed initially and as part of an ongoing process based on past and current performance, quarterly market analyses and the regulatory environment to assure rapid cycle improvement and resource reallocation.

2.2a(4) Workforce Plans Key WF plans including organization-wide capacity and capability assessments are developed as part of the AOP to support short and long-term strategic objectives and APs. Current short-term and long-term WF plans with potential impact on WF capability and capacity needs are found in Fig 2.2-1.

Fig 2.2-1 FY14 AOP Key Workforce Plans

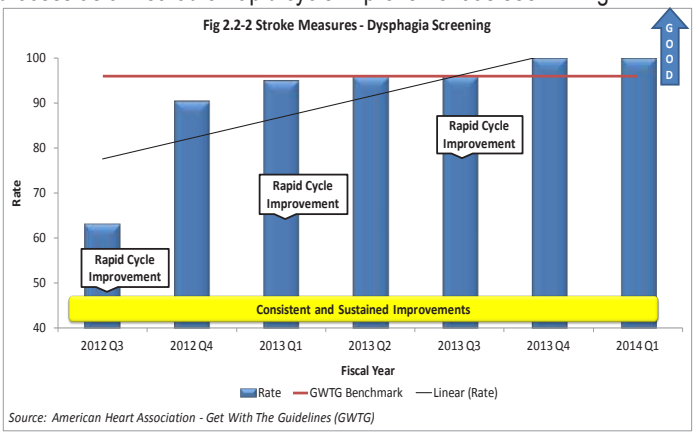
Strategic Objective: Best Place to Work		
WF Plans	**Key Measures**	**Key Tactics**
Engagement Plan – Develop/implement APs based on FY13 survey and conduct pulse check	Participation rate 80% Action items completed 100% EEI increase by 2%	Action Plans, Communication Strategies, Repeat survey
Leadership Development Plan	Meet dashboard targets Role Model retention 100	Leadership book club; required training, dashboard activities
Capability Plan – Identify Appropriate resource utilization by assessing skill mix	% BSN Degree % Annual Mandatory & Competency successful achievement Nursing Resources outcome measures	Increase RN to BSN scholarships Increase # of academic partnerships Develop 8 measures
Capacity Plan – Reduce WF shortages to achieve MSMH goals & action plans	Vacancy Rate Retention Rate Time to fill open positions Net gain 10 FTE for RN per diem pool	Hire 10.0 FTE Associate Engagement APs Implement SiTEL LMS

2.2a(5) Performance Measures AOP key performance measures (Fig 2.1-4) are shared with stakeholders via dashboards to reinforce organizational alignment. PMs are re-evaluated annually and PRN to ensure they track effectiveness and achievement of AOP/APs.

Annually, PM associates review regulatory requirements, literature and future EBPs across the nation to predict changes and improvement efforts. The research is compared to the AOP, APs and financial plans for alignment and to ensure that the overall management system covers key deployment areas and stakeholders. This research is shared at MS departments and committees, involved hospital committees and with SLs/DLs to determine indicators for the following year. Some dashboard indicators are retired and some maintained, new ones added or expanded as needed to ensure that MSMH is always on target to improve and sustain performance outcomes. SLs'/DLs' approach to achieving best practice is to proactively assess potential healthcare measures as specified by regulatory and accrediting bodies at least one year in advance. Furthermore, MSMH participates in beta studies and state collaboratives that evolve healthcare practice. Adopted indicators and associated APs are shared with key WF deployment areas, e.g. QSPAC, LC, department meetings, team huddles, division meetings, 1:1 leadership meetings, rounding, story boards, *The Performance Highway,* e-mails, bulletin boards and educational fliers with test questions documenting comprehension.

To further ensure that the AP measurement system reinforces organizational alignment and desired outcomes, the QSPAC performs an annual self-evaluation of all PI initiatives. This self-evaluation process includes an assessment of key deployment areas and stakeholder involvement (Fig 7.4-14).

2.2a(6) Action Plan Modification APs are dynamic and modified as needed to achieve desired results. Based on the FADE process used by teams and the continuous evaluation of progress to meet objectives, APs are modified when data analyses demonstrate the need. Teams report to SLs, BOD and MS committees, and others at least quarterly, and share APs with proposed modifications. SLs may empower teams to modify APs between quarterly updates as needed based on changing market conditions, new legislative or regulatory requirements. An example of the AP modification process was the need to reduce ED TAT for admitted patients. A cross-functional team used numerous PI cycles, resulting in top quartile state performance (Fig 7.2-17). When conditions warrant, SLs impose tighter timeframes on the FADE process as a method of rapid cycle improvement as seen in Fig 2.2-2.



2.2b Performance Projections Long and short term performance projections for key PMs are in Fig 2.1-4. Projected PMs are based on past performance, industry and EBP benchmarks and local competitor performance. Quarterly SLs/DLs compare projected performance to regional competitors, state and national benchmarks including market share data, QBR & MHAC standing, Hospital Compare data, TJC S3 scores, HCAHPS performance, and seek competitor market intelligence via advertising, web sites and social media. SLs set stretch goals to achieve top decile performance, above competitors, regulations and benchmarks. Performance gaps are identified through the PM process and APs are adjusted accordingly. If gaps between MSMH and competitor performance are identified, analyses are conducted to address the gaps which are incorporated in the next AOP/AP.

3. Customer Focus: MSMH's SPIRIT values are the guiding principles to overcome the strategic challenges to engage and balance differing expectations of POCs (e.g. ED utilization), creating strong relationships to ensure long-term market success and sustainability.

3.1a(1) Listening to Current Patients and Other Customers MSMH defines the patient experience as "*The sum of all interactions, shaped by an organization's culture, that influences patient & family perceptions of care regardless of the healthcare setting*." MSMH has a focused approach to listening to the VOC from POCs for both satisfaction and dissatisfaction through its POC committees. The PEC listens, observes and directs actions that are obtained from or affect the VOC. Each patient segment subcommittee listens to VOC for its segment and shares this information with the PEC for organizational learning across all segments. The PFPF, as a POC advisory group, provides a higher level capability to proactively obtain direct VOC information and observation of behaviors.

SLs/DLs learn satisfaction and dissatisfaction information through several mechanisms (Fig 3.1-1) in addition to the previously mentioned committees. Consistent with the Patient First SPIRIT value, SLs/DLs listen to the VOC in as many ways as possible. Information derived from these mechanisms is collected and used in the development of the AOP, in APs and as part of the cycles of learning to improve service.

Fig 3.1-1 Listening and Learning for Actionable Information

	Stage			Segment			Category			Stakeholder		
Mechanism Tools	Pr	D	Po	I	O	ED	C	F	P	A	MD	Co
NRC Surveys			*	*	*	*		*		*	*	
Focus Groups	*		*	*		*	*	*	*			*
MSMH Website	*	*	*	*	*	*	*	*	*	*	*	*
Social Media	*	*	*	*	*	*	*	*	*	*	*	*
Rounding		*		*	*	*	*		*	*	*	
Patient Adv		*		*	*	*	*		*	*		*
Point Prevalence		*		*	*	*						
Service Recovery		*	*	*	*	*	*	*		*		*
Discharge Phone Calls			*	*	*	*		*				*
Follow-up cards/ letters			*	*	*	*		*		*	*	*
President Letter			*	*	*	*		*	*	*	*	*
PFPF Advisor			*	*	*	*			*			*
Cross Continuum Committee			*	*	*	*	*	*	*	*	*	*
Guests at PEC		*	*	*	*	*	*	*	*	*		*

Key: Pr=pre; D=during; Po=post hospitalization; I=inpatient; O=outpatient; ED=Emergency Department; C=current; F=former; P=potential, possible competitor's; A=associate; MD=physician; Co=community member

The VOC is important to measure stakeholder engagement, e.g. MS, associates and members of the community. Fig 3.1-1 demonstrates some of the various tools available to listen to stakeholders and obtain actionable information, which may be built into the AOP, APs or may identify areas for immediate response and ultimate deployment.

Patient complaints, in person, by letter, social media comments from POCs, and NRC telephone surveys are common ways for SLs/DLs to learn from the VOC. In addition, every other month, POCs are invited to a PEC to achieve real-time organizational learning through more in-depth understanding of their experiences before they are discharged. Part of the process includes direct inquiry as to what made them dissatisfied while at MSMH. The PEC is able to observe behaviors and seek immediate, actionable information during these meetings. As an example, during an electrical outage, family members were not informed that OR patients were safe. As a result of verbal and nonverbal dissatisfaction expressed by a family member (other customer) during one of these PEC meetings, SLs required OR staff to share information should this situation reoccur.

MSMH uses the prevalence of returning patients as a key measure of POC behavior reflecting engagement, for example, for the past 3 years there has been a 9.2% increase in the number of patients returning for annual mammograms. In addition, SLs/DLs receive POC comments through web-based mail. These comments are distributed to the appropriate DL for resolution. Investigation results, solutions and follow-up are entered into the LS for internal tracking. With social media, MSMH has an additional mechanism for POC comments. Complaints are entered into the LS and followed with phone calls to the complainant as described in Sec 3.2. Compliments are forwarded to the DL for public recognition, instant awards, or hand written notes.

NRC surveys, used to measure patient satisfaction, are conducted through telephone interviews because phone surveys are reliable and diverse samples are achieved. Surveys are continued until a statistical sample size from each segment is reached: inpatients, outpatients and ED. These surveys provide both quantitative and qualitative data and comments. Survey results are shared on many levels and deployed to the departments that own the information. APs are developed with involved associates based on information obtained. Organizational learning starts at the unit level with the deployment and use of this information and subsequent changes to the unit-based actions are made as organizational learning occurs.

Unit level discharge phone calls are initiated by the third day after discharge. The purpose of these calls is safety and provides immediate actionable satisfaction/dissatisfaction feedback. These calls explore the quality of healthcare services, support for POCs, and dissatisfiers. Although associates aim to reach 100% of discharged patients, these calls actually reach about 70% because of incorrect numbers or non-answered phones. The feedback received from these calls, allows SLs/DLs to address specific areas that improve patient satisfaction, address dissatisfaction or meet specific needs of the patients. While calls ascertain the well-being of the patient, there are also specific segmented reasons for the calls (Fig 3.1-2).

Fig 3.1-2 Segmented Populations of Interest for Discharge Calls

Area	Populations receiving follow-up calls and Interest Reason
ASC (OP)	Patients from the prior day – evaluating possible complications
ED	Pediatric patients; young parents; adult patients with chest pain or abdominal pain – evaluating resolution of symptoms in high-risk populations
Telemetry (IP)	CHF and chest pain patients - evaluating recurrence of symptoms; appropriateness of discharge; possibility of readmission
Med/Surg/ Peds (IP)	Orthopedic patients; adult general surgical patients; adult medical patients – evaluating areas of hi-risk complications
WHFBC (IP)	All first-time mothers and those with cesarean section – evaluating loss of confidence, need of support
Hi-risk IP Populations	CHF, COPD, AMI, Renal Failure – evaluating diagnoses with hi-risk complications; possibility of readmission

SLs strive to be responsive to the MS. Physician satisfaction surveys are conducted triennially. Survey results are shared with MEC, MS and the BOD and APs are developed. SLs have routine meetings with MS Leadership. Physicians are formally and informally engaged by Physician Services as are their practice managers.

Associate satisfaction and engagement is discussed in Chap. 5. Similar to patients, VOC from physicians and associates, community and other customers is captured (Fig 3.1-1). Through SLs'/DLs' participation in community activities and focus groups with key community segments, they receive stakeholder feedback, support and a view into the long term needs of the community.

3.1a(2) Potential Patients and Other Customers SLs/DLs listen carefully to potential patients, visitors of current patients and competitors' POCs to obtain actionable feedback through the following systematic approaches and deployment efforts: community health assessments; focus groups; physician referral requests & physician feedback; market share analysis; PEC and PFPF meetings; community

forums; celebrations and learning activities for former, potential and competitors' patients; market intelligence via advertisements and competitor websites/social media. HC provides community outreach to promote awareness of services to potential/ competitors' patients.

Organizational learning occurred as a result of a focus group including patients living in the SSA who were hospitalized at MSMH or with a competitor. Group feedback indicated confusion about membership in MSH. As a result, MSMH integrated a branding strategy tying MSMH to MSH was integrated into all marketing approaches throughout the organization and the community (Fig 7.4-6). MSMH also uses social media for purposeful messaging to elicit interaction with potential POCs (Figs 7.2-34 & 7.2-35).

3.1b(1) Satisfaction and Engagement The systematic approach to determining satisfaction and engagement includes data collection, benchmarking, APs to address opportunities, and reporting to governance to establish accountability. Several exist to collect data on POC satisfaction. The most informative approach is the NRC survey which is customized for each patient segment. The question rating Overall inpatient experience is a measure of satisfaction (Fig 7.2-1). The question rating the patients' Willingness to Recommend (Fig 7.2-25) is used to measure engagement. Both of these questions are measured for each of the patient segment groups. The survey also contains specific questions which provide actionable information, such as the question pertaining to communication with nurses (Fig 7.2-2). Among the approaches for engaging other customers, are social media and written materials. Social media is reviewed daily at the MSH level and written summaries are shared with MSMH PRN and weekly for necessary action/response. These comments provide actionable information that is acted upon by MSMH. Attendance at community outreach events is another measure.

SLs/DLs determine MS satisfaction and engagement through qualitative and quantitative analysis of information from survey data, utilization statistics, and formal/informal communications. SLs/DLs actively elicit feedback from the MS. A plan to facilitate physician engagement was strategically locating the VPMA, Physician Service Director and MSO adjacent to the physician entrance and MS lounge.

Associate satisfaction and engagement is discussed in Chapter 5.

Although market share analysis is used in determining community and other customer satisfaction and engagement, additional qualitative methods are used including meetings between SLs and community leaders/governing agencies from diverse market segments.

Patients' overall satisfaction is consistently measured and standardized through the external CMS HCAHPS questionnaire, which allows hospital comparisons of standard questions across the nation. For the Overall rating, MSMH consistently rates higher than its Southern Maryland competitors and the Maryland state average. NRC scores, obtained weekly, monthly, and quarterly are shared throughout MSMH. Quarterly data includes competitor, state and national comparisons as seen in Sec 7.2. Comments provided by the POCs NRC surveyor, capture actionable information that is used to exceed patients' expectations and secure engagement for the long term. For example, through patient segmentation data in 2013, MSMH learned that the 55 year old male was statistically least satisfied with questions pertaining to communication, listening & respect by the nurses and doctors. In 2014, MSMH launched an increased awareness campaign for this population that will be re-measured in late 2014.

Based on analysis of the data, APs are developed to address those areas that are shown to have the highest correlation with patient satisfaction and engagement. Current deployment strategies include: implementation of the "The MedStar Way"; "SPIRIT Inside" training program; transparent sharing of data/results across the organization; standardized scripting; thank you notes; and the service recovery program. Organizational learning resulted from segmenting hourly rounding data and showed that those units with highest compliance rates had increased patient satisfaction (Fig 7.2-8). Hourly rounding is now integrated into "The MedStar Way" with improved compliance.

3.1b(2) Satisfaction relative to competitors External HCAHPS data as detailed in Sec 7.2, shows MSMH has more satisfied patients than its Southern Maryland competitors. As HCAHPS participation is mandatory, competitors' data are retrieved from public websites, analyzed, compared to benchmarks and distributed throughout MSMH and to stakeholders. Use of these external comparative data supports MSMH's strategic decision making for improvements in patient satisfaction. This universal tool is regarded as the most uniform and best tool for measuring patient satisfaction across the country. There are no publicly reported tools in healthcare that measure other customers' satisfaction relative to competitors. MSMH seeks information through competitor analysis as part of the SP process, anecdotes, focus groups, local media, competitor websites, advertisements, press releases, social media, associate visits to competitor patients, and physicians credentialed at competitor hospitals. For example, at the PEC, patients are asked to compare their experience at MSMH to other hospitals. Deployment, learning, and integration based on competitor information occurs in a manner similar to that described in Sec 3.1b(1).

3.1b(3) Dissatisfaction MSMH's approach to determining POC dissatisfaction is determined through several mechanisms. POC complaints are received through formal and informal sources, including negative comments on NRC surveys, the internet, social media, letters, direct phone calls, and PEC/PFPF meetings. Dissatisfaction that can be addressed immediately, e.g. poor service from an associate is investigated, addressed and followed up with a letter. Dissatisfied comments are entered into the LS for further trending.

Actionable information is aggregated into Pareto charts and further stratified to determine problems and are provided to departments which develop APs to remediate the causes of the dissatisfaction (Fig 7.2-23).

An example of learning from dissatisfaction resulting in an actionable improvement opportunity identified upon analysis of NRC data which demonstrated a statistically significant dissatisfied segment of MSMH patients was the 55 year old male. During PEC meetings, MSMH learned that old bulky televisions were a dissatisfier and were replaced.

3.2 Customer Engagement

3.2a(1) Service offerings MSMH's approach to determining service offerings includes: the SPP; patient, WF and MS surveys; market share analyses and focus groups. SLs lead efforts to identify POCs and market requirements for service offerings. Market share analysis by county region identifies where POCs seek healthcare. SLs analyze physician density and specialty ratios as a component of the SPP. As presented in Sec 7.2, SLs identified the CMS HCAHPS question results on Willingness to Recommend as a measurement of engagement and a strength compared to competitors and State averages. Market data analysis identifies strong, lost, competitor and opportunity markets in Southern Maryland. These external data are evaluated and addressed in the SP/AOP and APs. From the analysis, deployment opportunities are identified (Fig 3.2-1).

Information in this figure demonstrates examples in which physician and patient market awareness was helpful in exceeding the expectations of the POCs and market segments. This identification is instrumental when entering new markets or attracting new POCs and providing opportunities to expand relationships with existing POCs.

Examples of other pioneering service offerings to expand relationships with existing POCs to attract new business include the

following: established GCTH mobile outreach van to improve primary care access to underserved population segment; HEZ programming for underserved in eastern SMC; establishing a Wound Healing Center with hyperbaric chambers; expanded evening hours for mammography and bone density scanning for working women; expanded Express Care evening hours and appointment slots in the competitive northern market; and created a unique billing program to respect the Amish culture.

Fig 3.2-1 Use of Patient/Physician Knowledge/Strategic Planning Input to Drive Strategic Initiatives

Customer Segment	Knowledge & Expectations	Development/ Innovation	Market Change
Patients – Cancer service-line growth	Patients/ physicians; Market share knowledge	Competitive site in Pavilion; improved triage process; marketing; ACS CoC certification	Increased outpt utilization
Patients – orthopedic service-line growth	Low patient satisfaction in MD front office; Market share stagnant; No program qualification	Office staff training/ turnover; Marketing of program; Pre-op teaching program; Recruited spine surgeon	Increased spine volume & patient satisfaction
New service line – Ophthalmology Practice	Limited MS availability; lack of access to latest technology	Recruited ophthalmologist with national reputation; Changed process in OR to increase efficiency; Ophthalmologic subspecialists recruited	Increased utilization; Development of a destination practice

Key: ED = Emergency Dept MPP = MedStar Physician Partners MD = Physician tx = Treatment Outpt = outpatient Inpt = inpatient

SLs grew service line offerings in response to POCs needs and subsequently decreased patient out-migration to tertiary hospitals keeping patients closer to home. SLs learned that this is important to POCs through the various processes identified in Sec 3.1a(1). SLs/DLs use these tools to create innovative service offerings, enter new markets, attract new POCs, and provide opportunities for expanding relationships with existing POCs. For example, after organizational analysis, MSMH learned cancer patients in SMC would best be served by being able to receive chemotherapy at MSMH, participate in clinical trials, cancer support groups, attend community education programs, have access to Look Good, Feel Better Programs, and participate in the Annual Cancer Survivors' Picnic – all of which expand the relationships with existing and former patients and attract potential patients. Integration of the expanded cancer program occurred through specialized education and training in numerous departments including imaging, rehabilitation service, pharmacy, nutrition services, case management, and social work. Additional specialty care is being provided by subspecialists heretofore not available in SMC.

3.2a(2) Patient and Other Customer Support SLs/DLs enable POCs to easily seek information and support (Fig 3.2-2). Various approaches are used to obtain feedback and provide support, based on the unique needs of customer segments, ensuring POCs' support requirements are met. POC requirements are determined through the listening and learning mechanisms identified in Fig 3.1-1.

3.2a(3) Patient and Other Customer Segmentation Through a robust systematic approach to listening and learning from the POCs in our 3 market segments, and incorporating this information into the SP/ AOP, SLs identify and anticipate future market segments as part of the SPP. As detailed in 3.1a, the approach includes gathering information from the following sources: community health assessments; environmental scans; focus groups; physician referral requests & physician feedback; regional market share analysis; PEC and PFPF meetings (VOC); community forums (VOC); former and potential/competitors' patient celebrations and learning activities; market intelligence via local media advertisements and competitor websites/social media sites. Based on analysis of those data, SLs/DLs emphasize business growth opportunities to pursue. Priorities include: meeting unmet community needs; competitor service offerings; and innovative opportunities. One example of listening to the VOC was via the PFPF. MSMH learned that the hours of operation in Express Care (ED Segment) should start earlier than 4 PM. An integrated team of SLs/DLs and staff refined the hours, adjusting involved departments and services, achieving increased volumes to meet the demand identified in the PFPF (Fig 7.4-34).

Fig 3.2-2 Patient & Other Customer Communication, Support & Feedback

Communication & Support Mechanisms for Access & Feedback	Inpatients	Outpatients	ED Patients	POCs	Competitor Patients	Potential Patients
Website, social media	*	*	*	*	*	*
Newsletters, written media	*	*	*	*	*	*
Advertisements	*	*	*	*	*	*
One to one rounding/AIDET	*	*		*		
Discharge phone calls	*	*	*			
Whiteboards	*	*	*			
SL Community Involvement	*	*	*	*	*	*
Support Groups	*	*	*	*		*
On-site Service	*	*	*	*	*	*
EMR/Patient Portal	*	*	*			
Patient Surveys/PEC	*	*	*	*		*
Annual Meeting with Amish	*	*	*	*		*
Access Points	*	*	*	*	*	*
Advocates/Interpreters	*	*	*	*		
Call Center	*	*	*	*		*
MS Practice Managers' Meeting	*	*	*	*	*	*
Health Fair/Screening/Education	*	*	*	*	*	*
Complaint Management Process	*	*	*	*		

The needs of competitors' patients are assessed as MPR utilizes data and information gleaned through the SPP to develop marketing plans for SP targeted service lines. This data analysis leads to focused approaches to reach segmented markets, competitors' patients, potential POCs. As an example of deploying a more POC focused culture, SLs gathered and analyzed market data, identifying the need for outpatient endocrinology. These data, along with feedback from the MS, associates, POCs and community stakeholders, led to a refinement in the existing level of services to include both pediatric and adult outpatient endocrinologists recruited for the MSMH community and resulting in high demand since opening.

3.2b(1) Building Patient and Other Customers Relationships SLs/DLs use multiple approaches to build and manage relationships with POCs. This process begins with the vision and sets the stage for using the VOC to develop activities to acquire, retain and engage POCs. Mechanisms including marketing, social media, publications, membership on the PFPF and community outreach provide a process for POCs to identify MSMH as an HRO, committed to the health of the community. This commitment is demonstrated to the community through SLs' pursuit of awards and accreditations that are publicized in order to instill confidence within the community that MSMH delivers safe, high quality healthcare as measured against external standards. Once POCs have interacted with MSMH, SLs/DLs further listen to the community by reevaluating the VOC with the goal of retaining POCs, meeting their requirements and exceeding expectations. For patients, mechanisms include post-hospitalization follow-up and support, i.e., discharge phone calls, select home visits, and support groups. For other customers, these mechanisms include hospital branding,

community education/events and direct marketing efforts. Other avenues include zip code specific direct mailings, website, social media communications (Figs 7.2-34 & 7.2-35), and specific targeting of known POCs with a certain diagnostic and demographic profile that indicates likely utilization of services, e.g. targeting patients with diabetes for wound healing services. The systematic deployment of building and managing relationships with patients and other customer groups is most readily evident with the community outreach programs offered by HC, the mobile van with GCTH and the HEZ whereby other customers can be identified and referred for appropriate services. By meeting their requirements as identified, exceeding expectations with each stage of their relationship as previously described in Fig 3.1-1, these mechanisms allow MSMH to acquire, retain and increase the relationship and engagement with POCs.

MSMH uses creative approaches to engage current and potential patients on Facebook through trivia contest and "Throwback Thursdays", along with posts that feature new services and current events. In addition, our patient portal helps retain patients by allowing them on-line access to test results and other health information.

3.2b(2) Complaint Management POC complaints are rigorously managed. On a patient unit the bedside nurse, charge nurse, DL, case manager and/or patient advocate respond to patients' issues as quickly as possible. For the last 3 years, on average 96% of initial complaints are resolved immediately. All associates are empowered and expected to handle such issues using the service recovery process. Complaint resolution is to be within the shift of occurrence and less than 24 hours.

When a complaint cannot be resolved within 24 hours, it is regarded as a grievance and entered into the LS. DLs are assigned responsibility for follow-up and SLs track completion. Investigation and resolution are completed within 30-days. Service recovery is provided through a personal connection with the patient, where an apology is offered. When complaints start with or reach the President, she writes a letter to the patient stating that the issue will be appropriately addressed. The DL is notified and completes the process as described above.

Complaints are aggregated through several mechanisms: analysis of LS data (Pareto), NRC survey comments, social media comments, telephone or written letter complaints and a comparison of the number of complaints to compliments. These dissatisfaction measurements are further enhanced with qualitative information received through other VOC mechanisms such as rounding and discharge phone calls. Cumulative measurements of dissatisfaction are trended and used to create APs to meet and exceed POC expectations. For example, through this type of data analysis, MSMH learned that patients were dissatisfied with pain management. As a result an interdisciplinary Pain Team was formed to better address pain management and patient satisfaction scores on pain management increased. Through prompt and personal attention and hospital-wide refinements, POC confidence, satisfaction and engagement improved (Fig 7.1-21).

4. Measurement, Analysis, and Knowledge Management MSMH is a data driven organization effectively measuring, analyzing and improving performance while managing organizational knowledge to sustain excellence, grow and maintain competitive advantage.

4.1 Measurement, Analysis, and Improvement of Organizational Performance

4.1a(1) Performance Measures MSMH uses a systematic approach to select, collect, align, and integrate data/information for tracking daily operations, overall organizational performance, APs and strategic objectives and outcomes. The following criteria are used in setting priorities for PI: sentinel event or near miss activities; improved patient safety; patient outcomes; customer service; cross functional problem solving; cost containment; improved competitive position; community health priorities; and opportunities identified by MSMH performance monitoring. SLs in concert with stakeholders set strategic, operational, long and short term goals and objectives along with key operational and performance measures (Fig 2.1-4). SLs align meaningful metrics with each goal to establish the evaluation phase of the FADE methodology (Fig. P.2-5), measuring process consistency and desired results. Led by process owners, interdisciplinary teams provide feedback to SLs about metrics and team performance. Key organizational performance measures, including short term and longer-term financial metrics and results can be found in Fig 2.1-4 and Chapter 7.

Data are used to proactively assess performance in a dynamic healthcare environment. Metrics are also employed to analyze and evaluate high risk, problem prone processes and outcomes to determine if change is required during the Analyze portion of the FADE process. As AOPs change and business planning warrants, performance metrics are either retired or maintained, new ones added or expanded to ensure MSMH remains on target for AP achievement and stays 1 year ahead of regulatory and accreditation targets.

Metrics for each goal, process and outcome are selected by leadership, MS and stakeholders based on desired results using statistical analyses, review of literature and top decile regional, state and national performance indicators. Objectives, metrics, and performance measure selection are aligned with the SP/AOP to dictate timing of data collection and to hardwire alignment. Metrics selected by involved teams are vetted by the PM associates and SLs to ensure validity and reliability. The systematic process to select, align and integrate data further requires that data are presented as information to process owners, leadership, associates, MS and BOD members at prescribed intervals to enhance decision making at all levels. Leaders and/or process owners educate involved stakeholders about metrics, use them in the goal setting process and display them for transparency.

Data are extracted from the EMR and billing system using automated report writing whenever possible. Individual chart reviews are also conducted as indicated to mine for data to understand processes and outcomes. Depending on the goal and timing set by SLs, process owners and teams, data are tracked and analyzed at different intervals: e.g. daily (ED TAT), weekly (patient experience), monthly (financial ledgers), or quarterly (clinical dashboards). As a learning organization, SLs/DLs use data to make evidence based decisions. Therefore, data analysis and identified data trends, (e.g. special cause vs. common cause variation) result in deploying innovative or routine changes, either rapidly in the case of daily operations or more deliberately in addressing strategic objectives. Data/information are analyzed in detailed form in quarterly MS meetings, monthly LC meetings, departmental and interdepartmental performance team meetings (monthly and PRN), and at quarterly committees. The MS receive data reflecting individualized clinical and non-clinical work semi-annually. Control charts with benchmarks and trend lines are accompanied by segmented data for further analysis and decision making and are part of systematic processes and outcomes analysis. QSPAC reviews quarterly dashboards and data are cascaded to leadership and the WF.

4.1a(2) Comparative Data The systematic process for PM ensures effective use of key comparative data. Numerous sources are used to support operational/strategic decisions. During the FADE process when metrics are selected, comparative data are identified by teams to advance performance. As part of benchmark and comparative data selection, SLs/DLs determine when to use best practices, top performers, peer groups with like size or services, regulatory and publicly reported data bases, professional organizations, competitors, and suppliers based on comparative data that will advance the SP/AOP and the timely availability of information. When healthcare benchmarks

are unavailable, SLs/DLs use other industries to identify EBP benchmarks (e.g. Fig 7.3-4, 7.3-12 & 7.3-13). When MSMH is already best in class, or no other benchmarks are available, SLs/DLs benchmark MSMH against itself, continually raising performance targets.

MSMH selects comparative data and information to support effective operational/strategic decision making by using external benchmarks, best practices and top decile performance. Comparative data sources are integrated throughout the organization on dashboards to enhance learning. Comparison data are depicted by bolded benchmark lines on graphs so stakeholders can compare performance. Comparative data sources are reviewed at least annually. MSMH subscribes to numerous external comparative data sources for diverse benchmarking capability; e.g. Press Ganey, NDNQI, QAPI, NHSN, TJC, CMS, MIEMSS, VHA, MHCC, AHA, HSCRC, NRC and others.

4.1a(3) Patient and Other Customer Data VOC data and information with the strongest correlation to patient engagement are collected to support operational and strategic decision making. Sources include NRC survey data, departmental level point of care survey data, focus group data and patient interviews. One method in collecting POC data is related to the use of diverse focus groups. Focus groups include patients with similar or dissimilar conditions; and others (see Chapter 3). Goals are to understand customer satisfaction overall and within segments, to hear the VOC about potential and existing services and promote overall customer engagement incorporating input into the next wave of strategic and operational planning to build a more patient focused culture. MSMH has an on-line reporting system used to capture, analyze and segment individual and aggregated compliment and complaint data trends.

VOC data are analyzed and presented using graphed information to SLs/DLs, MS, associates and BOD as previously described. SLs celebrate successes with the WF and true to the core competency of continuous performance improvement, formulate new stretch goals to establish future targets. APs that include VOC data are executed to ensure goals are achieved and improvement is sustained. Social media is monitored on a daily basis to capture positive and negative comments from VOC and interactions are trended (Fig 7.2-35).

4.1a(4) Measurement Agility SLs/DLs ensure the PM system responds to rapid or unexpected organizational or external changes by systematically using the FADE process. To reduce the need to rapidly react to change, SLs/DLs proactively monitor data from the internal environment and external influences, the literature and VOC to focus on new performance measures. An example of proactive methodology is the early identification of new ICD-10 medical record coding requirements from industry publications. Though regulatory agencies pushed the start date backwards by one year, MSMH is identifying new processes and metrics associated with successful implementation.

An example of agility in response to an unexpected regulatory change happened when the HSCRC gave Maryland hospitals 30 days to implement observation status, requiring rapid modification to segregate the patients as outpatients and develop tools to bill their LOS in hours.

Since data are constantly collected and studied**,** SLs/DLs and MS rapidly identify even subtle data shifts during the analysis and evaluation portions of the FADE process. When data reveal the need for rapid or unexpected process changes, (e.g., when a special cause variation is identified), the process owners and involved teams immediately engage as rapid response teams to re-stabilize processes. Based on the core competency of transparency, data and changes are shared with stakeholders as part of organizational learning by fact.

4.1b Performance Analysis and Review As part of FADE, performance and capabilities are routinely reviewed using dashboards during the Evaluation step at prescribed intervals. Key performance measures are selected for each financial, operational and clinical initiative and data are benchmarked against internal and external comparative information to evaluate performance. APs are developed and implemented by process owner led teams including representation of involved stakeholders. Outcomes are reviewed monthly for celebrations or improvements. Additionally, annual reports, which summarize performance and identify APs to address gaps in performance or capability, are also presented to SLs, DLs, MS and the QSPAC on a rolling calendar schedule so there is sufficient time and resources to focus on each initiative. Annual goals for the next year, based on both prior year and projected year's performance and capability in concert with the SP/AOP are designed from performance analysis and review. Annual reports for departments, committees or functions summarize organizational successes, competitive performance, financial health and progress relative to AOP/APs.

Performance measures are evaluated at least annually at which time they are reassessed, scrutinized for relevance and reprioritized as needed. During these evaluations, performance measures are also matched to strategic, operational and financial goals, as well as customer inputs. These performance evaluations are further considered and approved by the MS at department and committee meetings and by other involved stakeholders in staff and action planning meetings and are documented. The metrics are updated in the data dictionary.

With focused data management, monitoring expertise and resources, the centralized PM efficiently analyzes data that is shared with stakeholder groups. Performance is measured using statistical tools that include control charts to identify common cause vs. special cause variation and Pareto charts to identify root causes. Data segmentation is also used to understand nuances related to process and outcomes. Reliable comparative data are used to benchmark processes and outcomes against evidence based or top performance metrics, ensuring best practices are hard wired. Through this layered approach of multiple reviews, measures are vetted and conclusions are validated.

Performance and capability reviews are completed at prescribed intervals, based on projected time frames for successful completion of projects and the acuity of the process or outcomes. Even with proactive planning, environmental and regulatory changes, customer expectations and emerging evidence require SLs/DLs to respond rapidly. Because of the frequency of data measurements and their depth of understanding, SLs/DLs rapidly identify changes requiring new or improved interventions and are agile in responding.

Performance measurements reflecting progress on AOP objectives and APs are shared with Governance quarterly through a comprehensive report to QSPAC and through a report on AOP/SP performance given to the full BOD at each meeting.

4.1c(1) Best Practice Sharing SLs/DLs review data to identify top performance at intervals aligned with organizational priorities and data availability. When data show high levels of achievement, processes are analyzed and best practices identified for applicability to other areas (Fig 7.1-37). Once identified, best practices are shared in many ways including: LC, department meetings, performance committees, *The Pulse,* and interactive use of bulletin boards. SLs/DLs value communication mechanisms to foster learning and integration throughout MSMH, using a 360 degree approach to reach all stakeholders. These approaches foster organizational learning.

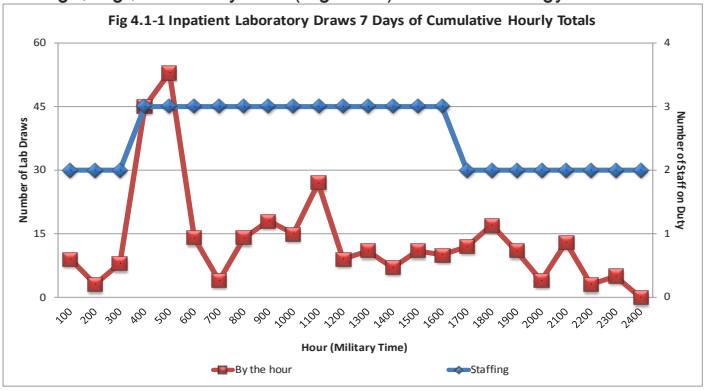
An example of best practice sharing is the use of "safe zones" in the laboratory to reduce distraction when performing complex testing. This best practice was shared at PSC, resulting in the adoption of the practice in the OR and Express Care to promote distraction free

medication administration. This new work process is being deployed to other areas of the hospital through the Clinical Practice Council.

4.1c(2) Future Performance As part of the SP/AOP processes, performance review findings, key comparative and competitive data are used to project future performance. Historical performance, industry, regulatory and best practice benchmarks are analyzed and compared with MSMH performance to set short term and stretch goals to ultimately achieve top decile performance. Actual performance is compared to projections to identify variances (favorable or unfavorable). When performance variation is identified, data is further segmented to identify root causes. In the case of unfavorable variations, mitigation strategies are employed to close performance gaps. When the variance is favorable, the cause is also determined and if determined to be a best practice, the process is shared as appropriate.

4.1c(3) Continuous Improvement and Innovation Organizational performance review findings are used to develop priorities for continuous improvement and opportunities for innovation in two ways. When there are gaps in performance, as identified during the evaluation portion of the FADE process, creativity and innovation are encouraged for problem solving and course correction. Innovation is valued at every step when new ideas are being launched during the SP/AOP processes, and during ongoing assessment of market, regulatory and best practice programming is in process. This may include Lean redesign, e.g., laboratory staff (Fig 4.1-1) or via technology advances.

Fig 4.1-1 Inpatient Laboratory Draws 7 Days of Cumulative Hourly Totals



Opportunities for improvement and innovation are deployed to the work group and functional level operations throughout MSMH (Fig 4.1-2). Priorities and opportunities are deployed to suppliers, partners and stakeholders through the VAT meeting structure, meetings with vendors and stakeholders and publications that are mailed to households in the community. Priorities and opportunities are discussed in depth with the MS (Fig 4.1-2) and through 1:1 meetings with members of the MS and the VPMA. In addition, the COS meets weekly and as needed at 1:1 meetings with the SLs wherein continuous improvement and innovations are discussed. As a result of sharing best practices among MS, PCM & IT, a process to ensure compliance with new VTE prophylaxis requirements was designed in the EMR. The process also met MU criteria by allowing data extraction directly from the EMR.

4.2 Knowledge Management, Information, Information Technology

4.2a(1) Knowledge Management MSMH embeds organizational learning on multiple levels to solve problems and to build and share a knowledge base as part of the core competency of continuous improvement. SLs developed an IMSP as a supplement to the SP/AOP process. The IMSP details MSMH's priorities at a high level in information and knowledge management and IT. SLs/IT DL engage in direct knowledge transfer with Cerner via quarterly meetings where project status and pending software enhancements are reviewed and specific issues addressed.

Fig 4.1-2 Best Practice Sharing Communication Mechanisms

Communication Mechanism	Attendees	Impact
Town Hall Meetings	SLs and Associates	AOP Data sharing; associate feedback; brainstorming; story telling
SL Rounding	Associates, MS	Weekly Pt satisfaction data sharing; associate feedback; brainstorming; story telling
QSPAC	SLs, DLs, MS, BOD	Annual and quarterly AOP data; team reporting; BOD feedback; brainstorming; story telling
MEC & MS Meetings	MS leaders, SLs, DLs, BOD	Annual and quarterly AOP data; MS department & committee reporting; MS feedback; brainstorming; story telling

MS, SLs, DLs & associates participate in functional councils at the System level where System-wide best practices are identified, shared and if applicable, implemented. MSMH has a Best Practice Task Force charged with identifying, evaluating, and driving the implementation of best practices. MS knowledge transfer also occurs through avenues such as the Tumor Board, CME offerings and focus groups.

Workforce knowledge is collected from front-line staff through involvement in committees and work groups, e.g. the Patient Safety Council. Transfer of organizational knowledge to the workforce begins with new associate orientation and is reinforced with annual mandatory education. This knowledge transfer is validated through the use of post tests. Workforce knowledge is also gathered from and shared with front-line staff through SL departmental rounding.

Knowledge transfer occurs with POCs through patient education and patient focus groups. As new best practices are discovered, the ability to rapidly identify and share data and implement new processes occurs through the use of rapid cycle improvements and pilots. Relevant organizational knowledge is incorporated into the AOP (Fig 2.1-4) through use of the FADE process (Fig 4.2-1).

Fig 4.2-1 Knowledge Management Process	
Focus	Assemble patient, physician, workforce, community, vendor, partner collaborator data
Analyze	SLs analyze data collected in Focus phase other resources
Develop	Identify improvement opportunities, achieve desired performance, new service line opportunities, consider technology and market development from current processes
Execute/ Evaluate	Develop policies & procedures; deploy to LC, QSPAC, BOD, MS, WF, community, vendors, partners; educate/train staff; re-evaluate organizational learning using data.

MSMH transfers knowledge and best practices to suppliers and partners as needed to address operational issues. For example, when the infection preventionist identified the use of a specific bactericidal agent for intravenous insertions, MSMH shared this information with the supplier and insertion kits were changed to include this new agent.

4.2a(2) Organizational Learning MSMH incorporates organizational learning into its operations through its continuous improvement strategies. Resources are provided to support learning at every level of the organization. Organizational learning occurs on a daily basis via: leadership safety calls; on-line resources embedded in EMR to support nurses and MS; on-line policy and procedure manuals and external learning internet links on the MSMH intranet portal; through the deployment of super-users and functional experts. Learning activities are targeted at the personal, unit and organizational level. Learning at the personal level is supported by annual learning plans, SiTEL, education center/simulation lab, orientation, competency plan, and CME/continuing education. Organization-wide and unit learning is achieved through the use of disaster/emergency preparedness drills; mock codes; RCAs; town hall meetings and the RRB.

Organizational learning allows MSMH to solve problems at their source; e.g. the daily safety call identified issues involving shortages of linen. DLs met and determined that inventory and par levels were too

low. As a result, inventory was increased and par levels were adjusted; the shortages subsided.

Organizational learning is also used to build and share knowledge throughout the organization. For example, at town hall meetings the MSMH president briefed associates on the SPP/AOP process and how goals align from MSH down to the individual level allowing associates to better understand how the work they do every day supports the strategic direction of the system.

Lastly, organizational learning drives opportunities to effect change and support innovation. For example, the RRB evaluates requested changes to the EMR and facilitates learning as members review proposed changes and how they will impact functionality of the system and impact different users. Also considered is how new refinements might apply elsewhere.

4.2b(1) Data and Information Properties Fig 4.2-2 depicts some of the steps MSMH takes to ensure the accuracy, integrity, reliability, timeliness, security and confidentiality of data, information and knowledge in the organization.

One of the critical elements to data and information management is the conscious decision the BOD made to adopt an integrated EMR solutions approach as opposed to 'best in breed'. As such, there are 40 integrated Cerner solutions deployed in the information system, which has been certified as HIMSS Stage 6. SLs deviate from this approach only where Cerner does not provide a needed solution or the Cerner product is inadequate or clearly deficient to a competing product. This integration provides for real-time dynamic display of information necessary to support the workforce, streamlines software maintenance and obviates the need for multiple interface solutions.

Fig 4.2-2 Data, Information & Knowledge Management

Properties	Data	Information	Knowledge
Accuracy	Device interface, Drop down menus, Templates, Discrete elements	Data Dictionary Identified data sources	2nd source validation
Integrity	Validation Reconciliation, Audits	Benchmarking Identified data sources Audits	Validation by content knowledge experts
Reliability	Remote hosting, Database backups, Redundancy	System downtime monitoring Ongoing hardware replacement	Super users, Internet reference Validation
Timeliness	Real-time versus batch process & interface	System response time monitoring Periodic reporting Demand reporting	Imbedded web-based resources
Security	User access control, Access needs validation, Device tethering	Network firewalls Risk Assessment Login lockouts Information stored on secure servers	Password Protection, Encryption, P&Ps, Education, Orientation
Confidentiality	Position access Rights	Patient chart access audits	Identification and limited distribution of confidential material, P&Ps, Education, Orientation

A final key element of this information management approach is the control of the outbound sources of critical data elements reported to external parties. Specifically, core measures and other forms of clinical or quality data are only reported by PCM. Likewise, all financial or productivity data are only reported by Finance/Decision Support. This helps ensure the quality, reliability and consistency of data reported.

Another critical element of IT management is to incorporate lessons learned through the formalized change management process. SLs established an interdisciplinary team called the RRB which meets monthly to review, coordinate and recommend prioritization of system change requests initiated by users.

4.2b(2) Data and Information Availability Information is made available to the WF, suppliers, partners, collaborators and POCs through numerous methods. To improve user-friendliness, and increase efficiency, patient safety and enhance decision support, clinical data summaries (M-pages) are used by associates and MS to easily review pertinent clinical data upon EMR sign-on. To improve efficiency and user satisfaction, MSMH users employed the principles of human factors engineering in collaboration with Cerner, increased computer distribution, improved the sign-on process (minimized the number of "clicks"), created customized "favorites" and supported users' selection of various input devices. MS has easy remote access to the EMR via the internet. Key collaborators such as nursing homes and home health agencies have remote access to clinical data and information.

The EMR also has hyper-link short cuts to web-based knowledge sources. A broad data feed supports telemedicine in the ICU. In addition, ADT, laboratory, and imaging reports are fed to CRISP. ADT data are directly fed to key business partners such as the emergency physicians, radiology group, and to the third party professional fee billing company. Key contractors such as KIWI-TEK (MR coders) also have remote access to the EMR. A broad data feed is provided to the MSH Infomart Database; this database is used by MSH to compile statistical information for System business units for budget tracking and benchmarking purposes.

Patients can access charts and perform basic functions through the patient portal. Associate-centric information is made available through the associate portal/intranet. This portal also contains links to various internet based reference sites and other resources. Customers also share and receive information through the website and through social media via a Facebook page. Additionally, information is made available to the public at large through local print, television and radio media.

4.2b(3) Hardware and Software Properties IT associates' efforts are largely directed toward ensuring that hardware and software are reliable, secure and user-friendly. IT associates include on-site technologists who maintain wiring requirements, updates to programs, and troubleshoot problems. The IT staff ensure hardware and software connectivity for the MS offices. The Cerner system allows a degree of program customization to improve ease of use and increase user satisfaction. A 24-hour help line assists MS and associates.

To ensure reliability, IT associates begin with product evaluation to ensure stated functionality and fitness. Input is obtained from interdisciplinary sources, stakeholders and primary users. First consideration is given to Cerner products to maintain system integration. This efficiency reduces the need for interfaces. The overall system design is considered for user need; user interface; functional requirements; processing requirements; availability requirements; accessibility; performance requirements; standards' compliance; reporting capabilities; and response time. Other considerations are references; risk assessments; user training requirements; service agreements; installation; testing; data validation; and access controls. These considerations are established upfront to ensure reliability.

Regarding security, several features were previously discussed relative to passwords, time-outs and automatic sign-offs (Sec 1.2b(1)). The system provides audit trails that identify users, times and operations performed. Breaches in data integrity and security are addressed in policy. SLs establish security parameters based on EBP (e.g. NIST guidance). IT monitors system use and identifies concerns.

User-friendliness is addressed by clinical IT staff. During the design and build phase of new programs or changes to existing programs, modifications and report capabilities and program "breaks" are tested in

a training environment prior to being added to the live environment. Onsite Clinical Application Specialists are available to associates and MS and may be called upon for 1:1 education. Additional support is provided to certain departments through super users in the department. Any system improvements requested by end users must first be evaluated, prioritized and recommended by the RRB for final approval.

4.2b(4) Emergency Availability With the original design of the EMR installation, the BOD, MS and SLs in concert with the IT DL, determined that it would be best to have remote hosted connectivity with Cerner rather than establish servers on site. As a result, there is redundant connectivity to the servers, increasing reliability and minimizing downtime (Fig 7.1-27). Through Cerner monitoring, there is continuous evaluation of potential system failures that never reach the local user because Cerner resolves them before MSMH is aware.

Although rare, emergencies happen. In these instances, MSMH's Code I Emergency Plan is part of Disaster and Emergency Preparedness. Each department has a coordinated downtime plan addressing clinical, non-clinical and MS workflows that is practiced through hospital-wide drills and used during planned down time. Subsequent critiques by interdisciplinary teams result in APs and continuous improvement. These approaches ensure continued availability of information that is critical to the seamless functioning for patient care, stakeholders and MSMH.

5. Workforce Focus: Workforce capability and capacity are assessed during the SPP in response to the strategic challenges of the academic qualifications of associates and workforce shortages to ensure a high performance work environment. Capability and capacity over longer periods of time are also assessed for success in adapting to the changing environment and during succession planning.

5.1 Workforce Environment

5.1a(1) Workforce Capability and Capacity Assessing workforce capability and capacity is a dynamic process incorporating learning from past staffing experience, the changing needs of the community, the ongoing and future needs of the workforce, long-term projections, annual budgets, industry staffing and productivity standards.

SLs/DLs' approach to assessing WF capability is to annually review data related to learning and educational needs of associates, MS and volunteers. OLR conducts annual capability needs assessments, reviews outcomes data from quarterly and annual reports, and assesses perceptions of associates, MS and volunteers. OLR correlates these assessments to competencies, skill levels, and strategic and operating initiatives. With input from OLR, SLs/DLs develop annual departmental and individual learning plans. Planned educational and practice activities are designed and deployed based on identified needs and in response to the strategic challenge for advanced academic degrees. The MSMH Foundation sponsors a scholarship program to address advanced academic needs. SLs/DLs develop and document individual associate educational plans including tuition reimbursement and scholarships, certification requirements and bonuses during the performance evaluation process.

MSMH's approach to manage capacity involves shift, daily, weekly and monthly monitoring of staffing levels using a dynamic data base including on line acuity systems and best practice matrixes for both fixed and variable departments. Huddles are used to evaluate and redistribute staff to meet workload. Based on patient volumes and acuity, full time associates are augmented first by part time and then by PRN associates. Travel staff is employed for 8-12 week intervals when the need exceeds staff capacity. Each department has specific staffing policies to memorialize the process and maintain transparency. DLs are held accountable for ensuring adequate staffing capacity.

HR provides data about vacancy, turn over, exit interview information and hiring TAT to complete capacity assessments that are part of the annual and monthly reporting structure.

5.1a(2) New Workforce Members MSMH has a systematic approach to recruit, hire, and orient the best talent, place and retain associates. HR uses numerous methods to recruit the best candidates for each job, reflecting the diversity of the community. HR deploys a data-driven approach to track the most effective recruitment strategies including: associate recommendations, web advertisement, affiliations with schools and local business associations, job fairs, direct mailings, social media and networking sites, print ads, regional educational programs with on site DLs and HR who tour and interview candidates. The hiring process is made efficient through the use of an on-line applicant tracking system. The request triggers HR literature review for industry changes to job qualifications prior to posting positions. This innovative process assures candidates have the most current skill set. WF diversity vs. community composition data are shared with DLs and the WF bimonthly keeping leadership mindful of matching the diversity of the WF to the community to optimize culturally competent care. HR works with hiring managers via 1:1 meetings and departmental rounding to understand the work, tone and pace of each area. To hardwire integration, MSMH's 360 degree hiring process requires SLs/DLs and associates to evaluate the diverse ideas, cultures and thinking of candidates [Sec 5.2a(2)]. Unique aspects of the 360 degree hiring process include the following:

- DLs, supervisors and associates interview candidates using culturally sensitive behavioral questions in structured group interviews. Candidates ask questions of interviewers as well.
- Interviewers use scoring sheets which are sent to the hiring DL
- DLs consider HR metrics and interviewers' input
- DLs/HR determine salary based on education, experience and internal equity, using industry and market data
- SLs interview candidates applying for positions that have hospital-wide impact. These candidates are evaluated using behavioral assessments, i.e. Myers Briggs and DISC
- The President interviews candidates for DL/SL positions

Hospital and departmental orientations are part of the on-boarding process for associates and MS. OLR leads orientation, which is evaluated annually by the workforce (Fig 7.3-31). Modifications are made based on aggregated data, regulatory requirements and changing needs. Hospital orientation lasts 1.5 days and includes an introduction to the MVV; goals; performance requirements and metrics; SPIRIT values; and an introduction to the EMR and other diverse topics. Departmental orientations teach specific duties, requirements and work processes of each area and reinforce learning from the hospital orientation. Peer mentors orient new associates into departments. At the conclusion of a 90-day introductory period new associates are evaluated and orientation milestones are reviewed before being advanced. In addition to a solid orientation, other retention mechanisms include: modifying orientation as needed; introductory and annual evaluations requiring bi-directional feedback; career counseling; walk-a-mile program; associate engagement survey; reward and recognition; and leadership development opportunities. Similarly, new MS members participate in an orientation with key MSMH departments and are appointed for a 6 month probationary period and data (FPPE) are used to evaluate performance prior to advancing to active status.

5.1a(3) Work Accomplishment SLs approach organizing the workforce by structuring positions around work systems processes including nursing, clinical, and administrative support. MS is similarly organized by specialties. SLs/DLs manage the workflow across

departments. MSMH has a data driven committee structure to involve associates, MS and stakeholders that assures policy and processes are Patient First focused. SLs/DLs deploy organization and management strategies by selecting top talent; orienting them to work processes; providing education and performance feedback throughout employment or MS membership; recognizing excellence and providing improvement opportunities. Work accomplishment is communicated in many ways. Goals are cascaded to associates to align around the AOP using TM, allowing continuous access to document performance.

Processes and outcomes are measured with the goal of exceeding expectations and are shared transparently at varying frequencies depending on the strategy. Data are aggregated quarterly and presented to the WF at Town Hall meetings; on bulletin boards; at monthly staff meetings; shift huddles; and during SL/DL rounding. Associate performance is evaluated mid-year and annually.

Reinforcing a focus on POCs and healthcare is done in the following ways: SPIRIT values are used as hiring criteria, taught during orientation and throughout the year, and evaluated at the end of the introductory period and semiannually. Patient safety and patient experience expectations are reinforced during leader rounding and formal meetings.

The WF is organized and managed to exceed performance expectations through review of JDs and MS clinical privileges, setting annual performance goals, providing the tools to do the job (policies, procedures, training), and holding associates accountable through performance management and MS reappointment.

5.1a(4) Workforce Change Management As part of the SP/AOP processes, staff capacity and capability needs are forecasted to proactively anticipate requirements and WF programs are designed to incorporate just-in-time flexibility based on industry best practices. When there is a need to grow WF capability, recruitment and education strategies, including cross training, are designed by the involved SLs/DLs with consultation from OLR/HR, associate feedback and external experts as needed. Partnerships with schools and other organizations are used to facilitate capability growth. Other efforts to expand capability include: competency development, tuition reimbursement and scholarships (Figs 7.3-8 through 7.3-10, 7.3-29 & 7.3-33).

Departmental productivity information is used to develop annual budgeted staffing plans and allows for rapid adjustment in workforce capacity, e.g. nursing associate staffing levels are flexed up or down every four hours depending on volume and acuity. When staffing is flexed, careful consideration is given to ensure the staff skill mix remains aligned with patient needs. When there is a need to expand workforce capacity anywhere in the organization, flexible cross-training, recruiting plans, PRNs and/or use of long term travel agency staff are considered to improve staffing levels. As an example, staff in the ED designed a capacity alert policy to address acute volume surges that render staffing capacity inadequate. When the alert is called, staff from throughout MSMH with appropriate skills responds to the ED to assist.

When the WF needs to contract based on decreasing volumes or work process redesign, staff is right-sized or vacancies are not filled. In the unlikely event that RIFs are necessary, SLs, DLs, HR and OLR minimize the negative impact by helping associates locate other positions. Assistance with resume writing, job placement and benefits are provided. The RIF is then communicated to other associates.

Associates and stakeholders are included in the change process. ASERC and frontline associates provide input to HR policy and process and vet proposed changes (Fig 7.4-3). SLs/DLs proactively share changes with staff via LC and department meetings, huddles, memo, email, and the WF portal. Like all change at MSMH, the WF is prepared by using a team approach to ensure seamless care for patients.

5.1b(1) Workplace Environment SLs believe in a workplace environment focused on health and safety, security, accessibility and engagement. MSMH's Safety & Security Subcommittee of the EOC is responsible for ensuring the health, safety, security and accessibility of the workplace. Each department has a safety representative who conducts semi-annual surveys of the work environment and the data used to make improvements. To further ensure workforce, patient, MS and stakeholder safety, practice drills for safety events are conducted at regular intervals. Drills are critiqued by associates and leadership to ensure high reliability in responding to crises. SLs/DLs perform EOC rounding biweekly to identify safety risks for timely correction. Results of rounds are presented and APs are developed, implemented and monitored to ensure compliance to the 7 TJC EOC standards through interdisciplinary teams. Data are aggregated and evaluated by the EOC and QSPAC with an annual report presented to the BOD.

Other health and safety strategies include: designs to maximize ergonomics utilizing Lean principles so equipment and supplies are grouped and placed in proximity for use; interdisciplinary VAC recommendations on equipment and supplies to include WF input; lift equipment strategically placed to assure safe patient movement; and offices outfitted with ergonomically appropriate furniture.

Staff is trained at least annually about EBPs to prevent back injuries, infections, workplace violence; appreciate diversity; recognize and eliminate harassment; improve associate health and other safety topics. Clinical and non-clinical associates have overlapping and separate content related to interacting safely with patients. Safety training is mandatory when there are changes in practice.

SLs use population health strategies to help associates prevent illness and reduce the effects of chronic diseases. OH leads a WF wellness team that develops health fairs, screenings and healthy habit activities. Associates participate in Yoga, Tai Chi, Living with Chronic Disease classes and other stress, self help and weight loss programs. Associates are encouraged to understand their own health status; are provided with an on-line self health assessment; and are incentivized to complete them with a reduction in insurance premiums. To reinforce healthy lifestyles, the cafeteria has nutritious choices, with reduced sodium and no trans fats. Exercise equipment is available, campus walking trails are marked, weight loss and tobacco cessation programs are free for associates and the hospital property is smoke free.

Security associates round to ensure the physical security of the premises and they are trained in crisis prevention intervention to assist clinical associates with combative or aggressive POCs. Surveillance is provided by strategically placed cameras. The LS is used to document security breaches for trending, learning and correction purposes.

MSMH ensures accessibility as follows: ADA compliant facilities and accommodations to eliminate accessibility barriers for associates with temporary or permanent disabilities; light duty assignments are created for associates with temporary work restrictions; the WF and MS wear badges with names and pictures visible; visitors and suppliers are provided badges to identify them as guests. High security areas are locked with badge access doors with audit trails.

There are process and outcome metrics related to the work environment based on health, safety, security and accessibility needs. Metrics for WF health and safety include: slips, trips and falls; back injuries; exposure to blood borne fluids via needle sticks; and vaccinations (Figs 7.3-11 through 7.3-13 & 7.3-15). Metrics for security and accessibility include injuries from responding to aggressive POCs (Fig 7.3-16). Data are segmented by work place environment, i.e. patient care versus non patient care areas, with stratification by

department, staff impact, and risk and exposure level. WF and MS are encouraged to complete satisfaction and safety perception surveys (Sec 7.3).

5.1.b.(2) Workforce Policies and Benefits SLs support the diverse WF by designing creative policies, services and benefits relating to personal needs of WF and families through their work-life cycles. The associate handbook, JDs and information on Total Rewards benefits and services are given during on-boarding (Fig 5.1-1). Orientation for the staff, MS, volunteers and students includes an explanation of benefits to refresh education provided during the interview process. HR rounds with associates, volunteers/students on all shifts to explain benefits and answer questions. *The Pulse* advertises benefits monthly. Total Rewards summaries are sent to associates' homes annually.

Fig 5.1-1 MSMH Total Rewards Benefits and Services

	WF Segments		
Key Benefits for Diverse Workforce Segments	**Associates**	**MS**	**Vol/ Students**
Health Insurance (Self/Spouse/Family)	X		
Life Insurance (Self/Spouse/Family)	X		
Disability Insurance; long Term Care Insurance	X		
Vision & Dental Insurance (Self/Spouse/Family)	X		
403B with Employer Match	X		
Reduced Cafeteria & Pharmacy Costs; Free Parking	X	X	X
Free NP Services on Site (Associate only)	X		X
Discount Cell Phone Plans	X		
Discount Home Computer Prices via Payroll Deduction	X		
Reduced Fee Legal Services Package	X		
Employee Assistance Program	X	X	
Flexible Medical/Daycare Spending Accounts	X		
Free Smoking Cessation Programs	X	X	X
Free Access to In House Fitness Equipment	X	X	X
Reduced Membership Fees to Area Gyms and pools	X	X	
Enrollment in Wellness Committee, HC Offerings	X	X	X
Free Influenza, Pneumonia, Hepatitis Vaccinations	X	X	X
Discounted Theater, Concert Tickets, Retail discounts	X	X	
Discounted Tax Preparation Services	X		

Other services and benefits to promote engagement and satisfaction across workforce segments include: flexible schedules; PTO; career ladders with pay increases; competitive wages validated by semiannual compensation reviews; scholarships/tuition reimbursement; CME for MS; education programs, free meals, vaccines and health screenings for volunteers; and decision making committee participation. Associates' perceptions of benefits and WF policies are measured by surveys and APs are developed based on feedback received.

5.2.a.(1) Elements of Engagement SLs/DLs determine key elements that affect workforce engagement for different groups and segments through biennial surveys conducted by our partner TW. WF data are aggregated and segmented by various elements such as job category, department and division. Results are in Section 7.3 and available on-site. TW's research shows the key elements of engagement are segmented into commitment and line of site and include: pride, loyalty and satisfaction; understanding MVV, business direction and alignment of goals; commitment to MSMH's journey to achieve the SP/AOP; seeing value in the work; and understanding performance related to goals. Data analysis indicates that MSMH's key drivers of engagement in aggregate include: acting on associate suggestions; responding to changing market conditions; exploring career opportunities within the organization; focusing on associate health and well-being (Sec 7.3). Mid-cycle pulse checks are completed on-line, with hospital and department specific questions.

5.2.a.(2) Organizational Culture MSMH's systematic approach is to foster an organizational culture that is characterized by open communication, high performance work and an engaged WF utilizing diverse teams employing the FADE methodology. Every voice is considered equal and innovation occurs during the Development phase. MSMH's flat organizational structure allows for frequent two-way open communication among associates, MS, and DLs/SLs, ensuring SLs receive direct input about the diverse ideas, cultures and thinking from the WF. Purposeful SL/DL rounding allows time to discuss topics of staff choice, suggestions, concerns, and satisfaction and engagement.

MSMH surveys the WF to measure various elements of the organizational culture, segments and shares the results with comparisons to ensure that MSMH benefits from the diverse ideas identified in surveys. Examples include improved satisfaction due to the close working relationship between MS and nurses and improved interdepartmental relations (Figs 7.2-22, 7.3-25 & 7.3-27).

ASERC develops hospital-wide APs when scores show opportunities for improvement. Prior to implementation, hospital-wide APs are shared with DLs at LC and with associates at quarterly Town Hall meetings for input. Departmental APs to improve engagement and perception of safety are developed by staff with DLs. Monthly and quarterly updates are shared with staff at departmental and Town Hall meetings.

MS survey results are presented at the MEC, departmental, and quarterly MS meetings. APs are developed, executed and tracked for effectiveness with formal and informal communications. The volunteer and student service coordinator seeks formal and informal feedback, working with SLs/DLs to address concerns.

The president holds monthly LC meetings providing AOP updates. SLs then hold smaller group division meetings wherein DL development and deeper discussion of topics from LC occur. SL meetings with division supervisors are held quarterly with the same aims. DLs/SLs attend MS meetings to share information. These communication strategies, in addition to 1:1 SL/DL meetings and SL/DL huddles, foster communication and teamwork. DLs hold departmental staff meetings within 1 week of LC. The hospital's Diversity Committee is an interdisciplinary group of front line associates led by the Director of HR/OLR to promote diversity awareness. Its goal to promote culturally competent care across the continuum uses EBPs to foster valuing people. Diversity perception surveys are conducted and results reviewed against annual goals. MSMH utilizes an on-line database of staff suggestions with a tracking element to foster transparency. SLs use these strategies to ensure the organizational culture benefits from the WF's diverse ideas, cultures and thinking.

5.2.a(3)Performance Management MSMH's approach to performance management supports high performance and WF engagement through EBPs that ensure engagement and satisfaction, establishing expectations, accountability and rewarding results.

TM is used semiannually to evaluate associate performance against standardized technical skills, SPIRIT values and goal achievement to advance MSMH's work. Associates complete self-evaluations for DLs to consider in annual and mid-year evaluations. Associates and DLs may document notes in this on line tool, promoting comprehensive evaluations. Scoring is completed using a criterion referenced process, wherein leaders rate each performance element and the tool summarizes an overall evaluation rating of role model, key contributor or below expectations. Associates with role model behavior receive bonuses to value high performance. Associates with below expectation ratings are placed on a PI plan.

Using EBPs for performance management, rewards are designed to be intrinsic to foster engagement (e.g. empowerment, autonomy, career ladders, continuing education). SLs/DLs routinely publicly recognize excellent associate performance during rounds. Patient Safety Heroes are selected quarterly by the PSC from the LS and are recognized. Monthly SPIRIT awardees are chosen from candidates submitted by fellow associates, and one is celebrated as Associate of the Year. Recognition for MS and volunteers also reinforces the focus on engagement. Shared governance is used to promote engagement, leading to high level performance. Associate feedback used in decision making leads to commitment to work process development, implementation and improvement (Figs 7.3-28, 7.4-2 & 7.4-3). Extrinsic rewards include: financial incentives, promotions, thank you notes and small gifts to reinforce high performance. Semi-annual compensation reviews are conducted against benchmarks within and external to the healthcare industry to ensure competitiveness (Fig 7.3-17).

The performance management system is designed to reinforce intelligent risk taking to achieve innovation (e.g. evaluation of leadership competencies); to reinforce a focus on POCs (e.g. SPIRIT Values ratings); and achievement of APs (e.g. scoring goal accomplishments and SL performance bonuses). For example, the leadership competency of "managing for results" includes rewarding intelligent risk taking at the role model level. The Wound Healing Center is an example of an intelligent risk, incorporating SPIRIT values (Patient First, Innovation and Teamwork) resulting in a successfully implemented AP.

5.2.b(1) Assessment of Workplace Engagement SLs/DLs assess WF satisfaction and engagement via surveys no more than every 3 years with mid cycle pulse checks. These surveys are reliable and valid tools to measure changes and results are aggregated and segmented (Section 7.3). Volunteers are surveyed annually. The WF is asked for feedback both formally and informally. Interaction at Town Halls, staff meetings, huddles, rounding and 1:1 meetings are used to assess engagement. These quantitative and qualitative data reflect satisfaction, engagement and morale.

Rounding occurs with each department on different shifts which augments segmented information. Additionally, the President has quarterly meetings with randomly chosen associates to elicit feedback. There is a suggestion hot line to the President's Office. Suggestions are analyzed for trends and associates complaints are managed as previously mentioned (Sec 3.2b(2)). Other WF assessment indicators include: turnover rate, vacancy rate, staff/role model retention, intention to remain employed, safety and productivity (Sec 7.3).

5.2.b(2) Correlation with Organizational Results Annually, SLs and the HR DL review workforce engagement and correlate the findings to benchmarks and organizational results, identifying opportunities for improvement with subsequent APs and implementation. These results are reported in the HR annual report to QSPAC and the BOD. Results and correlation to MSMH outcomes are incorporated into the AOP (Figs 2.1-4, 7.3-20, 7.4-42 & 7.4-43).

5.2c(1) Learning and Development System SLs/DLs implemented a learning and development system for the WF and LC. An on-line learning system provides training, education and development activities. The EMR build integrated real-time clinical references. A competency plan, including return demonstration requirements, was designed by a cross section of leaders and approved by SLs/DLs. OLR is an AHA accredited training center for ACLS/BLS/PALS, used by students, volunteers and the community. To make the learning and development system more robust, MSMH partners with higher education institutions.

To further integrate the learning and development system, MSMH created an interdisciplinary LDC comprised of front line staff. LDC goals include correlating staff learning needs to core competencies, strategic challenges and accomplishing short term and long term APs. Using a POCs focus, the LDC correlates learning needs to PI, by matching performance gaps with creative educational solutions. This process includes information gathered through needs assessments with data from quarterly and annual reports to QSPAC. Further, the LDC membership reinforces new knowledge, institutional memory and job skills for current and future associates.

OLR has responsibility for a MedChi accredited CME program for MS. FPPE/OPPE trends are used as indicators to guide CME programming and improve patient care. Further, MS suggestions and feedback are used to evaluate and improve the CME program. Additionally, associates and MS co-participate in programs to maintain and advance competencies. An example of this is MOST, combining the disciplines of nursing, OB, Pediatrics and Anesthesia. MSMH was an early adopter of fully interactive remote grand rounds with MGUH. Library services are provided online and in print.

Based on the scope of care provided to the community, associates must stay abreast of innovations in medicine in spite of the strategic challenges of workforce shortage and lack of proximity to advanced academic institutions. Annual learning plans are designed and developed by SLs/DLs for each associate regarding orientation and annual mandatory requirements. Associates also self identify areas for additional education, training and self-fulfillment. Educational and development activities include online learning, MSMH sponsored webinars, seminars and simulation training, and immersion training at other System facilities with high volumes of activity that are high risk/low volume at MSMH. SLs, DLs, and associates are encouraged to attend regional seminars to network and learn (Fig 7.3-33).

Ethical healthcare is monitored by the MS Bio-Ethics Council to raise awareness about medical ethics and recommend care decisions. The Council recommends educational activities for clinicians based on trends in care or the environment. Facilitating the use of burdock leaves for Amish burn patients is an ethical treatment example.

SLs design DL development plans based on performance evaluations and AOP initiatives. Leadership education focuses on a theme each year, selected by SLs. Off-site LC retreats are held semiannually to provide SP/AOP updates, market performance, industry trends, community needs, governmental requirements to facilitate brain storming and future planning. Off-site retreats are held annually by each SL with his/her DLs to formulate personal goals in the AOP.

Knowledge transfer is a critical component of learning and development when associates retire or otherwise separate from MSMH. This is accomplished by ensuring hand-offs include didactic and hands-on practice. Education is reinforced through annual mandatory training, matching the diverse needs of clinical, non-clinical and nursing associates. Competency programs are designed for WF segments based on changes in the patient care environment and MSMH's work.

5.2.c(2) Learning and Development Effectiveness Learning and development efficiency and effectiveness are evaluated via individual/group metrics. Learning and development plan designs ensure learning occurred vs. information sharing.

Satisfaction with learning and development is part of associate and MS satisfaction/engagement surveys. Positive and negative performance trends are gleaned from TM, the LS, annual competencies, mandatory education and departmental education. Online learning, which is increasing yearly, is developed in response to evaluation of the efficiency of learning as noted from associates and MS in satisfaction/engagement surveys (Figs 7.3-32 & 7.3-33). Success

was also achieved in improving MS satisfaction with nurses, as well as increasing academic preparation of nurses (Figs 7.3-10).

5.2c(3) Career Progression MSMH follows a standard approach to managing effective career progression for its WF that has evolved from the full application of the FADE process. WF engagement surveys identified the need to improve internal career progression opportunities. In response, SL/DLs follow a recruitment decision tree requiring attention to internal versus external candidates. In a second FADE cycle, to ensure opportunities for career progression are easy to explore, JDs were posted online for associates to prepare for advancement. Associates can now meet with HR, OLR, DLs or SLs for career counseling. Policies related to advancement, transfer, scholarships and tuition reimbursement are on the associate portal (Figs 7.3-29). Associates are encouraged to use the Walk a Mile program or visit other MSH entities to explore new careers (Figs 7.3-33 through 7.3-35).

HR completes succession planning assessments for leadership so APs can be created and implemented. Strategies include leadership development training, career ladders, and mentoring graduate students. To measure succession planning effectiveness, a goal of 60% leadership promotions from within is tracked on the HR dashboard (Fig 7.3-34). As another aspect of succession planning, MSMH developed a novel concept combining volunteers and students under one program with the desired result to create candidates to help meet the strategic challenge of WF shortages.

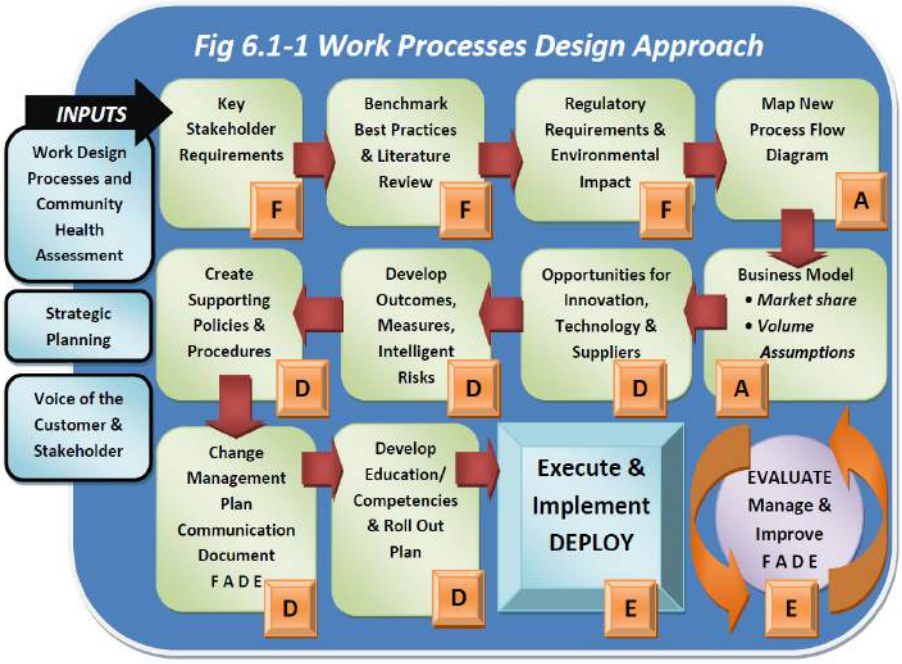
6. Operations Focus. MSMH's systematic approach to design, manage and improve healthcare services and work processes is guided by the MVV and SP/AOP to continuously improve, achieve success & long-term sustainability and meet the needs of POCs.

6.1 Work Processes

6.1a(1) Design Concepts Healthcare services are Inpatient, Outpatient, Emergency and Community Health, with key work processes of Care Delivery, Care Coordination, and Access to Care. Quality & Safety Oversight, MS Credentialing & Board Management work processes are included within the Governance Work System. Planning, organizing, staffing, directing, controlling & improving work processes are included in the Management Work System. Finance, Facilities, IT, Supply Chain, HR and Risk Management are key work processes within the Business & Support Work System (Fig 2.1-3). Healthcare services and work processes are organized within functionally related departments and committee structures. SLs identify healthcare services and design work processes using the FADE approach to innovate leveraging core competencies with a focus on delivering value, achieving high reliability and meeting future needs.

SLs analyze healthcare services and work processes, identifying new ones and assessing the continuation of existing ones to plan MSMH's future and manage change. SLs assemble design teams who flowchart new or existing processes. During Design, team members consider and incorporate POCs' input and expectations, market research, new technologies, organizational knowledge, EBPs, fiscal impact, physical requirements, flexibility and scalability. Design plans integrate cycle time, productivity, cost control and other efficiency and effectiveness requirements. Based upon the analysis, SLs determine if outsourcing is the best alternative. With respect to key suppliers, partners and collaborators, work process design incorporates collaborative feedback, cross pollination of ideas, industry best practices and benchmarks. Agility is achieved through ad hoc meetings to rapidly reassess data in response to new or modified process requirements, or to implement mid-course corrections in the design process.

6.1a(2) Service and Process Requirements Based on EBPs, healthcare services and work process requirements are structured to deliver care with systemic safeguards assuring patient safety and placing the Patient First. In addition to legal, regulatory, and accrediting requirements, when SLs/DLs design or improve healthcare services and work processes they also consider specialty expertise, equipment, technology and POC preferences. SLs determine healthcare services and work process requirements in the Focus/Analyze steps of the FADE process (Fig 6.1-1). These requirements are determined through input from POCs; benchmarking EBPs; environmental impact studies; technology evaluation; literature reviews; business model development; regulatory requirements; and process flow maps. Utilizing these elements provides POCs value, efficient operations, organizational success and sustainability (Fig 6.1-2).



6.1b(1) Process Implementation As part of the Execution phase of the FADE approach, work processes are implemented across the 3 patient segments: IP, OP, ED. In accordance with work process APs, ELs assign process owners who implement tactics including staff and equipment selection, policy and procedure development, staff education, trials and evaluation. SLs/DLs are accountable for successful project management.

Work processes are evaluated and refined or improved through the organizational PM processes. A dashboard of measures is developed to monitor quality outcomes, performance and sustainability ensuring delivery of POC value. When metrics demonstrate that initiatives are not meeting expectations, the appropriate EL will work with process owners to analyze the data and make mid-course corrections. Embedded into the PM dashboards are indicators that measure key work processes, including in-process measures for the control and improvement of day-to-day operations, for example ED TAT and Door-to-Doc time (Fig 7.2-15) and medication reconciliation (Fig 7.1-25).

Mechanisms to monitor work process implementation include discussions during daily safety calls; at the SL weekly meeting; at monthly LC meetings; during discussions at the monthly and quarterly MS meetings; and at semiannual LC retreats.

Fig 6.1-2 Healthcare Services, Key Work Processes, Requirements and Measures				
Work System	**Key Work Process**	**Requirements**	**Measurement**	**Results**
LEADERSHIP				
Governance	Quality & Safety; MS Credentialing; Board Management; Philanthropy;	Quality outcomes; Fiscal Accountability; Sustainability; Transparency; Forward Thinking	Governance Process Audits & Self-Assessment; PI Evaluation; Audit Results; BOD Ethics and Societal Impact	Figs 7.4-13 to 18, 7.4-23 to 32
Management	Planning; Organizing; Staffing; Directing; Controlling; Improving	Alignment, Communication; Effectiveness; Transparency	MVV Deployment; Associate Satisfaction and Engagement; Accreditation and Regulatory Compliance; Audits; Safety Metrics; Safety Prioritized	Figs 7.4-1 to 5, 7.4-7 to 11, 7.4-19 to 22
HEALTHCARE SERVICE				
IP, OP, ED	Care Delivery Models	High Quality Care/Clinical Excellence; EBPs	Clinical Outcomes; AOP Measurements	Figs 2.2-4, 7.1-1 to 6, 7.1-23 to 24, 7.4-42 to 43
		Patient Satisfaction & Engagement	IP Satisfaction Metrics; OP Satisfaction Metrics; ED Efficiency; Patient Dissatisfaction	Figs7.1-21,7.2-1 to 14, 7.2-18, 7.2-23 to 24, 7.4-42 to 43
IP, OP, ED	Care Coordination	Efficient Patient Care	LOS; CMI; APR-DRG and Patient Mortality; Imaging Throughput; Transfer Rates	Figs 7.1-10 to 12, 7.1-26, 7.4-35 to 37
		Performance Improvement; Data Driven	C-Section Metrics; CLABSI; Incidence of MDRO; SCIP	Figs 7.1-16 to 20
		Interdisciplinary; Transparency	Stakeholder & MS Engagement; Patient Portal Use; Returning Patients	Figs 7.1-34, 7.2-25 to 35, 7.4-12
		HIM; Innovation	Physician Query Response; HIM Record Delinquency	Fig 7.1-28 to 29
		Continuum collaboration	Readmission Rate	Fig 7.1-7 to 9
		Patient Safety; Innovation; Transparency	MHAC; Patient Safety Metrics	Fig 7.1-13 to 15, 7.1-22, 7.1-25, 7.1-30, 7.4-42
Community Health	Access To Care	Community Outreach; Efficiency; New Services	Community Obesity rates; ED throughput; Care for Uninsured; Express Care Visits	Figs 7.2-15 to 17, 7.4-34
BUSINESS AND SUPPORT				
Finance	Revenue Cycle; Marketing; Philanthropy; Accounting	Sustainability; Market share; Accuracy; Timely; Cost effective; Productive/Efficient	Gala Success; Operating Margin; Operating Income and Revenue; Revenue Cycle Metrics; Increasing Donations; FTE per Unit; Brand Awareness; Markey Share; Uncompensated Care	Figs 7.1-34, 7.4-6, 7.4-40 to 43, 7.5-1 to 3, 7.5-5, 7.5-7 to 15
Facilities	Facility Maintenance	Well Maintained Facility and Effective Operations	Waste Reduction; Age of Plant; Equipment Maintenance; Energy conservation	Figs 7.4-38 to 39, 7.5-6
IT	EMR Development & Solutions Support; Network Operations	Technology Innovation and Evaluation, Reliability	Uptime compliance; HIMSS Level	Figs 7.1-27, 7.4-21
Supply Chain	Procurement	Efficient Operations	Expense/EIPA; Pharmacy Inventory Turns	Figs 7.1-31 to 32, 7.1-36, 7.5-4 to 5
HR	Management of Workforce Capacity and Capability; Physician Recruitment	Efficient Operations; Learning Organization; Leadership, MS and Staff Development; MS and staff Wellness, satisfaction and engagement ; Physician Alignment	HR Metrics; Vacancy Rate; Turnover Rate; Retention Rate; Career Growth(Learning) Metrics; MS & Associates' Satisfaction and Engagement; Workforce Safety ; Teamwork; Assure Associate Licensure	Figs 7.2-19 to 22, 7.3-1 to 11, 7.3-17 to 35, 7.4-33, 7.4-42 to 43
Risk Management	Mitigate Risk, Assure Safety	Safe Environment	Emergency Preparedness; Workforce Safety Metrics	Fig 7.1-35, 7.3-12 to 16

Most key work processes are internal, however they may be outsourced when MSMH can benefit from economies of scale or when resources are limited or non-existent. An example of an improvement in healthcare services is the addition of wound healing services to meet POCs' needs in the community. The program was outsourced in order to leverage more fully developed external resources and expertise.

Key performance metrics to control and improve work processes and how they relate to the quality of outcomes are identified in Fig 6.1-2.

6.1b(2) Patient Expectations and Preferences Healthcare work processes are designed to address patient expectations and take their preferences into account. Aggregated patient expectations and preferences data are incorporated into process design during the Focus step of the FADE process. In-process steps for healthcare work processes specifically incorporate individualized patient expectations and preferences. For example, initial patient expectations are addressed and considered through information collected during the registration screening process, e.g. religious and cultural preferences. During the nursing admission assessment, a list of patient preferences and expectations are identified and used to individualize care plans with the patient, family and healthcare team. Setting expectations, explaining care, and alleviating specific patient concerns are integrated into clinical work processes.

Throughout the patient's stay, daily and long-term goals are established and reflected on the patient white boards, in care plans and discussed during hourly rounds. During bedside rounding and family meetings, MS and nurses encourage the patient and family to take part in decision making and set realistic expectations, and take patient preferences into account (Fig 7.2-9). Interdisciplinary team meetings are a means for modifying delivery of healthcare services based on patient care preferences. SL/DLs routinely measure patient satisfaction with taking their preferences into consideration and also take part in the PFPF to address expectations and preferences of future patients.

6.1b(3) Support Processes SLs determine support processes in the Focus/Analyze steps of the FADE process based upon industry and regulatory standards and internal customer requirements. Key support processes are structured around the capacity and capability of the WF, the ability to leverage technology, system integration, opportunities to innovate and coordinate, and legal and regulatory requirements. Key support processes are indicated in Fig 6.1-2. Dashboards for each department and committee that are monitored by SLs/DLs are

published for WF and MS. Department to Department surveys are conducted for feedback about day-to-day operations (Fig 7.2-22).

6.1b(4) Service and Process Improvement SLs/DLs improve work processes through deployment of a rigorous data driven PI approach (FADE), (Sec 4.1) and achieved through APs (Sec 2.2a). Suggestions originate from a variety of sources, including associates, MS or POCs. If initial process analyses and research indicate that a PI opportunity exists, then a formal team is chartered by QSPAC. Interdisciplinary teams with process owners and ELs are assigned and facilitated by LSS greenbelts. A black belt oversees LSS teams. Teams use peer review, business research, and LSS tools to understand the current situation. PI cycles of new or modified processes promote innovative solutions with testing of assumptions in a non-punitive environment. Teams develop dashboards for key performance indicators and implement corrective actions when indicators fall short of expectations. Metrics are selected with the express purpose of driving continuous improvement, reducing variability and ultimately achieving high reliability of service and care. For example, MSMH joined the Delmarva/AHRQ Medication Reconciliation Collaborative with specific goals of completing a home medication list and reconciling medications on admission and a team of staff was charged and improved the reconciliation process after multiple cycles of FADE. (Fig 7.1-25).

6.2 Operational Effectiveness

6.2a Cost Control SLs proactively set the framework for operational effectiveness through the budgeting process that includes forecasting, benchmark utilization, and input from the WF, MS and DLs. SLs/DLs control cost through many mechanisms including: Value Analysis (effectiveness), group purchasing contracts, managerial accountability, authorization policies and LSS (cycle time and efficiency). DLs review daily productivity reports and adjust staffing accordingly. Financial reports are monitored on an ongoing basis and DLs complete monthly expense variance reports that delineate mid-course corrections.

Standardization through IT and automation supports development of highly reliable work processes. These tools minimize re-work and are utilized to provide high quality care, which in turn controls cost. Policies and procedures are standardized within work processes and EBPs are facilitated through the EMR. ADCs for medication dispensing, bar coding and bedside verification for medication administration were implemented to reduce errors and minimize rework (Figs 7.1-30 & 7.31). Organizational learning to reduce rework is facilitated by tracking medical errors and safety concerns in the LS, conducting internal audits and mock surveys that measure early compliance with regulatory changes. Costs of inspections, tests and audits are minimized by MSMH's proactive standardization, preventative approaches, early adoption, and integration/consolidation within MSH.

Through the VAT approach, cost and quality are considered in selecting products to meet the needs of POCs relative to cost control efforts. During CY13, product selection resulted in lower cost only 58% of the time. 42% of the time MSMH chose higher cost items to maintain or improve quality.

6.2b Supply Chain Management Supply chain is managed using an integrated approach with MedStar to assure vendor performance remains at peak levels. Supply items are segregated based upon criticality to operations, par levels are established based on historical data and reviewed with vendors, to reduce the likelihood of stock outs occurring on critical items. Inventory of high volume and critical items are maintained as MSMH's rural location precludes participation in just-in-time programs with vendors. Vendors are selected through a data driven decision making process led by the Corporate VAT. Criteria include high quality products and services, patient and WF safety, POCs and WF satisfaction, MS preference, distribution systems, results of references and background checks, etc. MSMH may utilize an alternative vendor if greater value can be demonstrated. SLs/DLs and MS evaluate vendor performance through quarterly business reviews, and daily and weekly review of established metrics, depending on the type of service, e.g., pharmacy annual inventory turns were increased from 9.6 to 13.9 through an integrated approach with the prime vendor (Fig 7.1-32). Evaluation of supply chain performance includes analysis of: order accuracy, timeliness, quality, patient satisfaction, value, reliability and safety. Suppliers contribute to the decision making processes by presenting alternative products that add value, increase POCs' satisfaction and reduce cost, e.g. Becton Dickinson presented alternative safety needles to reduce associate needle injuries (Fig 7.3-15). This demonstrates suppliers' role in enhancing the delivery of care to patients. If suppliers perform poorly, associates refer back to contract terms to assure compliance, and may ultimately force contract termination if vendors are unable to consistently maintain commitments. Vendor performance data are evaluated prior to contract renewals.

6.2c(1) Safety MSMH utilizes TJC EOC standards as a framework to provide a safe operating environment and instills that safety is everyone's responsibility. This approach is organized into an oversight EOCC and 6 subcommittees where the following functions are addressed: life safety, utilities, safety and security, equipment management, hazardous materials and emergency preparedness. Interdisciplinary subcommittees analyze data, review standards, and adopt APs to address gaps and opportunities for improvement.

SLs and MS have established processes to ensure safe patient care. Clinical safety is monitored and assured by several committees: MS Peer Review Council, Nursing Peer Review Council and Patient Safety Committee. Information regarding potential clinical and operational safety concerns is shared daily on a "safety call" lead by the President. Feedback on areas of concern is addressed in the following day's call.

MSMH strives for a high reliability discipline and has adopted proactive processes to ensure a safe working environment, including the use of: tracers; safety rounds; RCAs following precursor events, near misses and SSEs; identifying and mitigating latent system failures; PMs on equipment; departmental safety representatives; simulation training of high risk procedures; FMEAs; Speak Up program for POCs; and an open culture of reporting for WF. Safety is reinforced by starting meetings and huddles with a safety story, through recognition of patient safety heroes and celebrating good catches.

6.2c(2) Emergency Preparedness SLs/DLs use a systematic approach to plan for disasters and ensure workplace preparedness for national, community and MSMH specific emergencies or disasters through a set of emergency plans and policies based on hazard vulnerability analysis. Plans and policies are designed to ensure continuity of operations and mitigation of the impact of the emergency. The approach is managed by the EOC committee structure.

MSMH disaster plans utilize HICS to promote effective response and communication. SLs/DLs are FEMA certified in the use of HICS (Fig 7.3-30). Disaster drills are routinely conducted with WF as well as external agencies and are evaluated for effectiveness (Fig 7.1-35). APs addressing improvement opportunities are developed based on opportunities identified. Preventive measures include vaccinations, education, orientation, hazard vulnerability analyses and facility lockdowns. To ensure continuity of operations, MSMH maintains backup generators, access to 96 hours of inventory, IT down time procedures (see Sec. 4.2), MS emergency credentialing processes and emergency staffing plans. Recovery activities are stated in specific policies and are dependent on the exact nature of the emergency.

SLs/DLs mitigate potential risks by completing risk assessments that rate and predict the probability of disaster occurrences. Plans are

developed to address each potential disaster or emergency. The approach to mitigation encompasses infection prevention, pandemic emergencies, and natural and organizational specific disasters. SLs/DLs participate in state and regional drills to test and educate the WF. Effective operation of alarms and fire suppression equipment is assured through regular testing and maintenance (Fig 7.4-19).

EOPs include a policy providing direction for potential evacuation of the facility. Agreements are in place with external entities to assure the continuity of patient care at off site locations in the event of an evacuation. The EOPs allow MSMH to meet capacity demands through deployment of rapid credentialing, orientation and education processes for clinicians, meeting TJC/CMS regulations.

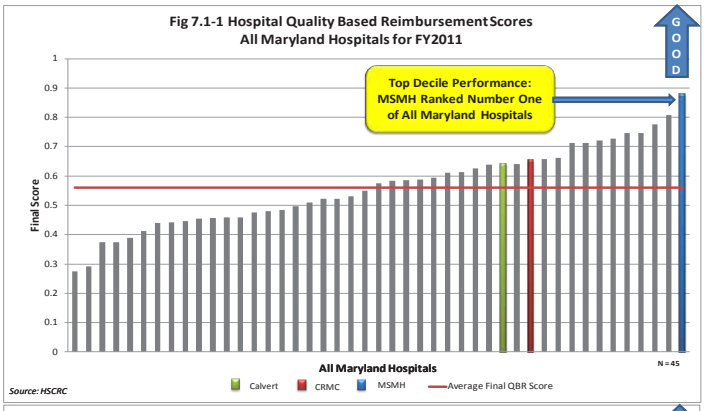
Disaster recovery is managed by assuring MSMH maintains a strong cash position to sustain operations through disaster events, and has insurance to ensure sustainability through and following a disaster and to fund repairs and reconstruction that might be necessary. The HICS leaders direct crisis event de-escalation as delineated in policy.

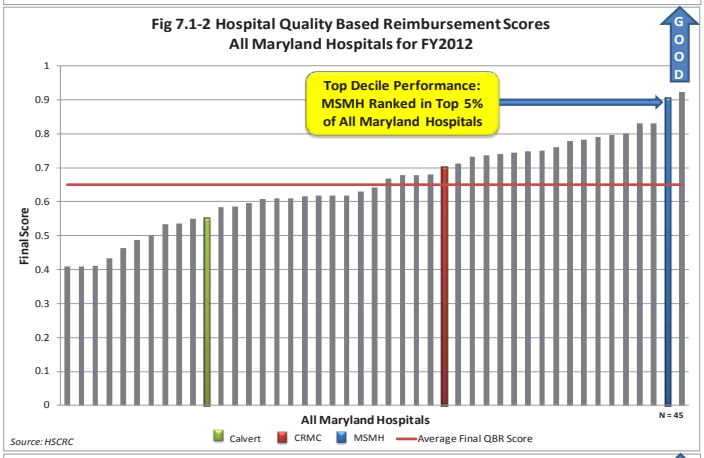
6.2d Innovation Management MSMH's approach to innovation management occurs during the Develop phase of the FADE, in which there are many opportunities for brainstorming, identifying alternatives and potential risks, and consideration of new technology. MSMH supports this by providing numerous opportunities to create and share ideas for the organization to consider pursuing, examples include: RRB, MI2, on-line suggestion database, President's hotline, SL/DL rounding, Town Halls, and an annual research symposium, etc.

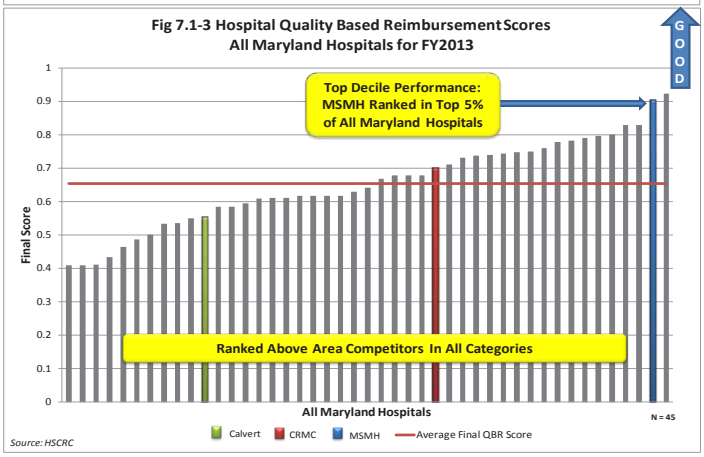
When a viable idea is identified, SLs determine if the opportunity is in alignment with the SP/AOP and if the capacity and capability exist or can be developed to support the initiative. If so, business plans are developed and potential ROI is determined and the initiative, if prioritized, is incorporated in the next SP/AOP cycle. One such example is the expanded application of telemedicine to augment Neurology services at MSMH in response to the Strategic Challenge of access to specialty care. When capacity and capability are limited, and/or the ROI is insufficient, MSMH will choose not to pursue an opportunity so scarce resources can be applied to higher priorities but is agile enough to reconsider if conditions change. For example, MSMH had determined that it was not a high priority to develop retail pharmacy services and redirected resources; however, based on POCs, payers and WF needs MSMH has now reprioritized offering this service.

7. <u>Results</u>. 7.1(a) Patient-Focused Healthcare Results The capability to efficiently collect, analyze, interpret, verify and execute change based on PI data facilitates accomplishing the AOP and fulfills MSMH's mission. This focus on PI allows MSMH to perform at the highest levels when benchmarked against national, state and regional targets. SLs utilize this performance driven rigor transparently as they strive to lead an HRO with emphasis on patient safety and excellent outcomes.

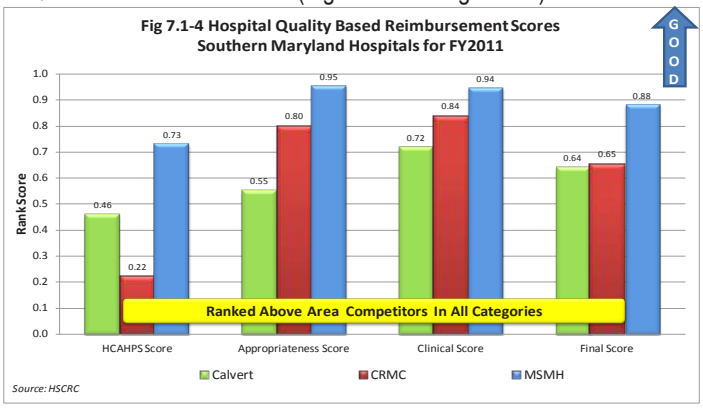
As a result of its CMS waiver and unique regulated rate setting methodology, Maryland utilizes a different value based purchasing system than the rest of the country. The QBR system adjusts hospital reimbursement rates by comparing state hospitals' performance on quality factors (70%) and patient satisfaction (30%). Since program inception 3 years ago, MSMH scored first in FY11 and second in FY12 & FY13 (Figs 7.1-1 through 7.1-3).

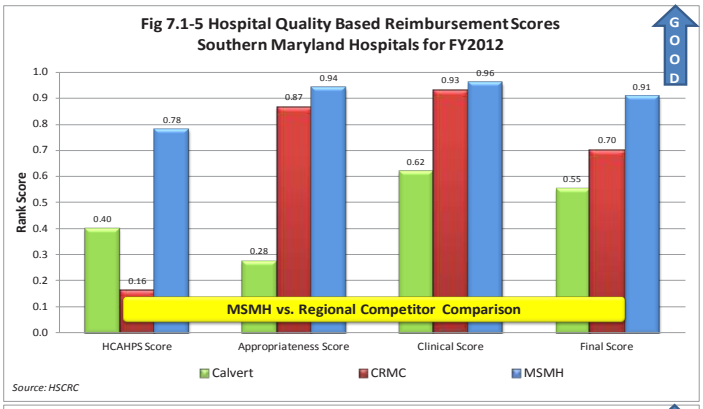


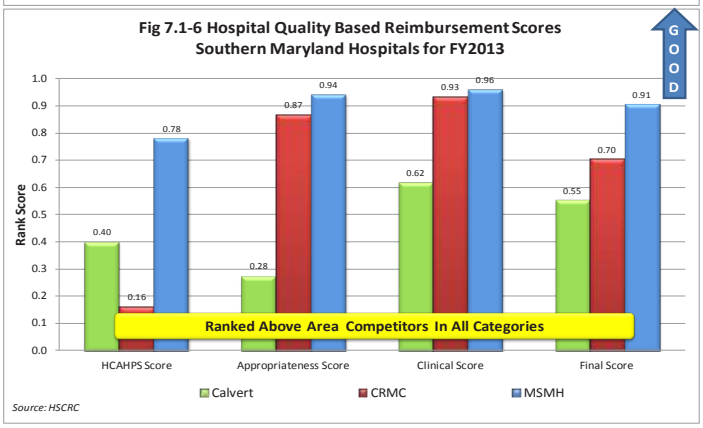




Regional competitor comparisons indicate MSMH out-performed on all QBR metrics in FY11-FY13 (Figs 7.1-4 through 7.1-6).



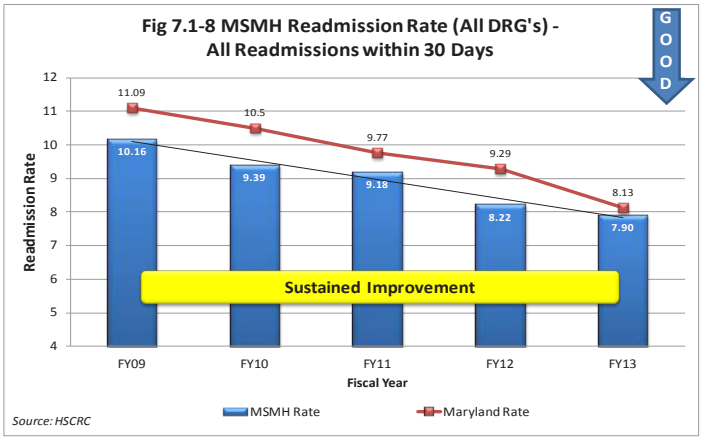




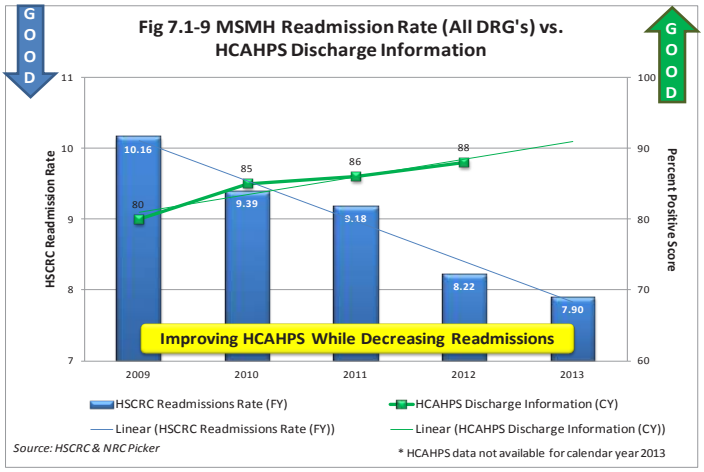
In 2010, long before the Affordable Care Act called for penalties for readmissions, SLs proactively identified readmissions as a quality indicator and launched a multiyear plan to reduce them (Fig 7.1-7).

	Fig 7.1-7 MSMH Readmissions Strategy
2011	Targeted high risk patients. Broader ED case management coverage Multidisciplinary daily huddles and bi-weekly Patient Care Rounds Implemented home monitoring equipment
2012	HSCRC strategy for ARR program with focus on 8 diagnoses Readmissions Executive Oversight Committee implemented Discharge summary made available to PCP within 48 hours post discharge Validated PCP appointment within 5 days of discharge Fortified inpatient pharmacist education
2013	MHA Cross Continuum: Partners Preventing Avoidable Readmissions Program attended SMC Cross Continuum Partners established to analyze transition processes between acute care, SNF, HH, primary care, assisted living facilities, etc. that lead to readmissions Project RED Discharge Checklist initiated Identify medication programs for those unable to afford prescriptions including bedside medication delivery Enhanced Discharge Phone Call program initiated using Studer software with specially trained RNs completing discharge phone calls and MSMH Health Educators focusing on patients with diagnosis of HF and Stroke/TIA
2014	Develop Heart Failure Clinic business plan for consideration Daily rounding with pharmacist, CN, CRM and RT Explore medication availability via MSMH for patients who cannot afford them Partner with local pharmacies Implement the "red envelope" discharge process Ensure all targeted patients have an appointment with either their PCP or Bridge clinic within 5 days of discharge Explore grants/methods to fund home visits not meeting medical necessity Establish palliative care program for chronic pain patients Regular meetings with area Skilled Nursing Facilities and Assisted Living Centers to determine optimal methods for communication Established MedStar Telecon centralized call-back system that refers patients with problems back to each entity's identified liaison for any required follow-up Develop Cross Continuum Care Dashboard Continue Cross Continuum Team with defined meeting dates/times Participate in MHA webinars and incorporate information in CCT meetings Explore mechanism for notifying PCP of non-availability of advance directives and/or MOLST for patients with chronic disease

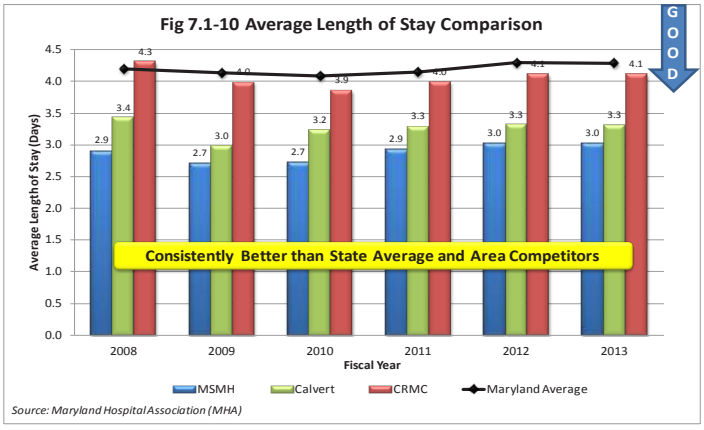
Since the regulatory environment in Maryland is unique, readmissions parameters are different from nationwide CMS metrics. Hospitals were required to decrease their specific readmissions below 2011 rates. MSMH already demonstrated a consistent decline in readmission rates yet was again able to improve in FY12 & FY13 and remain below the Maryland rate (Fig 7.1-8).

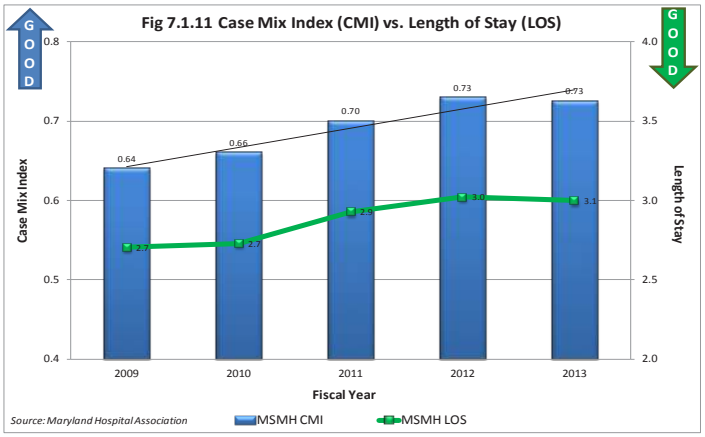


MSMH consistently scores above national and state averages in the HCAHPS Discharge Information metric (Fig 7.2-3). This correlation demonstrates that improved patient education translates to better compliance with discharge instructions and hence reduces readmissions (Fig 7.1-9).



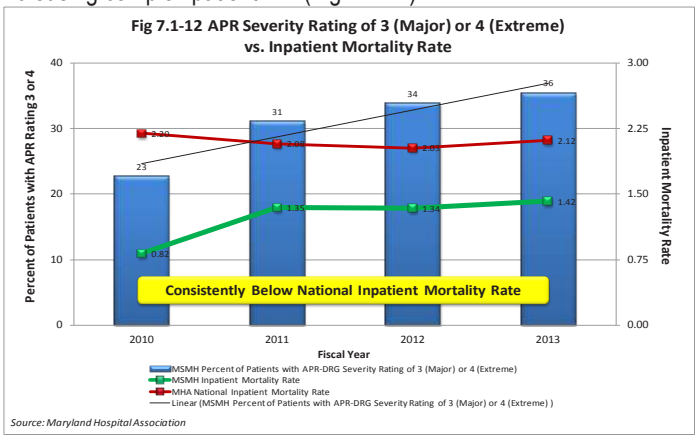
MSMH consistently has the lowest LOS among its regional competitors and is well below the Maryland average (Fig 7.1-10). Despite statewide implementation of observation status in July 2010, MSMH maintained a low LOS while increasing CMI (Fig 7.1-11).



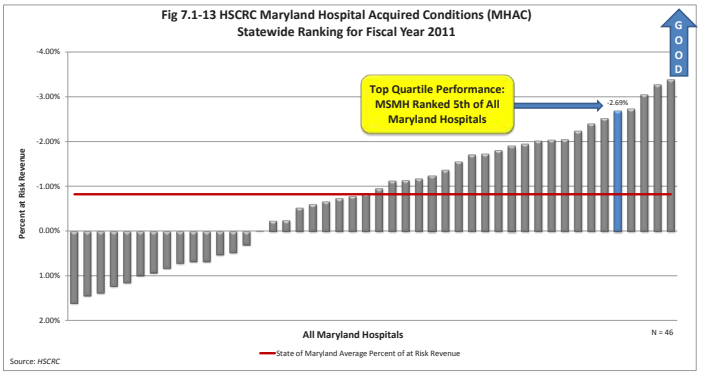


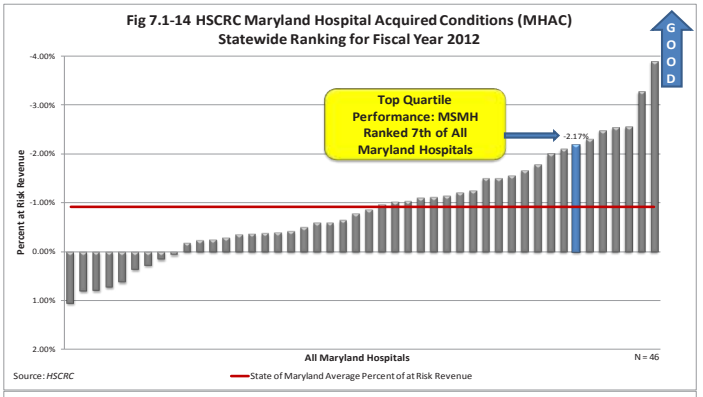
SLs embarked on an initiative to improve access to specialty care and reduce patient transfer to tertiary care centers. An innovative program included the establishment of an Intensivist staffed ICU with remote telehealth monitoring (eCare). Higher acuity patients receive safe, advanced care close to their families. Partly due to eCare, MSMH noted an increase in CMI. However, even with the rise in CMI, MSMH's LOS did not track up proportionally demonstrating consistent utilization of best practice case management and discharge planning (Fig 7.1-11).

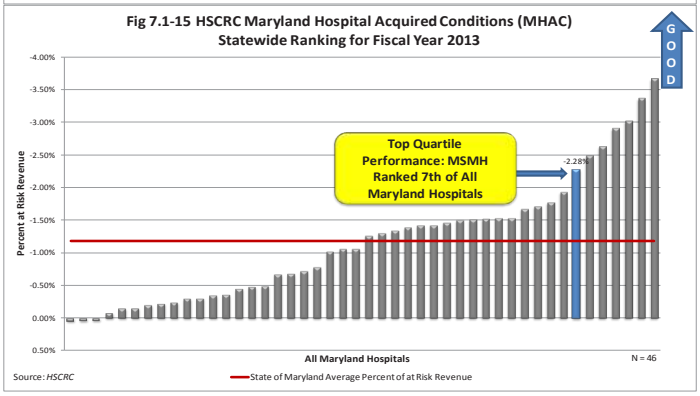
Comparing the increase in APR-DRG severity and inpatient mortality rate reveals better performance than the national average despite an increasing complex patient mix (Fig 7.1-12).



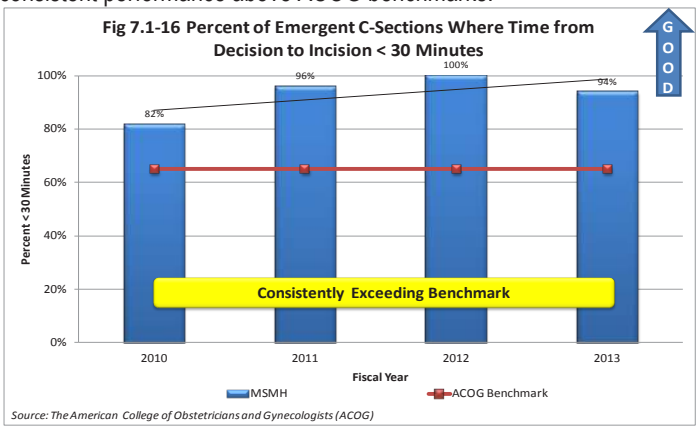
In 2009, Maryland instituted a pay for performance plan based on incidence of hospital acquired conditions (MHACs), which provides incentives based on the hospital's number of complications vs. the statewide rate. Since program inception, MSMH scored 5th in FY11 and 7th in FY12 & FY13 (Figs 7.1-13 through 7.1-15).

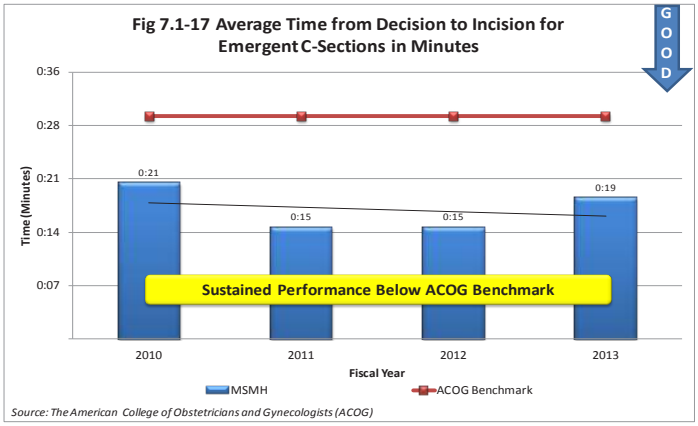






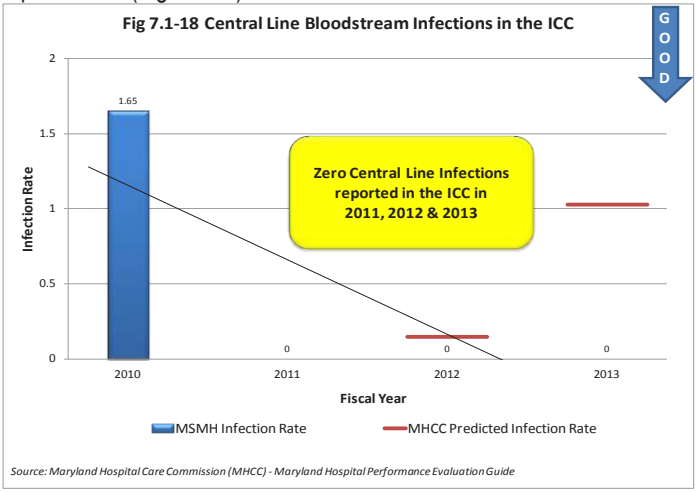
MSMH is a member of the MPSC and DHMH Perinatal Collaborative, setting a goal to reduce the average time from "decision to incision" for emergent C-sections to <30 minutes. Figs 7.1-16 & 7.1-17 demonstrate consistent performance above ACOG benchmarks.



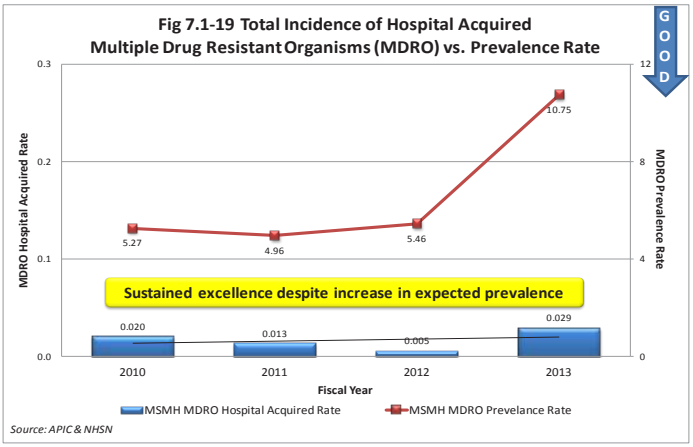


MSMH joined the MHA CLABSI Collaborative in 2010 and standardized central line insertion and maintenance techniques to reduce CLABSIs in the ICU. Despite increased volume, MSMH reduced central line infections demonstrating a cause and effect relationship

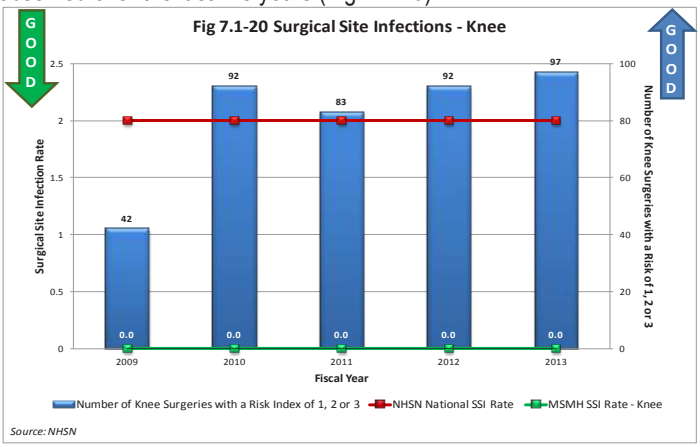
between operational performance and healthcare service performance improvement (Fig 7.1-18).



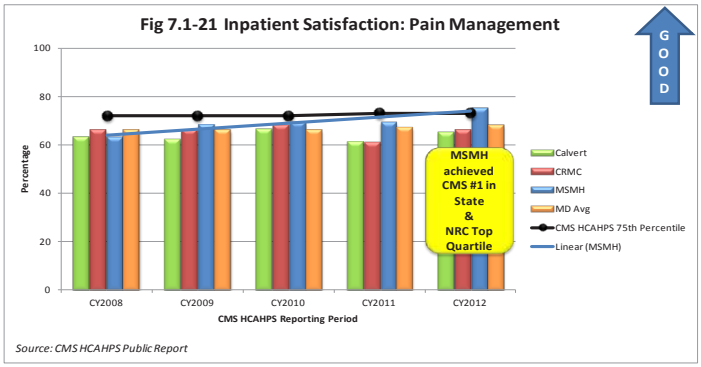
Enhanced vigilance led to reducing infection and the rate of MDROs has consistently remained low. The difference between the expected prevalence and the actual incidence has improved steadily (Fig 7.1-19).



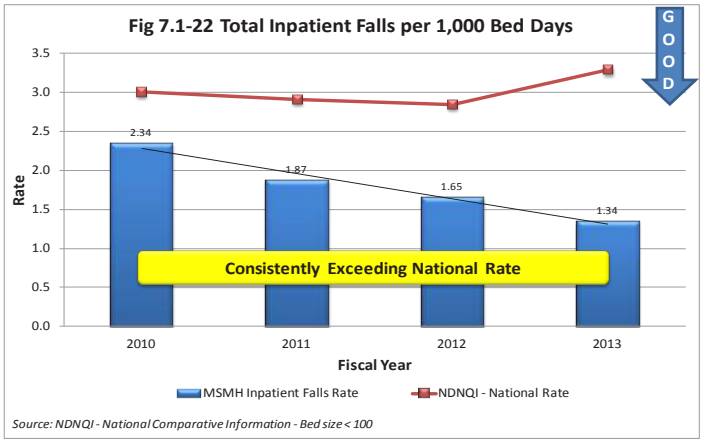
Total knee replacement SSIs remain at low levels and below state benchmarks. Despite increased TKR volume, no infections were observed over the last five years (Fig 7.1-20).



With respect to the measurement for pain management, a key driver in overall patient satisfaction and an example of patient outcome measures, MSMH achieved CMS best in the state and NRC top quartile performance (Fig 7.1-21).



EBPs to reduce patient falls resulted in consistent reduction in total falls below national benchmarks (Fig 7.1-22). Local competitive comparisons are not publicly reported and therefore not available.



7.1b(1) Operational Effectiveness. SLs/DLs design key work systems and processes to achieve high levels of operational effectiveness. MSMH demonstrated reliable and highly consistent performance on core measures. The Delmarva Foundation and the Medicare QIO for Maryland recognize individual hospital PI in the four national inpatient clinical areas - AMI, HF, SCIP and PN – and recognize top performers each year with The Delmarva Foundation Medicare Excellence Award for Quality Improvement. MSMH received this prestigious award 7 times and each year since 2008. In 2011, the Delmarva Foundation raised core measure compliance from 90% to 96% to qualify for the Award. MSMH consistently outperformed criteria to achieve the Award and posted core measure compliance rates of 96% in 2011 and 98% in 2012 and 2013. Individual performance data for each of the four core measures is presented in Fig 7.1-23.

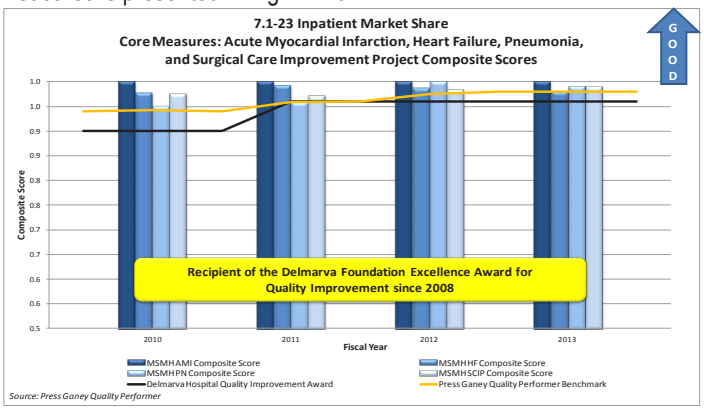
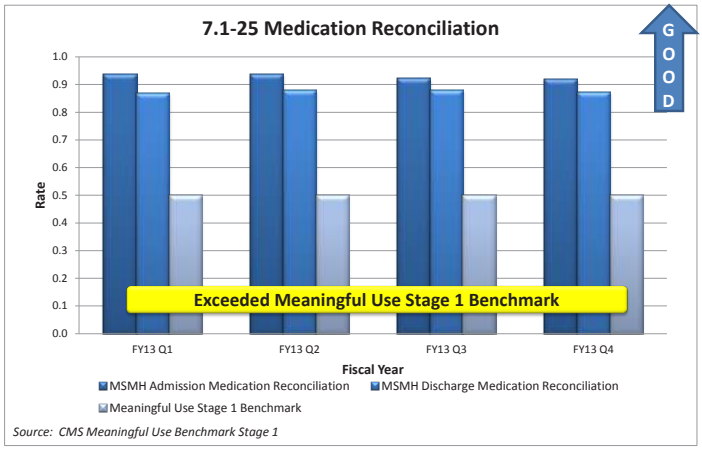


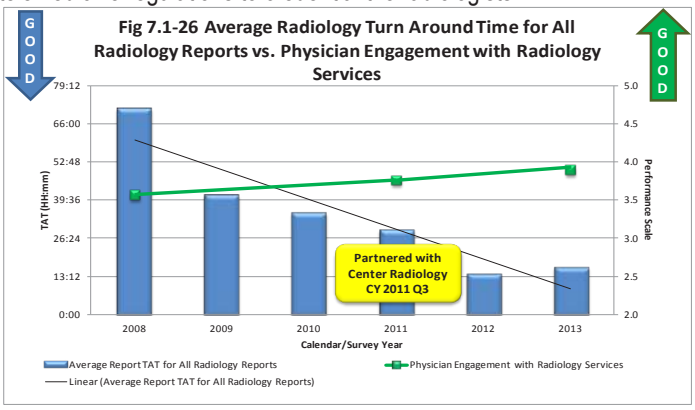
Fig 7.1-24 demonstrates consistency and superior performance when compared to local competitors in achieving the Delmarva Excellence Award.

Fig 7.1-24 Delmarva Excellence Award for Hospitals						
Delmarva Excellence Award	2008	2009	2010	2011	2012	2013
MSMH	Yes	Yes	Yes	Yes	Yes	Yes
Calvert	No	No	No	Yes	Yes	Yes
CRMC	No	No	No	No	No	Yes

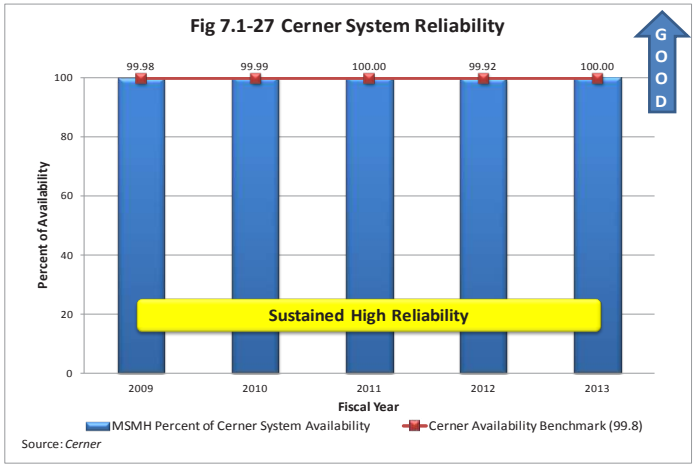
The importance of effective medication reconciliation emerged within the last 7 years and many hospitals experienced difficulty implementing effective measures. In 2011, MSMH joined 18 hospitals in a medication reconciliation collaborative sponsored by Delmarva/AHRQ, to improve completion of a home medication listing and achieve complete medication audit on admission. MSMH's team leveraged the IT platform to achieve the targeted results. MSMH was one of 5 hospitals recognized with the 2011 Medication Reconciliation Excellence Award. Fig 7.1-25 demonstrates consistent medication reconciliation rates above MU stage 1 benchmarks.



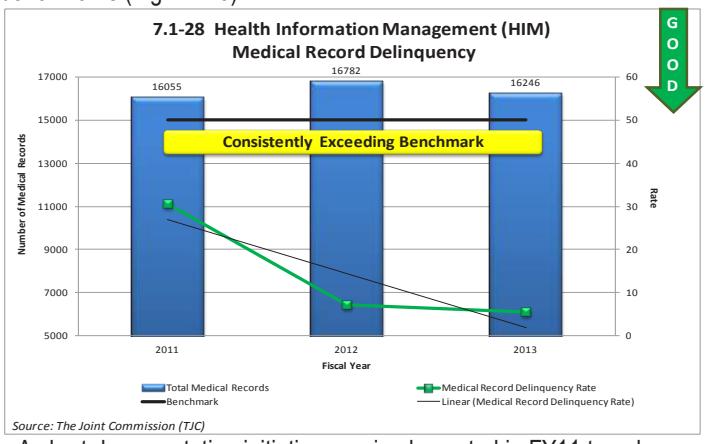
The 2008 and 2011 physician engagement surveys identify radiology TATs as an impediment to patient throughput and an opportunity to improve quality POC satisfaction. MSMH's partnership with Center Radiology allowed for leverage of the depth and availability of Center Radiology's specialty radiologists to improve TAT. This is an example of the correlation between healthcare services performance and POC satisfaction (Fig 7.1-26). MSMH was first in the State to utilize new telemedicine regulations to credential the radiologists.



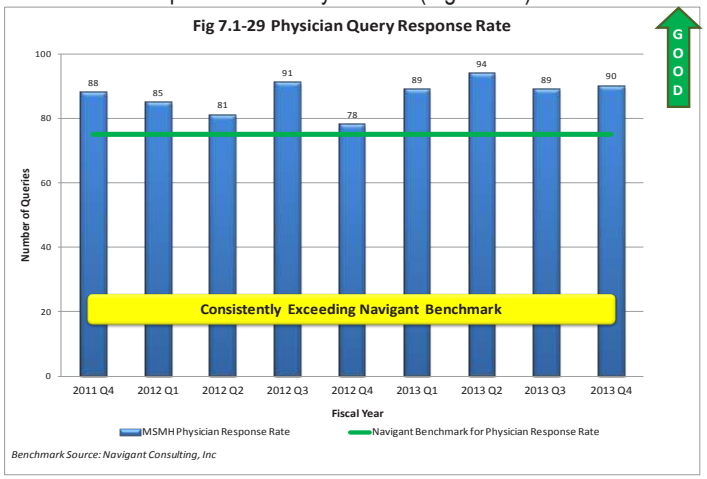
In 2008 MSMH became an early adopter of advanced EMR technology implementing a fully integrated Cerner solution. The safe, efficient and reliable care of patients depends on the availability and integrity of this system. Partnering with Cerner, MSMH maintains a highly reliable EMR (Fig 7.1-27).



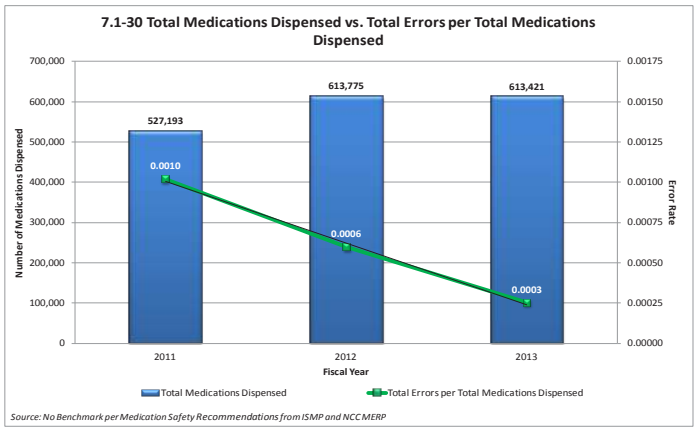
MS's long experience with EMR technology allowed the development of processes to facilitate medical records completion and has demonstrated a medical record delinquency rate well below TJC benchmarks (Fig 7.1-28).



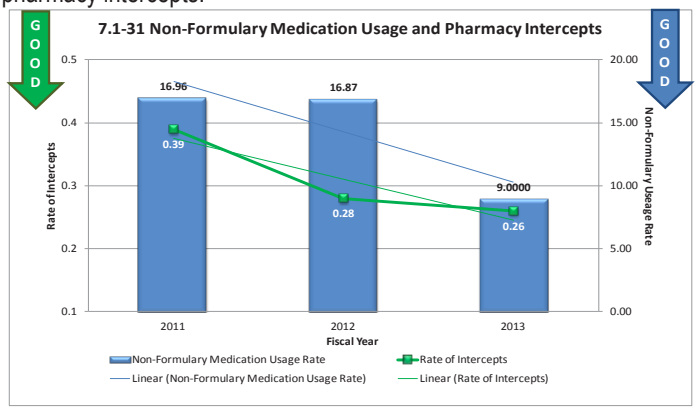
A chart documentation initiative was implemented in FY11 to enhance patient care and compliance by improving accuracy of MS entries. The EMR allowed a unique communication schema so MS could be queried and respond electronically to clarifications. This system produced higher physician response rates since they could review patient records and formulate responses from any location (Fig 7.1-29).



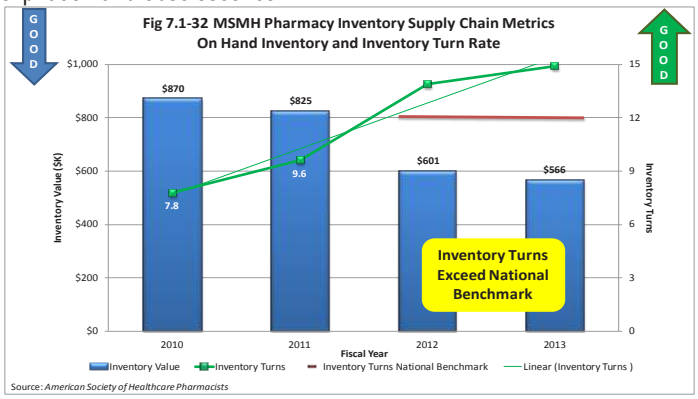
MSMH, utilizing FADE methodology, has greatly reduced the rate of medication errors despite increases in total medications dispensed (Fig 7.1-30). Per TJC guidelines, there is no benchmark for med errors.



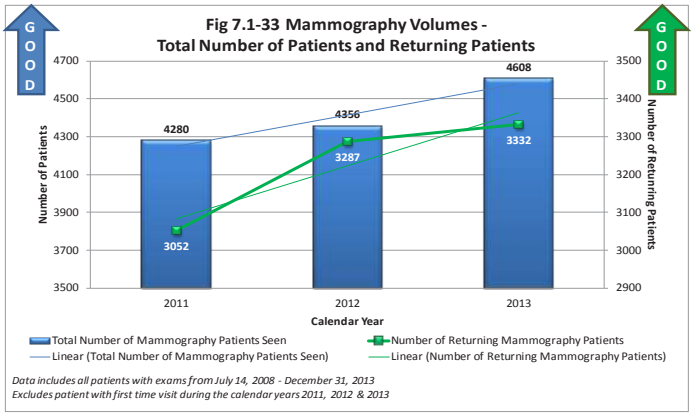
Progress in process effectiveness and efficiency is demonstrated in Fig 7.1-31 Non-Formulary Medication Usage and Pharmacy Intercepts. MSMH has decreased non formulary medication rate to below internal benchmarks which has also contributed to a reduction in the rate of pharmacy intercepts.



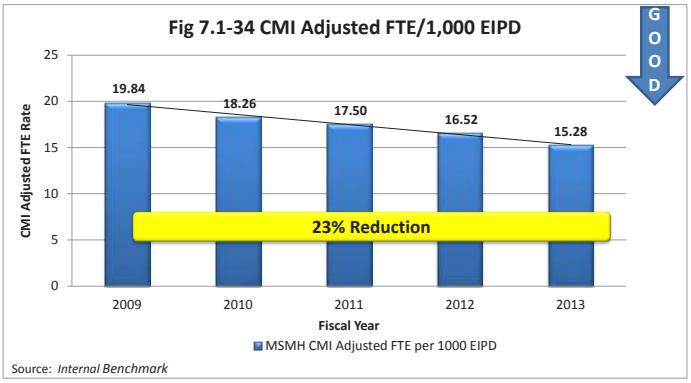
Further, MSMH's focus on productivity and cycle time is demonstrated in Fig 7.1-32. From 2010 – 2013, pharmacy inventory was decreased, resulting in $269,000 of reduced carrying cost. Additionally inventory turn rate increased thereby reducing waste from expiration and obsolescence.



MSMH identified the need for high quality breast imaging/intervention as a key service differentiator and patient satisfier. In May 2011, MSMH opened a new state-of-the-art breast imaging/interventional center and has recruited 3 fellowship trained breast radiologists/interventionalists. Fig 7.1-33 displays growing mammography volumes and patient loyalty.



Operational effectiveness and efficiency is also demonstrated in Fig 7.1-34. Despite an increased CMI, MSMH reduced FTE/1,000 EIPD. No external benchmark exists.



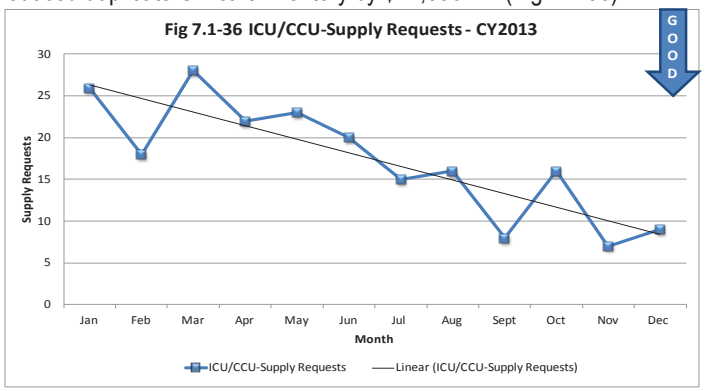
7.1b(2) Emergency Preparedness As the only hospital in SMC, MSMH is an integral part of the emergency response team. SLs/DLs coordinate with county, regional and state agencies and local utilities on matters relating to public health access, prevention, safety and healthcare quality. Formalized multidisciplinary emergency response processes are established with drills that incorporate training (Fig 7.1-35). SLs/DLs are trained in FEMA preparedness courses (Fig 7.3-30).

Fig 7.1-35 Emergency Preparedness

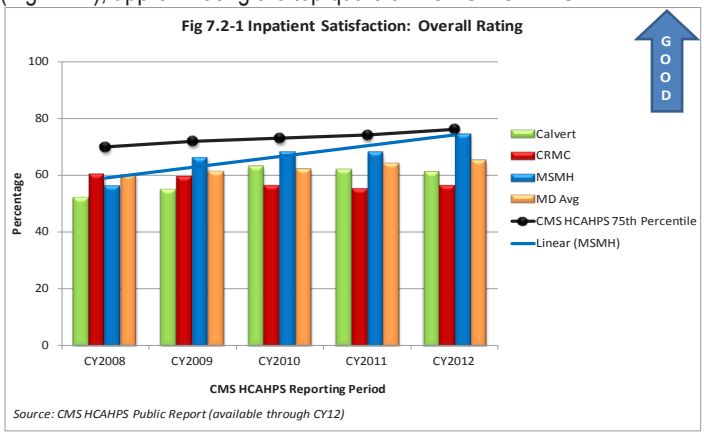
	CY11	CY12	CY13	Organizational Learning
Code Pink	4	4	4	Improved security documentation better coverage of isolated exits
Code Red	12	12	12	Reinforced RACE & PASS procedures
Code Tan	4	4	2	Hazmat cart & MSDS access for OP Pavilion; improved functioning of Hazmat carts
Hospital/Community (mass casualty drills)	0	2	2	Improved TAC Radio coordination
Real Events (Hurricanes, tornadoes, camps security situations)	2	2	1	Improved communication with out-buildings & off-site locations during weather disasters & security situations
State/Regional/System (pandemics, terrorism, radiation exposure, mass casualty drills)	3	1	2	Practiced decontamination procedures; identified need for additional HICS training
Total Drills/Events per CY	**37**	**37**	**35**	

7.1(c) Supply Chain Management The Materials Management LSS team achieved efficiencies in the number of storeroom supply requests and lines per request. The team achieved a 55% reduction in supply requests along with a 75% reduction in the number of lines per request. These efforts were achieved based on par level optimization and adding additional items to the ICC storeroom for management by

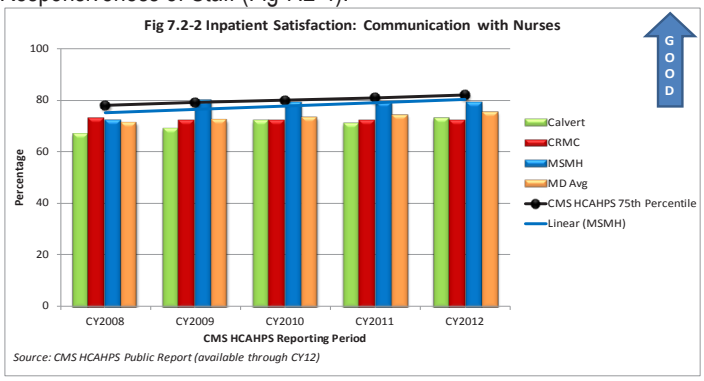
Materials Management associates. These efforts were achieved with input from unit leaders. These methods were also utilized to revise par levels/manage supplies in the Telemetry and Dialysis storerooms and reduced duplicate OR cart inventory by $12,856.74. (Fig 7.1-36)

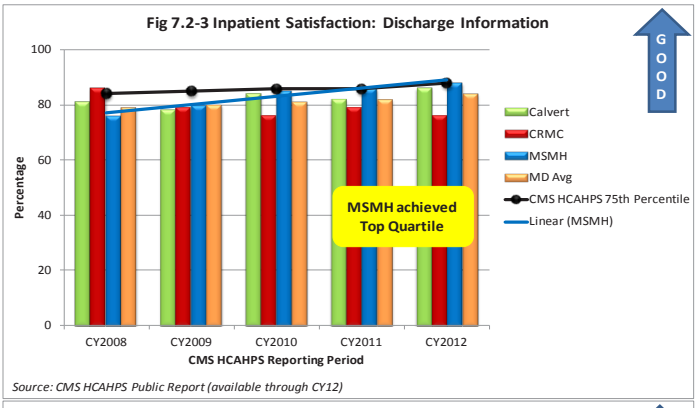


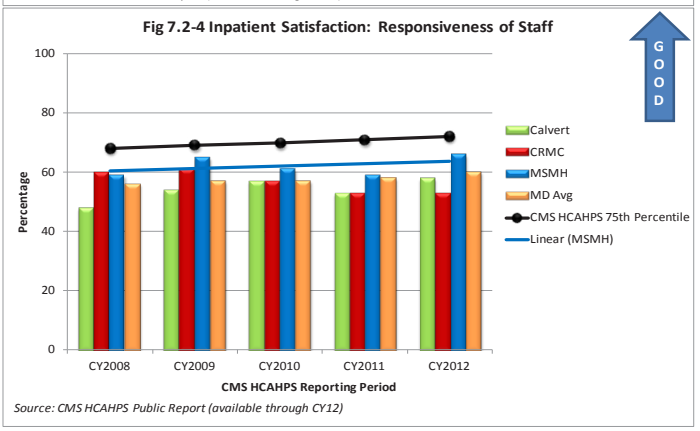
7.2 <u>Customer-Focused Outcomes</u>. 7.2a(1) Patient and Stakeholder Satisfaction The Overall rating for inpatient satisfaction is used to measure patient satisfaction. MSMH has consistently scored higher than the state average and highest in the Southern Maryland region (Fig 7.2-1), approximating the top quartile in CMS HCAHPS.



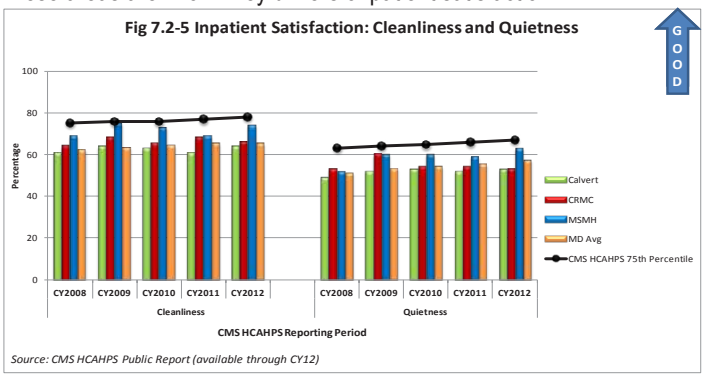
MSMH also performs higher in some of the specific CMS HCAHPS satisfaction questions relative to the state average and Southern Maryland region. These are in regard to Nurse Communications (Fig 7.2-2), Discharge Information (top quartile performance, Fig 7.2-3), and Responsiveness of Staff (Fig 7.2-4).



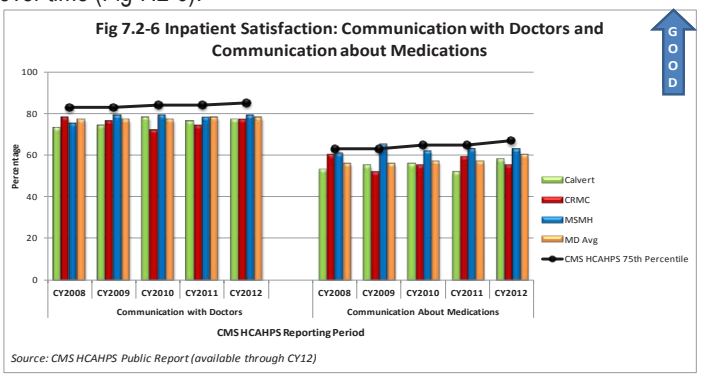




Cleanliness and quietness measurements also exceed the local competitor & state averages (Fig 7.2-5) and are nearing the top quartile. These areas are known key drivers of patient satisfaction.



The results for the remaining CMS HCAHPS questions also exceed the competitors and state averages and demonstrate increasing scores over time (Fig 7.2-6).



Tactics used to improve patient satisfaction include the area of Staff Responsiveness, e.g. associates perform hourly rounds on the patients. Fig 7.2-7 reveals hardwired compliance in performing hourly rounds leading to improved satisfaction (no comparative data is available).

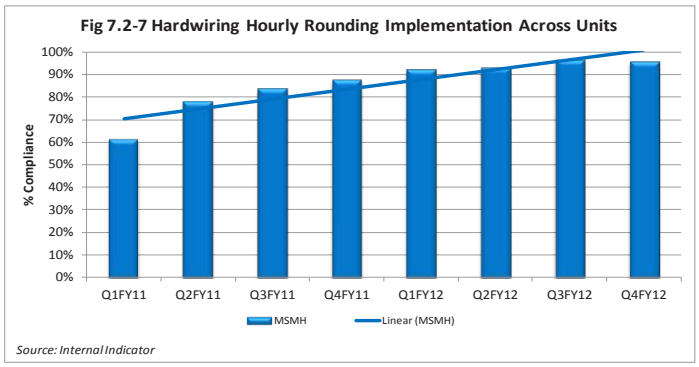
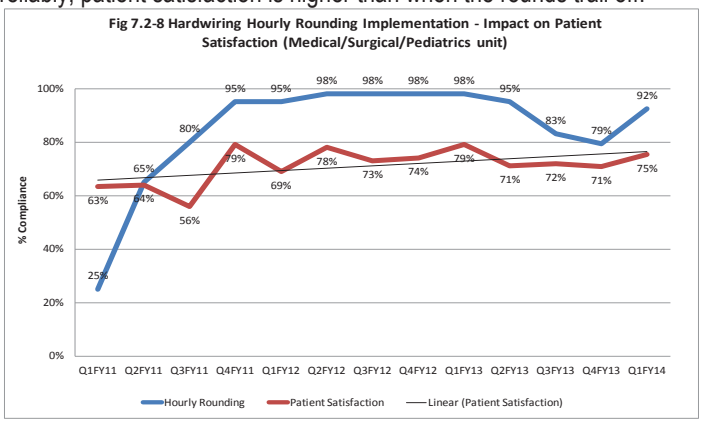


Fig 7.2-8 demonstrates that the increasing compliance with hourly rounds made a positive difference in patient satisfaction. Although true for all units, this figure is specific to MSP, the unit most challenged with achieving high patient satisfaction. Note that as the hourly rounds occur reliably, patient satisfaction is higher than when the rounds trail off.

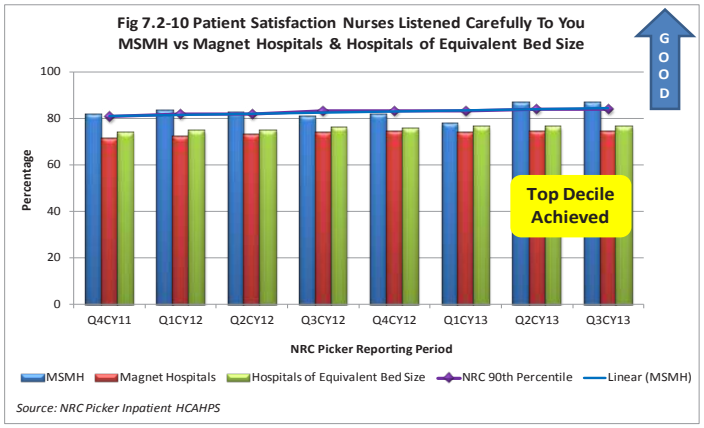


There have been many tactics utilized over the past several years to address the patient satisfaction continuum. Fig 7.2-9 indicates some of the more recent efforts.

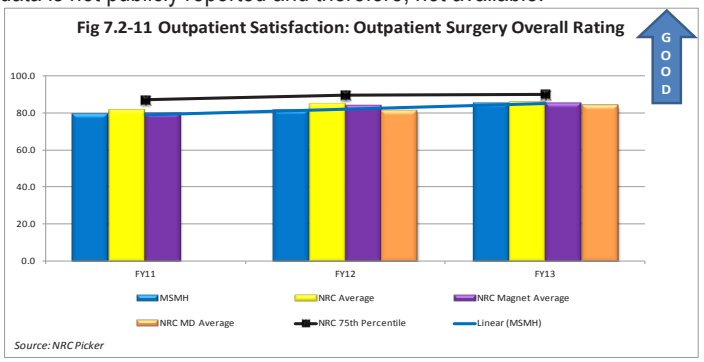
Fig 7.2-9 Going Beyond Satisfaction Measurements: Enhancing Patient Satisfaction

	CY2011	CY2012	CY2013
Consistent whiteboard use	√	√	√
PEC meetings	√	√	√
Hourly rounding	√	√	√
No Pass Zone		√	√
Pathway to Patient for associates		√	√
SPIRIT Inside training initiated		√	√
Bedside report			√
MedStar Way Dashboard			√
Begin PFPF			√
Add Patient Preference Consideration			√

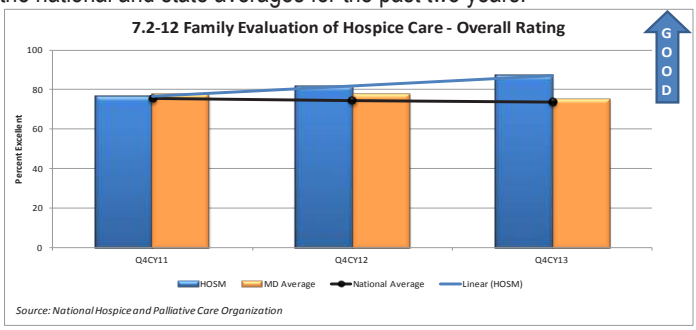
MSMH patient satisfaction is also benchmarked against Magnet Hospitals and hospitals of similar size in the NRC database. Magnet Hospitals are those where the nursing WF provides exceptionally high standards of patient care and are noted for excellent communication skills. Fig 7.2-10 demonstrates MSMH overall satisfaction wherein MSMH exceeds the average Magnet and similarly-sized hospitals.



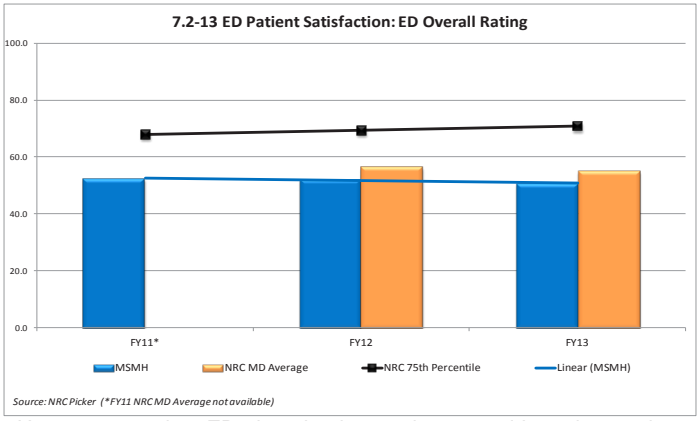
In the OP setting, the Ambulatory Surgery Center is the largest segment and has performed well against benchmarks to achieve high overall patient satisfaction. Fig 7.2-11 demonstrates the ASC patient satisfaction measured against the NRC average, NRC Magnet Hospitals average and NRC state average. Competitors' comparative data is not publicly reported and therefore, not available.



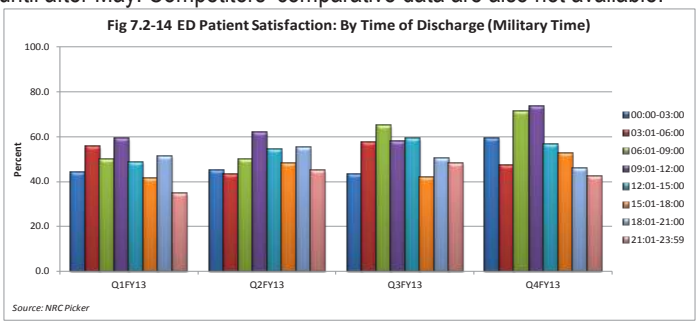
Another outpatient segment is the Hospice population. This population is also increasingly satisfied with the care they receive as seen in the overall rating in Fig 7.2-12, exceeding 90% and greater than the national and state averages for the past two years.



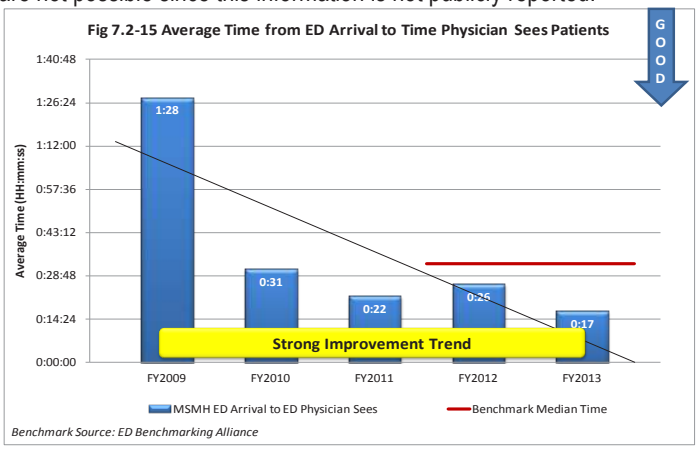
The ED is the 3rd segment and provides a significant level of primary care for the county. With a county population of >108,000, the number of ED visits for CY13 was >56,000. This high utilization of the ED, in combination with high familiarity of the ED, has contributed to stagnant satisfaction with the ED. Satisfaction of 52-56% reflects the ED satisfaction range. This is an area of focus in FY14 (Fig 7.2-13).



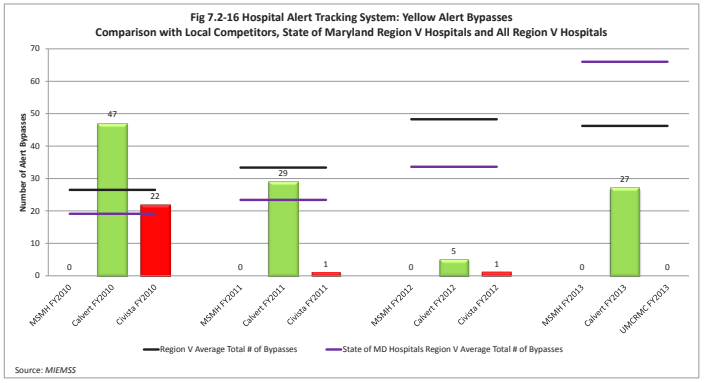
Upon segmenting ED data by hours, it was evident that patients arriving between 12 noon and midnight were the least satisfied, the same time period patients were prone to spend more time waiting to be seen and total ED TAT was its worst, exceeding 3 hours (Fig 7.2-14). In February 2014, the process for ED arrival changed to more timely accommodate the patients. While initial results are indicating a wait time reduction of almost one hour, satisfaction results are not available until after May. Competitors' comparative data are also not available.



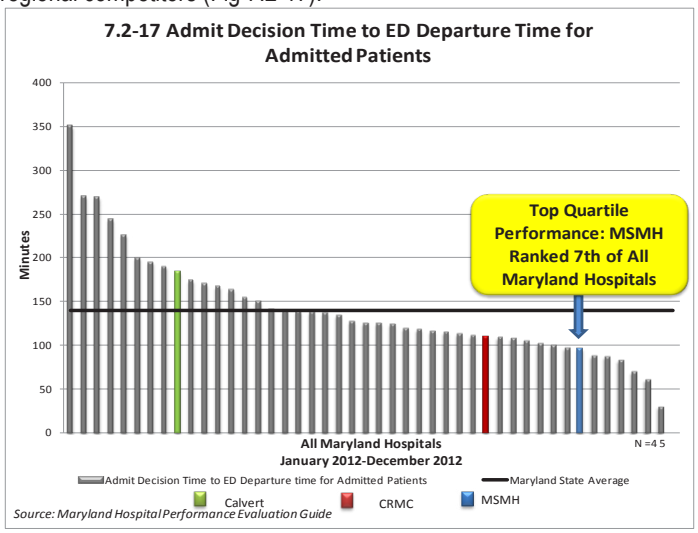
Nonetheless, other efforts are taken to improve satisfaction for ED patients. One important measure for ED is the amount of time it takes from patient presentation to the ED until seen by the doctor, referred to as Door-to-Doc time (Fig 7.2-15). The ED significantly improved this time and is better than the state average. Comparisons with other EDs are not possible since this information is not publicly reported.



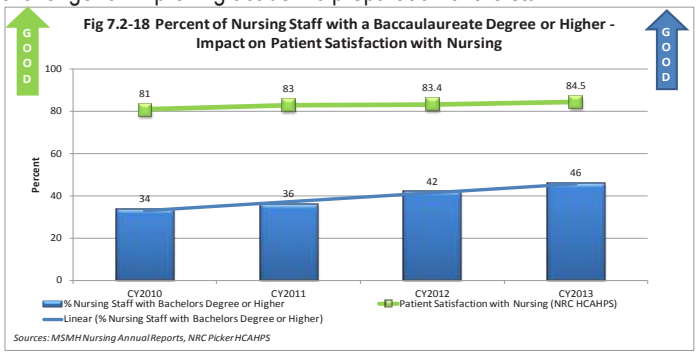
Another ED satisfaction measure is the number of hours spent on ED by-pass. When an ED is on by-pass, patients must be sent to other EDs. There are 2 reasons for ED bypass. A yellow bypass occurs when ED volumes are too high to handle patients timely and a red bypass is initiated when the hospital has no unoccupied IP monitored beds. These are dissatisfiers since it is inconvenient for families to visit hospitals farther away. As seen in Fig 7.2-16, MSMH has not been on yellow bypass for >4 years. As part of MIEMSS Region V, the comparative data demonstrates that MSMH is the leader in the region in accomplishing this for many years. The results for red bypass are similar and data is available on site.



Further improvement in ED patient satisfaction can be obtained with fast throughput from the ED to an IP bed. With ownership from the IP units, throughput has improved, exceeding national benchmarks and regional competitors (Fig 7.2-17).



Overall, MSMH has witnessed greater patient satisfaction with the improving academic preparation of the nursing staff (Fig 7.2-18). This improvement has been a secondary gain to addressing the strategic challenge for improving academic preparation of the staff.



There are other areas in which MSMH achieves other customer satisfaction. MSMH performs well over time with volunteer feedback relative to having the resources necessary to carry out their work (Fig 7.2-19). In CY2013 the evaluation tool was changed and high performance continued but is not reflected in the following figure. There are no external benchmarks.

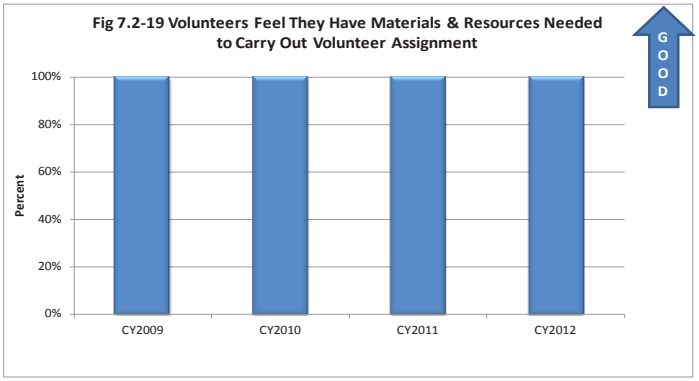
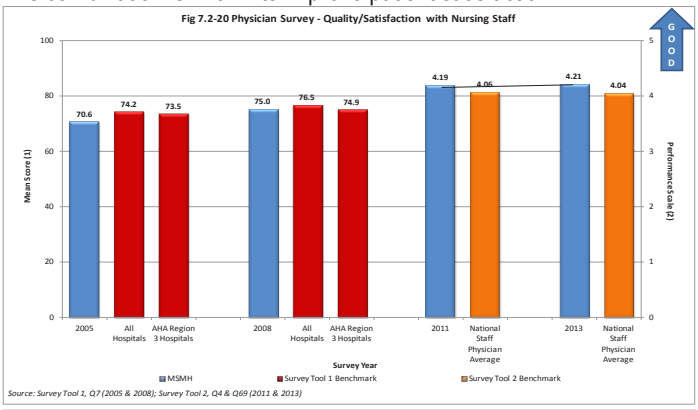
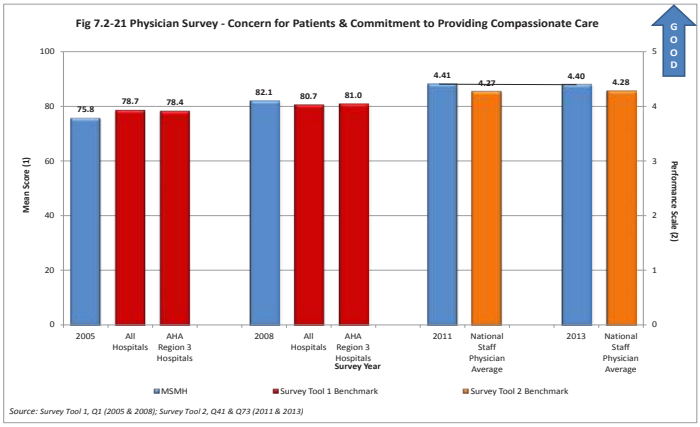


Fig 7.2-20 demonstrates increasing physician satisfaction with nursing staff which exceeds the survey tool benchmarks. Fig 7.2-21 demonstrates sustained physician satisfaction with the compassionate care and concern given to the patients and also exceeds benchmarks. This combination is known to improve patient satisfaction.



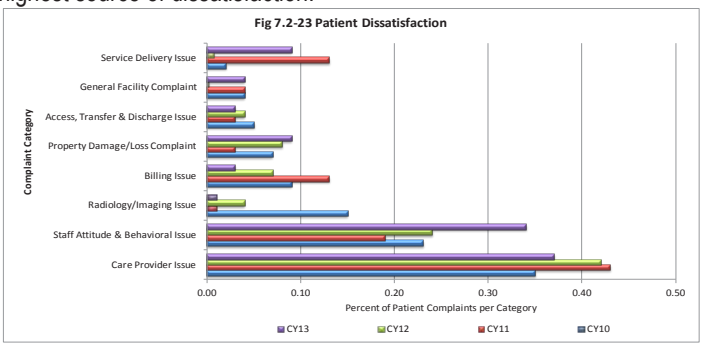


Similarly, satisfaction and courtesy are measured by the MSMH departments for each other. MSMH believes that if internal customer satisfying efforts are provided, then these efforts will be extended to the POCs. Fig 7.2-22 demonstrates a sampling of departments that received feedback and took corrective actions to improve, e.g. appropriate telephone etiquette.

Fig 7.2-22 Interdepartmental Survey

Department	Composite Score (% Always & Usually)			
	Mar 2012 - Jun 2012	Jul 2012 - Oct 2012	Nov 2012 - Feb 2013	Mar 2012 - Jun 2013
Cardiology & Neurology	71.43%	77.97%	42.86%	94.87%
Hospice	82.61%	94.29%	97.14%	100.00%
Human Resources & Occupational Health	74.83%	84.11%	84.75%	99.14%
Information Technology	78.23%	85.71%	86.55%	91.35%
Pharmacy	89.52%	84.82%	94.64%	97.14%
Rehab & Cardio Pulmonary Rehab	83.93%	87.30%	100.00%	100.00%
KEY: Department Composite Goals	≥ 88% - Green; > 75% to ≤88% - Yellow; ≤ 75%			

Dissatisfaction measures lack comparative data. SLs/DLs segment data into several categories identifying opportunities to improve. In 2010, the LS was changed and associates struggled to accurately report dissatisfying events. The reporting system was made more user-friendly and associates were strongly encouraged to increase reporting. Due to increased reporting, data shows a rise in patient dissatisfaction (Fig 7.2-23), while at the same time overall IP satisfaction is improving (Fig 7.2-1). By 2013, staff was more familiar with the system and it is believed that results now more accurately reflect dissatisfaction in the hospital. It can be noted that issues pertaining to care providers are the highest source of dissatisfaction.

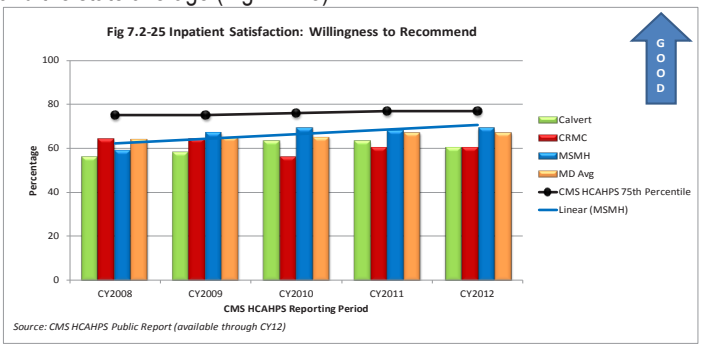


Complaints received in MSMH largely remain below or close to strict internal benchmarks (Fig 7.2-24). There is great performance in the OP segment while opportunities exist for the IP segment, however, less than 1% (i.e., <1 complaint per day) of inpatients are dissatisfied with their care. Complaints are handled as described in Chapter 3. Comparative data are not available.

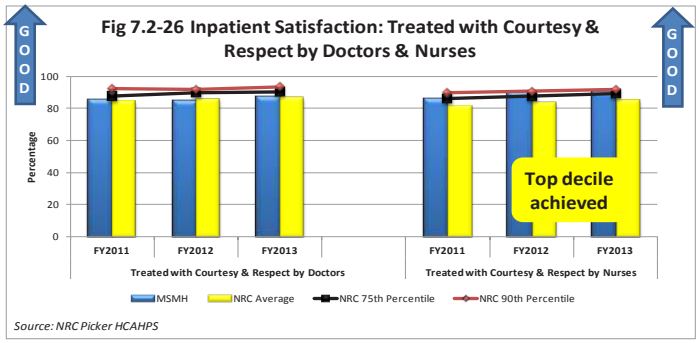
Fig 7.2-24 Complaints

Complaints	FY2013				FY2014	Benchmark
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 1	
Inpatient	0.59	0.98	0.91	0.79	0.65	< 0.77
Outpatient	0.03	0.03	0.05	0.01	0.05	< 0.10
ED Patient	0.26	0.18	0.18	0.15	0.24	< 0.21

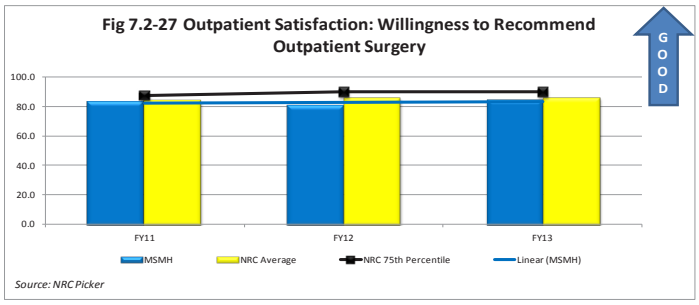
7.2a(2) Patient and Stakeholder Engagement Patients and stakeholders are demonstrably engaged with MSMH. Willingness to Recommend is a measure of engagement and is compared against other Southern Maryland hospitals and the state average. This measure is challenging for a sole rural hospital because some community members believe a really sick patient should go to a larger tertiary center. As a result, progress with this CMS HCAHPS question is slow, but MSMH exceeds the scores of other Southern Maryland hospitals and the state average (Fig 7.2-25).



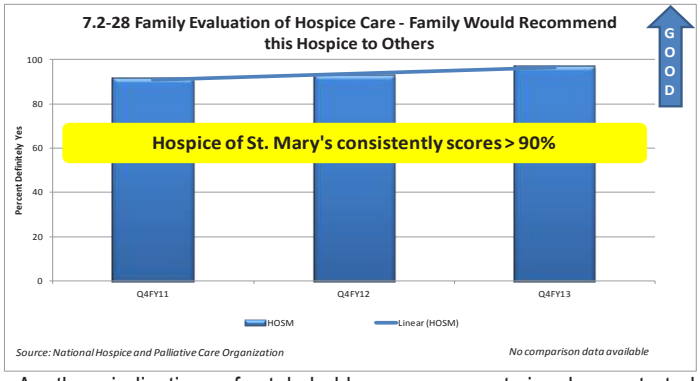
Areas in which MSMH demonstrates increasing success with engaging POCs is through the courtesy and respect shown to POCs by the physicians and nurses. MSMH performs at the top decile/quartile levels as shown in Fig 7.2-26. Here a second source of patient engagement data is used, NRC, as it is more current, though competitor data is only available through CMS HCAHPS.



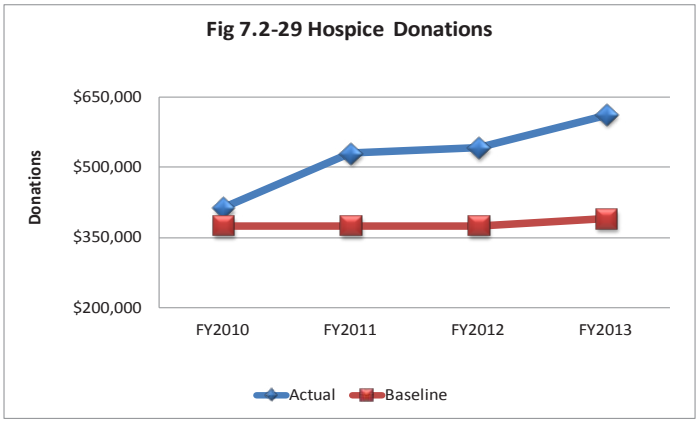
The ASC (Fig 7.2-27) are not measured by the CMS HCAHPS survey. Nonetheless, NRC ratings for this segment are at or near benchmark. NRC provides their own benchmark of other hospitals using the NRC tool but there is no comparable Southern Maryland data available.



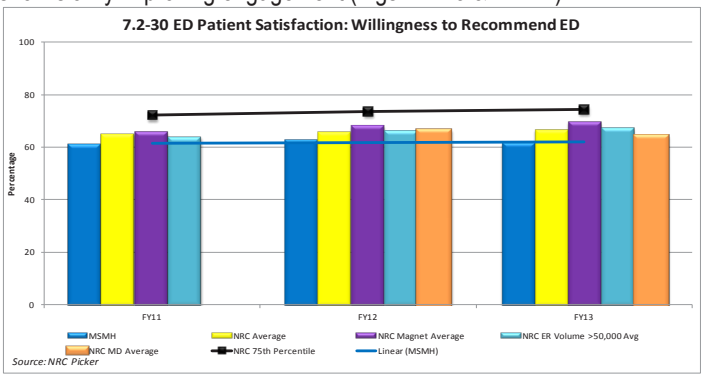
The Hospice population uses "Family would recommend this Hospice to others" as the measurement of engagement for Hospice families and this exceeds 90% ratings consistently (Fig 7.2-28). No benchmarks are available.



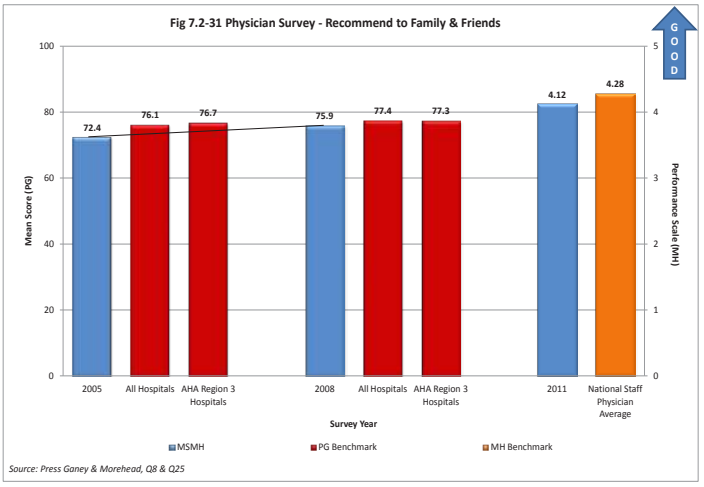
Another indication of stakeholder engagement is demonstrated through the construction of the Hospice House. MSMH paid $1 for the purchase of 23 acres and a 6-bedroom, 2-story house was built and outfitted with donations from the community. Donations continue to support the operations of the house (Fig 7.2-29) far surpassing the established goal of $375,000 per year.

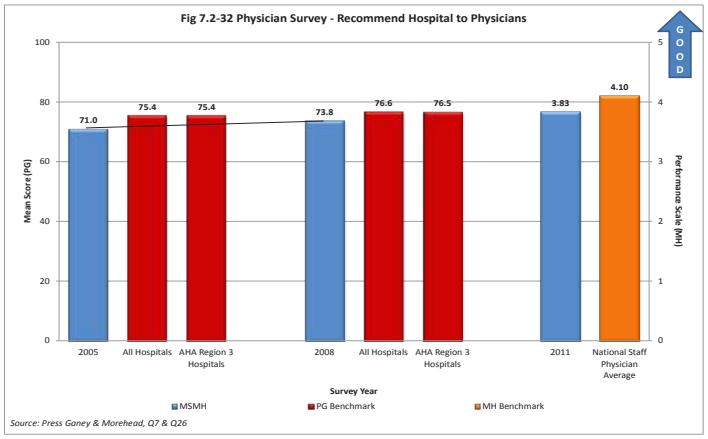


As with the ASC, the ED (Fig 7.2-30) is not measured by CMS HCAHPS. MSMH ratings cannot be compared to competitors & are below benchmark with the willingness to recommend question. Regardless, other questions indicate engagement where the results show slowly improving engagement (Figs 7.2-15 & 7.2-17).

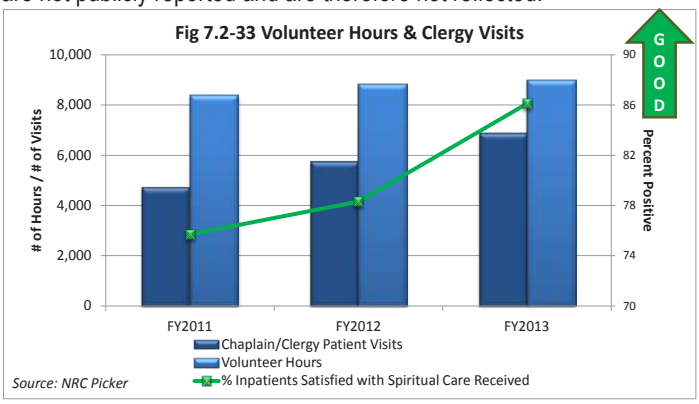


Other areas in which stakeholder engagement is measured include improving physician engagement as reflected by recommendation of the hospital to Family and Friends (Fig 7.2-31) as well as Colleagues (Fig 7.2-32). MSMH scores at or near benchmarks/comparisons in these engagement areas and is improving over time. Note: The full 2013 physician survey results are not available as of this writing. Specific questions about services are available however engagement and alignment questions, dimensions & segmented departmental results are not available from Morehead due to a survey process error. A second survey will be conducted later this fiscal year. The prior 2011 survey results are used here and in subsequent graphs.

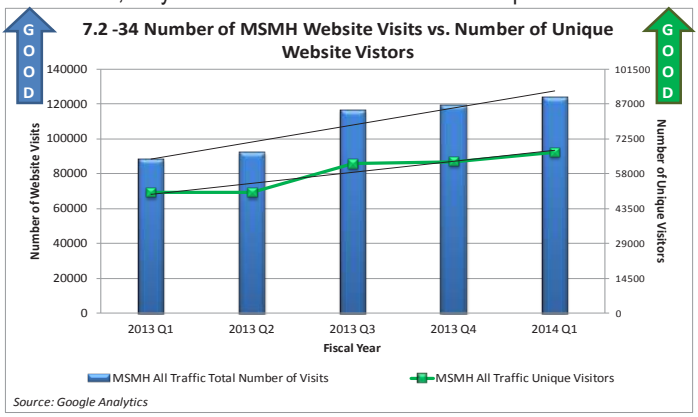


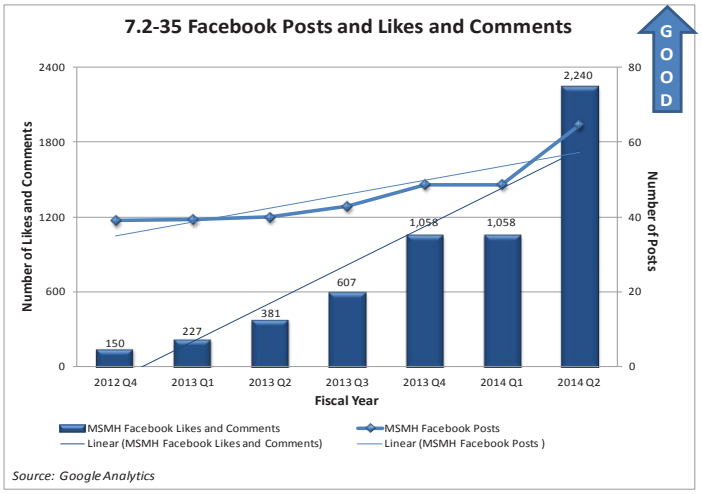


Clergy and volunteers are community members and donate many hours helping POCs and staff (Fig 7.2-33) demonstrating their engagement. With the patient satisfaction question specific to satisfaction with clergy, there is noted satisfaction improvement with the increased hours of clergy support. Benchmark and comparative data are not publicly reported and are therefore not reflected.



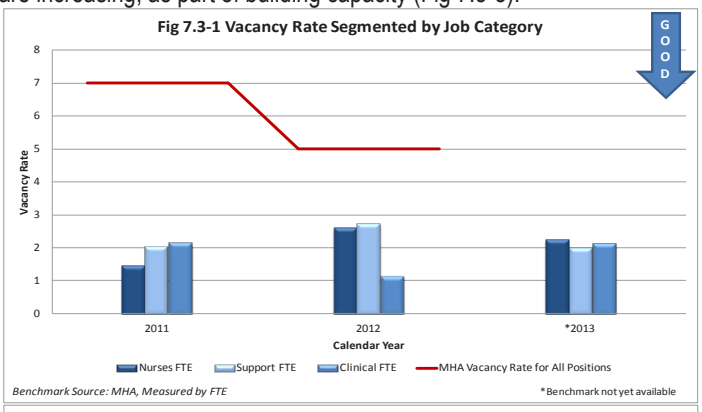
Social media and accessing the MSMH website are indicators of community engagement with the hospital. As noted in Fig 7.2-34, the number of website visits has increased over the past five quarters in addition to the number of unique visitors. Facebook posts have a similar trend with increasing likes and posts over the past seven quarters (Fig 7.2-35) indicating growing engagement from the POCs. If complaints are received, they are entered into the LS for follow-up.

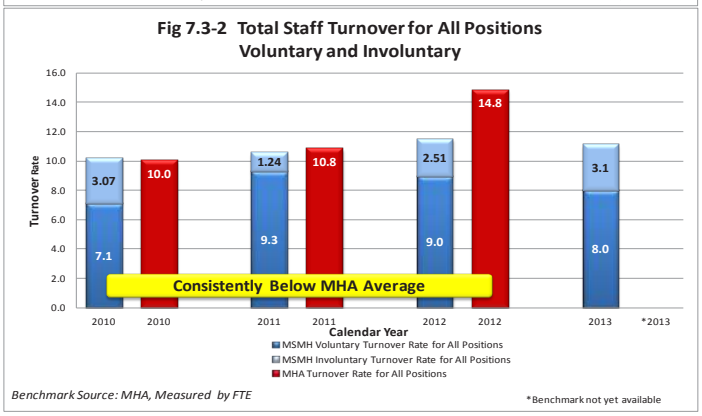


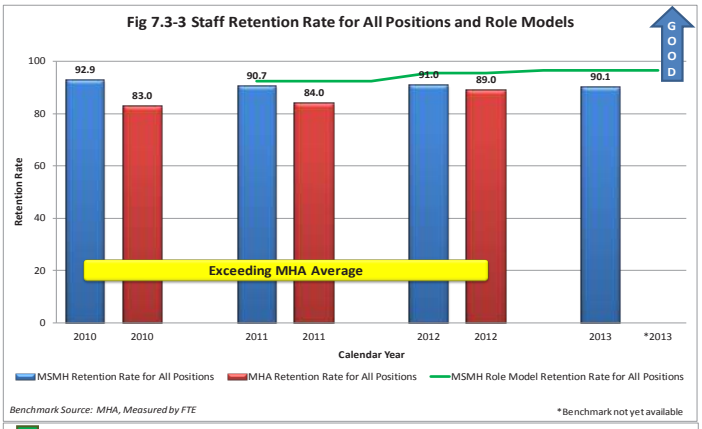


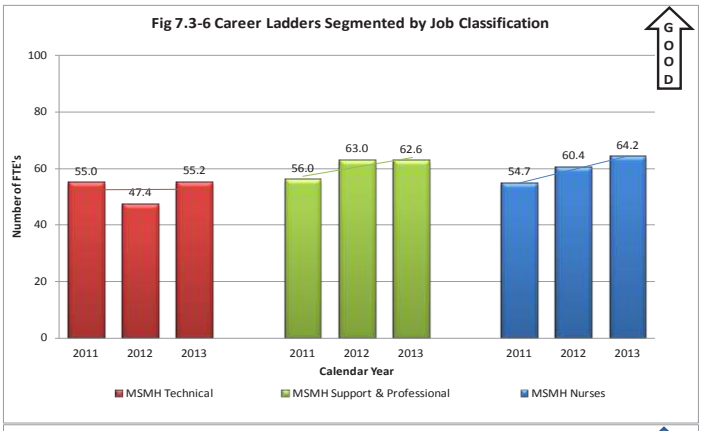
MSMH is conscious of its responsibility to the community. One example includes: when constructing the Pavilion, the drainage field was purposefully designed to improve storm water drainage in the area because of flooding of the town's main road after major storms. The efforts with the drainage field alleviated the problem. MSMH upholds its fiduciary responsibility and in building relationships with the community.

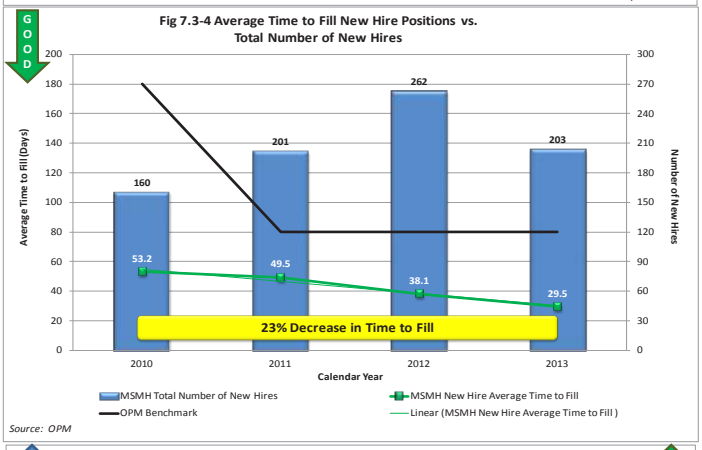
7.3.a(1)Workforce Capability and Capacity SLs/DLs ensure sufficient workforce capacity and capability to exceed customer expectations for quality, safety and customer service. Capacity is measured by vacancy rates, turnover & retention rates and position fill time. Vacancy rates (Fig 7.3-1) are lower than benchmark year over year even though nursing positions were added in 2013, as are Turnover rates (Fig 7.3-2). Retention exceeds MHA benchmark each year and the SL/DL focus on retaining role models is resulting in an upward trend (Fig 7.3-3). While MSMH is growing and there were more positions to hire in each year, the time to fill (Fig 7.3-4) is decreasing annually. Volunteer hours are increasing, as part of building capacity (Fig 7.3-5).

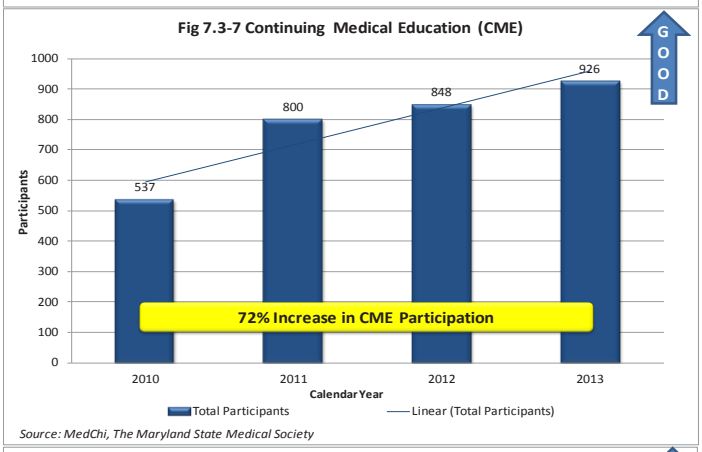


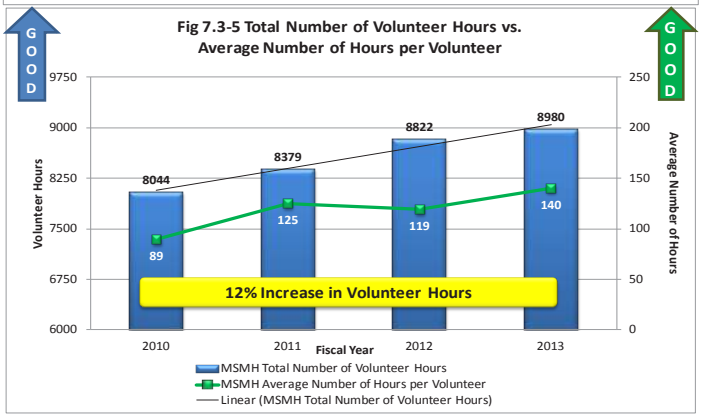


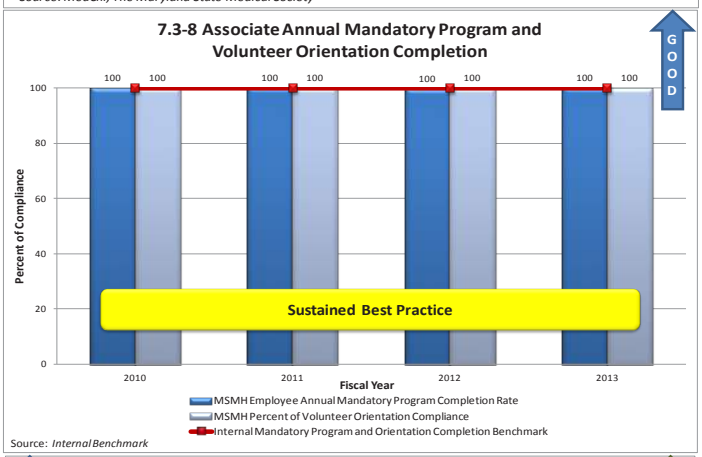




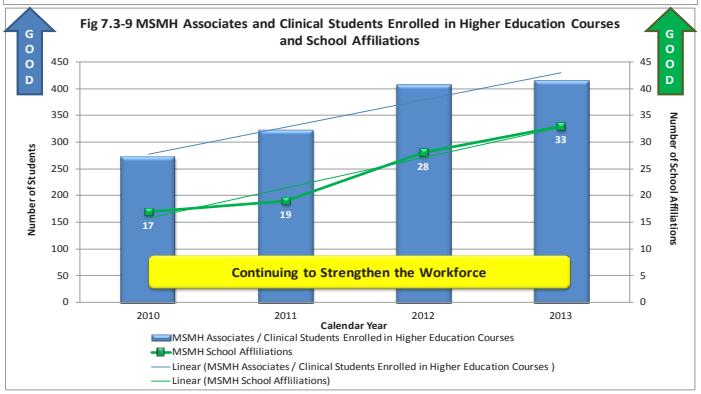


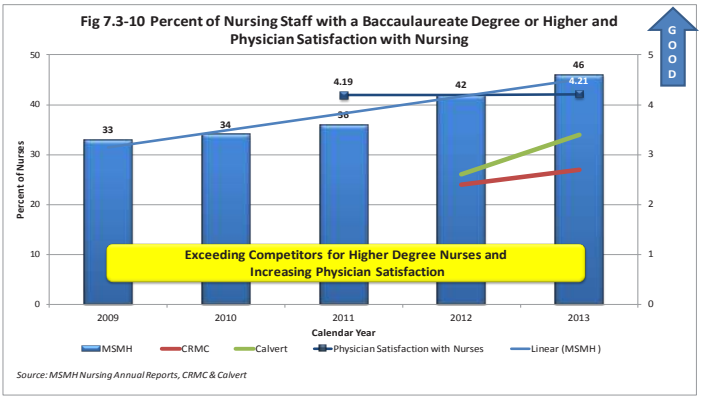




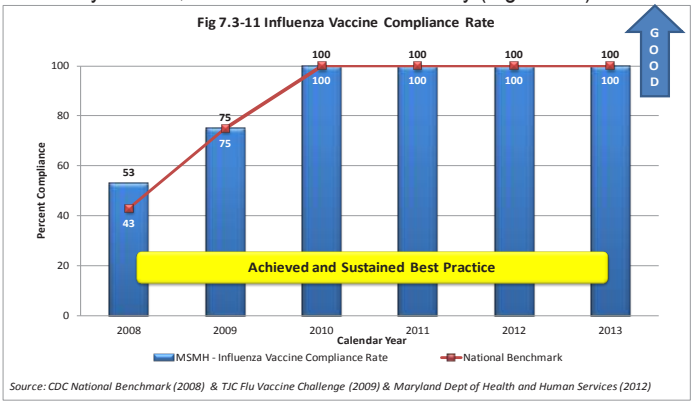


Increasing numbers of engaged clinical, technical and support associates are participating in career ladder opportunities (Fig 7.3-6) to improve capability. CME participation (Fig 7.3-7) increases as well. Participation in capability enhancing programs is increasing for all staff segments, demonstrating SLs commitment to create a learning organization by dedicating resources for MS, associates and volunteers (Fig 7.3-8). To combat the strategic challenge of lack of academic qualifications, the WF is encouraged to use external resources to enhance capability. More students are enrolling at a greater number of schools affiliated with MSMH (Fig 7.3-9). Fig 7.3-10 illustrates the associates' increasing educational levels with more baccalaureate and advanced degrees. MSMH outperforms competitor hospitals in the region for the number of RNs with BSN or higher degrees.

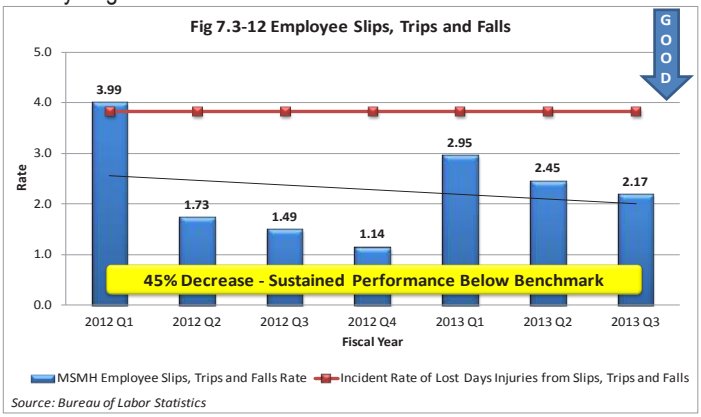


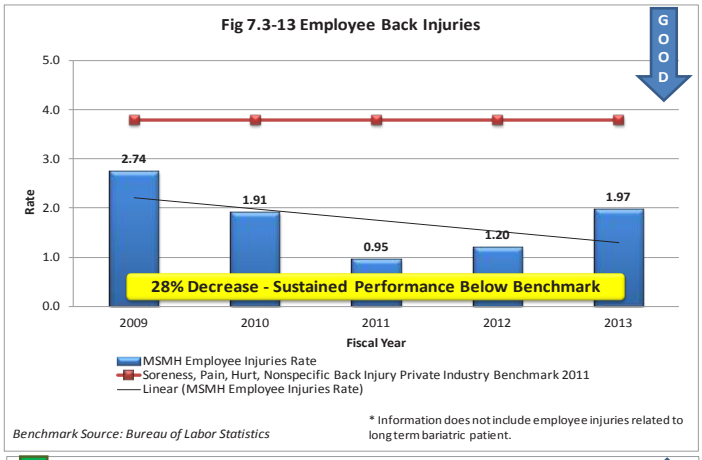


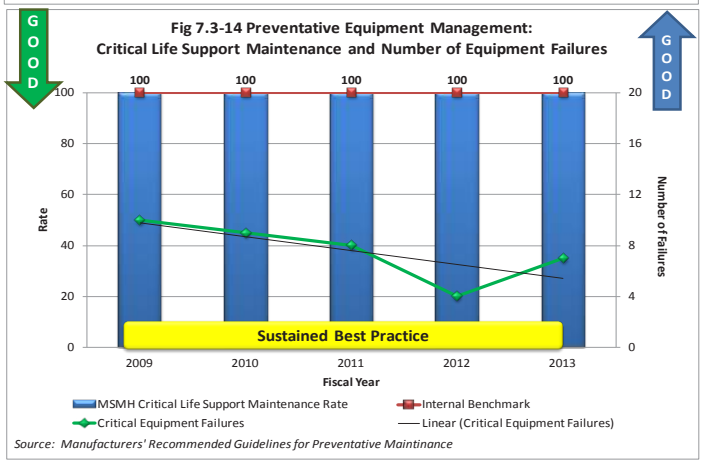
7.3a(2) Workforce Climate SLs use a data driven approach to manage the health and safety of the WF. Metrics illustrate results in WF health, safety, security, services and benefits, starting with associate health, wherein MSMH exceeded CDC benchmarks for the last 5 years for influenza vaccination. SLs used EBPs, making influenza vaccination mandatory in 2010, ahead of most of the industry (Fig 7.3-11).



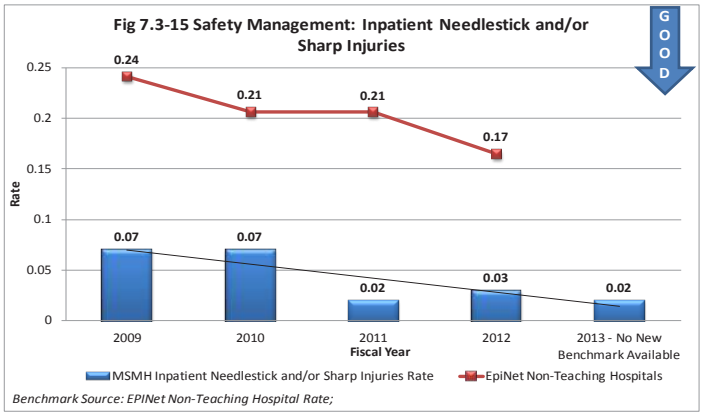
MSMH's better than benchmark performance in employee slips, trips, falls (Fig 7.3-12) and back injuries, (Fig 7.3-13) contributed to workman's compensation insurance rebates for the past 4 years. Injury management included associate education and process changes such as strategic placement of lift equipment for ease of use. SLs/DLs ensure proper maintenance of the equipment associates use (Fig 7.3-14) so associates can provide services safely and efficiently. These processes led to outperforming Bureau of Labor benchmarks, since industry targets do not exist.



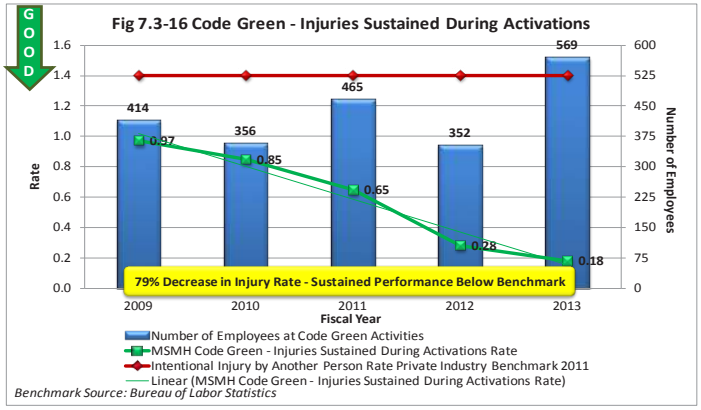




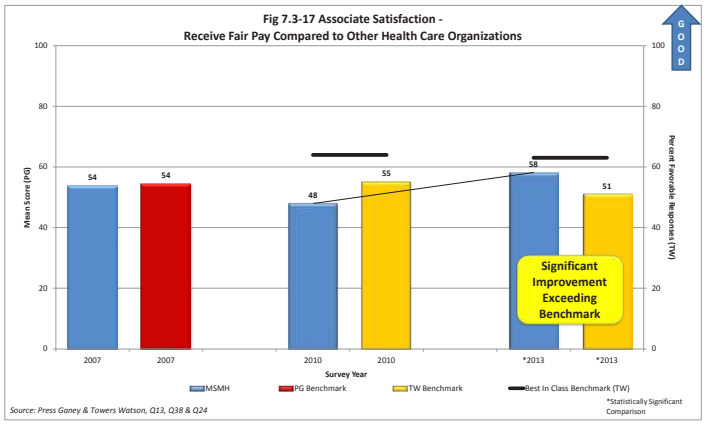
Sharps and needle stick injuries improved year over year (Fig 7.3-15) and were below industry benchmarks because the VAT implemented the use of innovative technology, recommending ever improving safety devices to protect associates.

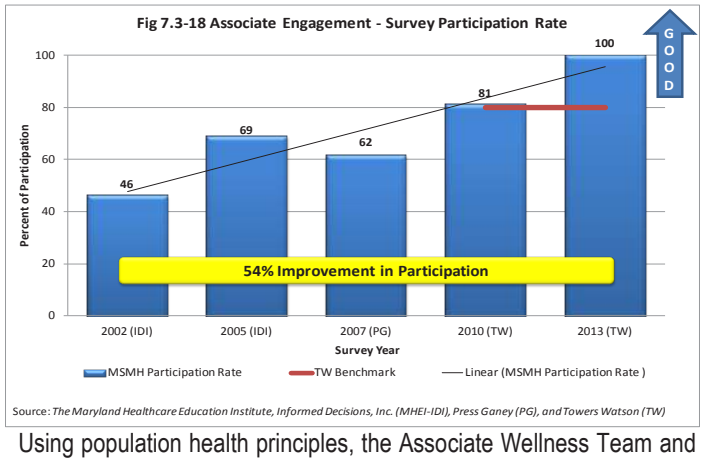


SLs/DLs consider the physical environment to promote associate safety and security. The security program includes crisis intervention training for security and non-clinical associates to reduce staff injuries inflicted by aggressive patients (Fig 7.3-16). Additionally each code green has a debriefing post episode to critique the process.



After the merger, MSMH switched to the TW associate satisfaction/engagement survey in 2010. While results were meeting/exceeding the PG benchmarks for pay and benefits using that tool, the data declined in 2010 because the new survey had unfamiliar terminology. Once MSMH moved to MSH's program and SLs/DLs educated staff, associate satisfaction with pay and benefits outperformed the TW healthcare benchmarks and exceeded the World Class benchmark for perception of fair wages (Fig 7.3-17). Increasing engagement is demonstrated by increasing associate participation (Fig 7.3-18).



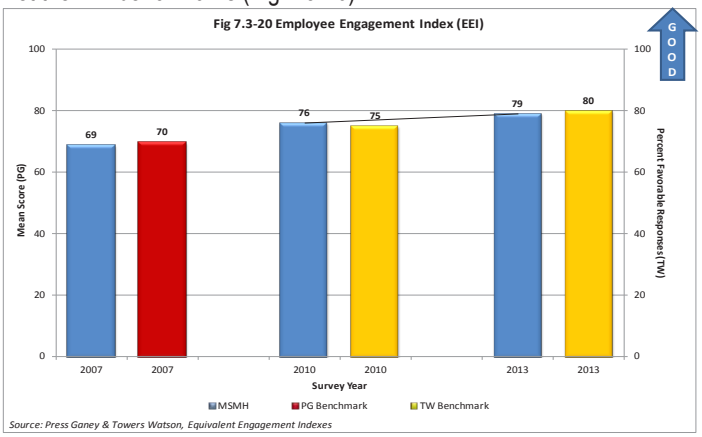


Using population health principles, the Associate Wellness Team and OH provide programs to promote health and prevent progression of chronic illness year-round. Each year activities are added and more associates participate in the activities (Fig 7-3-19).

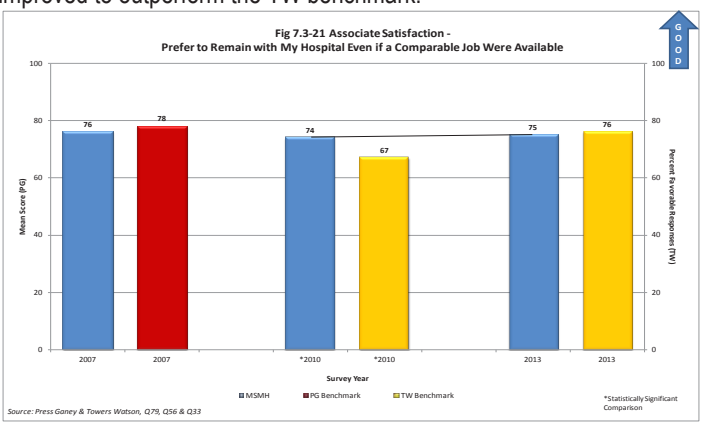
Fig 7.3-19 Occupational Health Wellness Initiatives & Activities

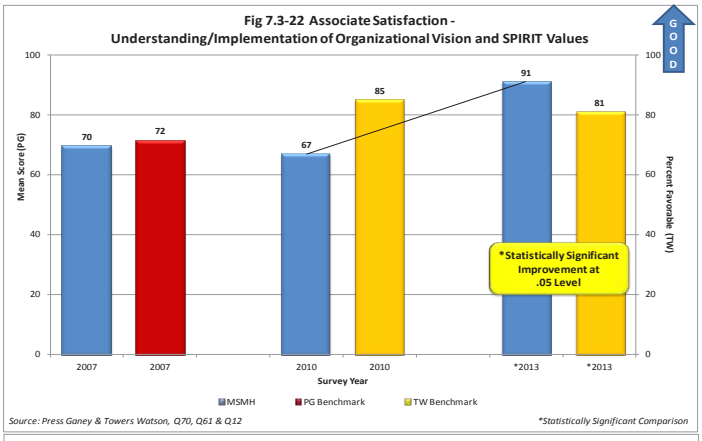
	2010	2011	2012	2013
Total Occupational Health Interactions	4,713	4,765	5,412	8,406
Nurse Practitioner Visits	2,162	2,011	1,796	2,319
Employment Physicals	185	211	276	293
PPDs	1,592	1,595	1,564	1,720
Respiratory Fit Testing	803	1,016	825	903
Wellness Fair Participants	115	104	147	591
Smoking Cessation	24	23	31	53
Vaccine Program	53	86	153	206
Exercise Program (Facility Gym)/Walks	14	27	49	27
New in 2013: Wellness Walking Program, Blood Pressure Screening, Yoga, Zumba, Self Defense, Biometric Screenings, Let's Get Active Challenge				646
Total Participants	**9,661**	**9,838**	**10,253**	**15,164**
Percent Increase in Participation		**2%**	**4%**	**32%**
Percent of New Wellness Programs Developed				**41%**

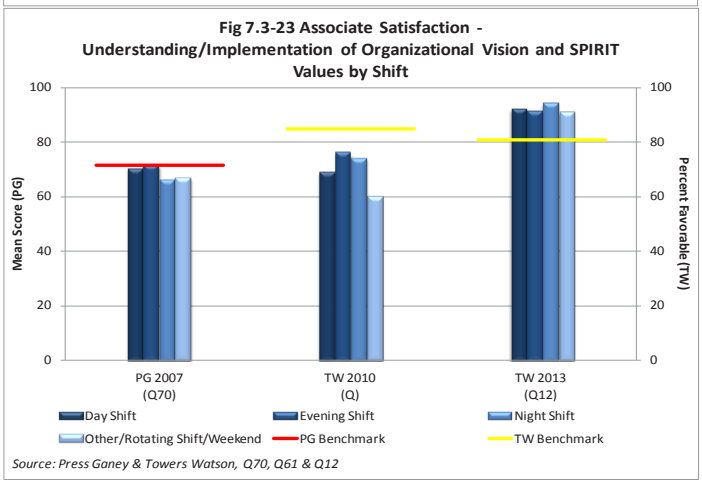
7.3a(3) Workforce Engagement The EEI is used to measure improvements. Results from the 2010 and 2013 surveys statistically met the TW benchmarks (Fig 7.3-20).



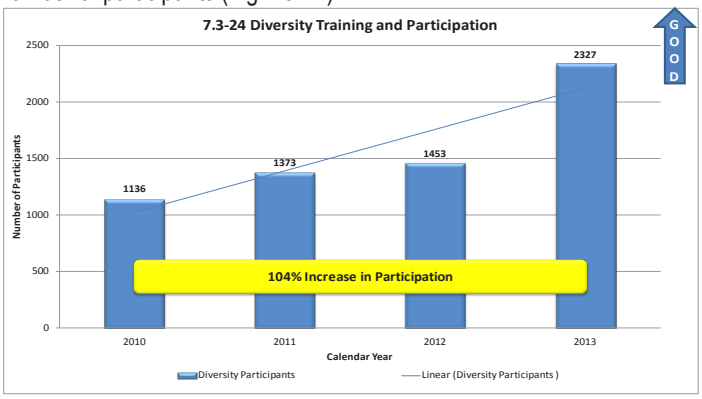
WF deployment to achieve the work of MSMH is evidenced by meeting and/or exceeding 2010 and 2013 benchmarks for the engagement questions, "I would prefer to remain at MSMH even if a comparable job was available at another hospital" (Fig 7.3-21) and "I have a good understanding of MSMH's vision and SPIRIT values" (Fig 7.3-22). Data segmentation, routinely performed using multiple subsets, revealed that in 2010, associates on the evening and night shifts had the least connection with MSMH's MVV (Fig 7.3-23). Understanding that these WF segments had less daily interaction with SLs/DLs, SLs followed AP's to improve communication with the entire WF, with attention to evening and night shift staff to ensure they became increasingly connected to MSMH's MVV. AP steps included: increased SL/DL rounding during evening, night and weekend shifts, adjusting evening and night shift Town Hall meeting hours, small group huddles and the use of standardized tool kits, designed to communicate using multiple modalities. In 2013, all WF segments' engagement scores improved to outperform the TW benchmark.



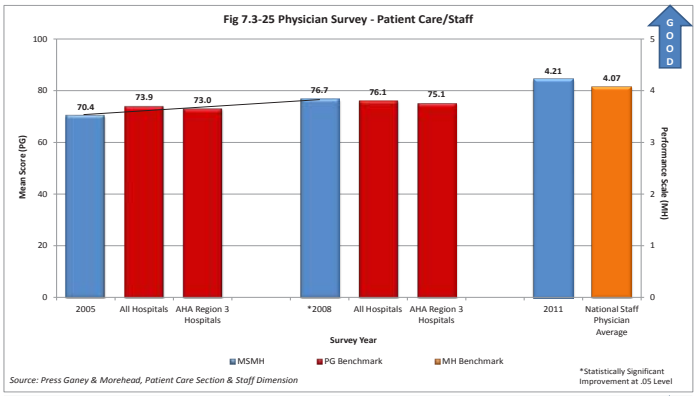


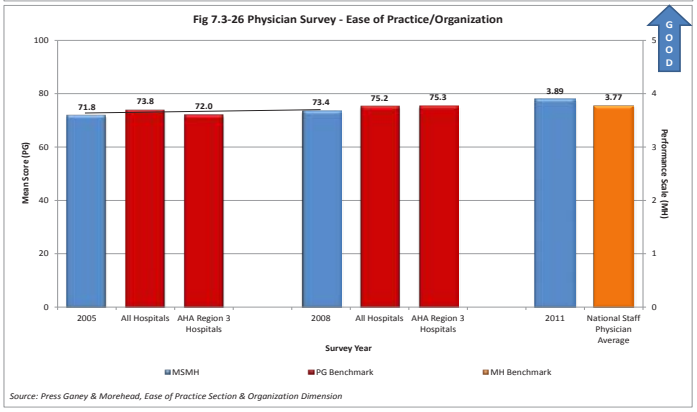


The Diversity Committee encourages associates to value each other and the patients served. Metrics below demonstrate an increasing number of participants (Fig 7.3-24).

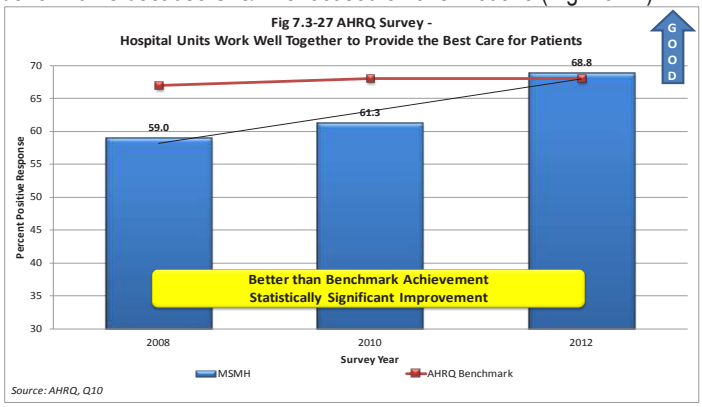


MS satisfaction and engagement is key to optimal patient care, treatment and service. During the last 2 MS surveys, MS exceeded benchmark for satisfaction with the care delivered to patients by associates (Fig 7.3-25) and ease of practice (Fig 7.3-26).

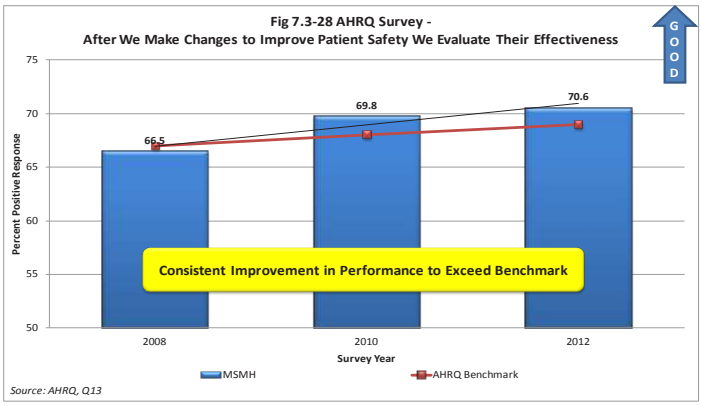




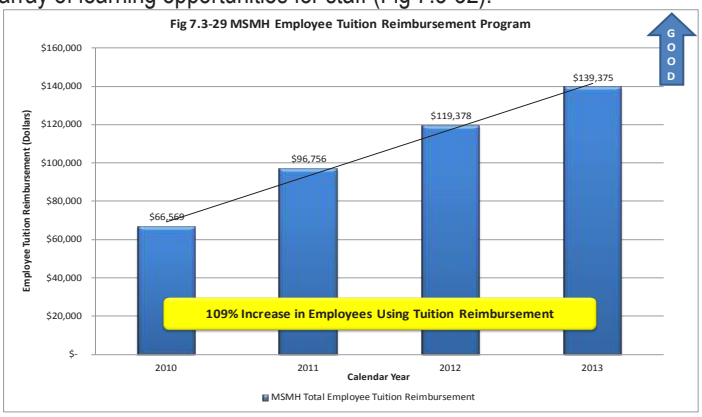
Positive relationships contribute to safety and associate engagement. Teamwork scores tied to patient safety rose to exceed AHRQ benchmarks because SLs/DLs focused on this initiative (Fig 7.3-27).



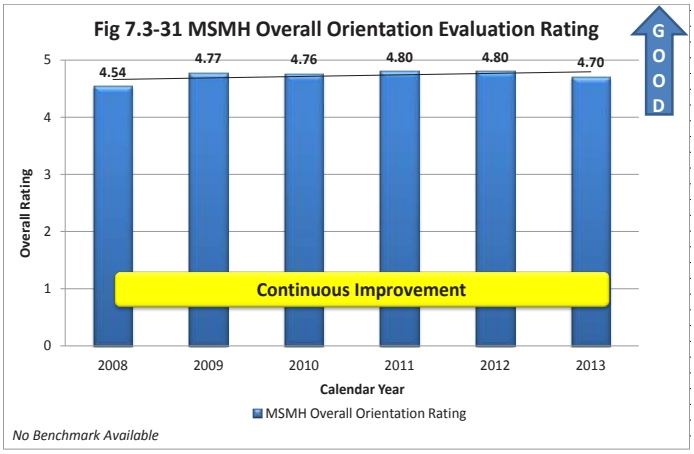
SLs/DLs evaluate and publish results of process changes that enhance patient safety. The associates' improving perception of evaluation of safety changes demonstrates deployment and integration of these processes throughout MSMH. Over 188 safety barriers were overcome through staff identification and solution development, which resulted in improved scores of associates' perceptions on the AHRQ surveys (Fig 7.3-28).

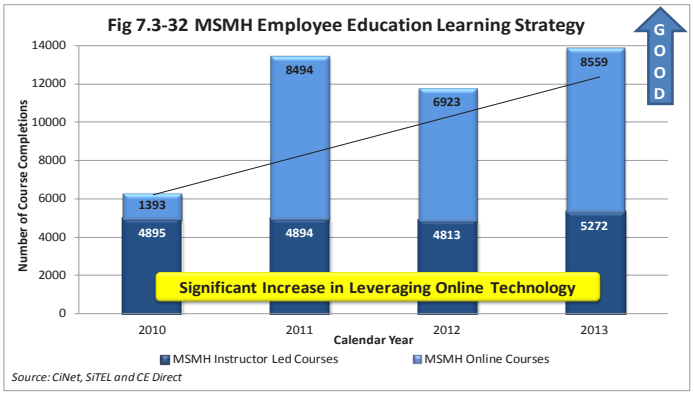


7.3a(4) Workforce Development WF and leadership development builds staff capability to meet and exceed community expectations, while increasing WF satisfaction and engagement. In response to the strategic challenges of WF shortages and academic qualifications and to sustain high reliability, SLs/DLs continuously increase resources to develop associates (Fig 7.29). Fig 7.3-30 shows leadership activities SLs designed over the last 3 years to match DL needs in the changing environment and Fig 7.3-31 shows increasingly positive evaluation of orientation. SLs/DLs also use the latest technology to provide a wider array of learning opportunities for staff (Fig 7.3-32).

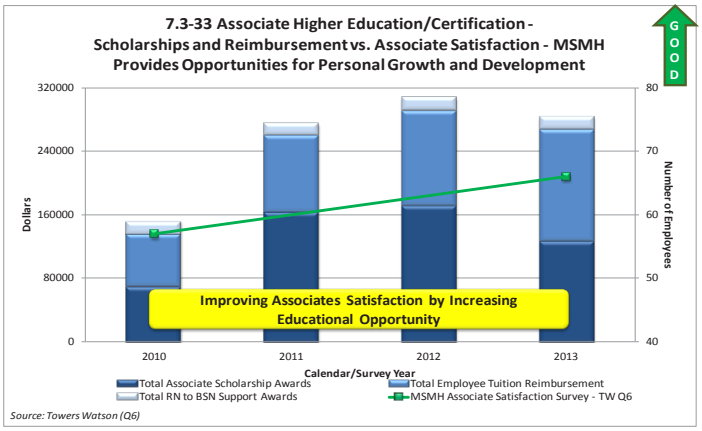


7.3-30 Leadership Development	
Courses	**Percent Completed**
FY13	
Juran Yellow Belt Lean Six Sigma	100%
Good to Great	100%
Advisory Board Courses	97%
FY12	
Juran Yellow Belt Lean Six Sigma	100%
Good to Great	100%
FEMA: EOC Training (HICS Courses)	92%
Advisory Board Courses	98%
FY11	
Advisory Board Courses	97%
Talent Manager Training	86%
FY10	
Nursing Leadership Academy	85%
Advisory Board Courses	95%
Quantros Training	95%

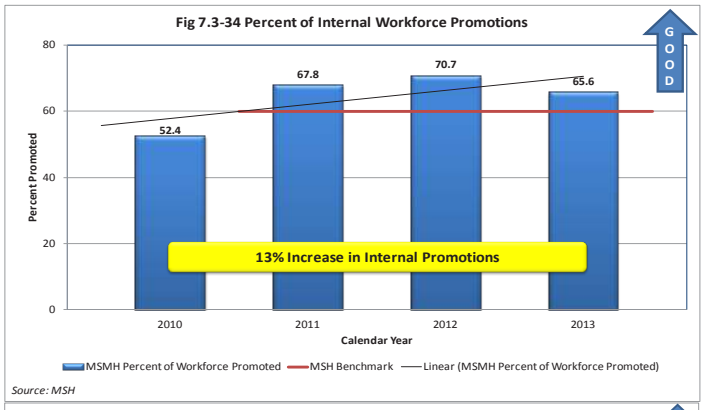


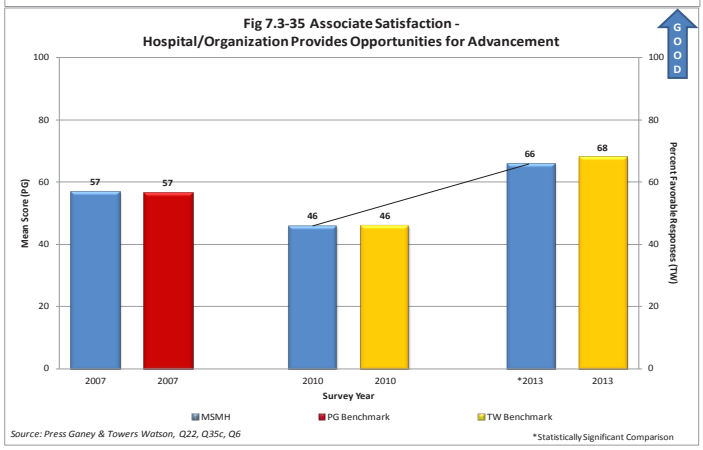


Associate course completions, tuition reimbursement and scholarships are highly used each year as a result of SL/DL planning for WF development (Fig 7.3-33). Associate satisfaction with providing opportunities for personal growth and development is increasing too. External benchmarks are unavailable.



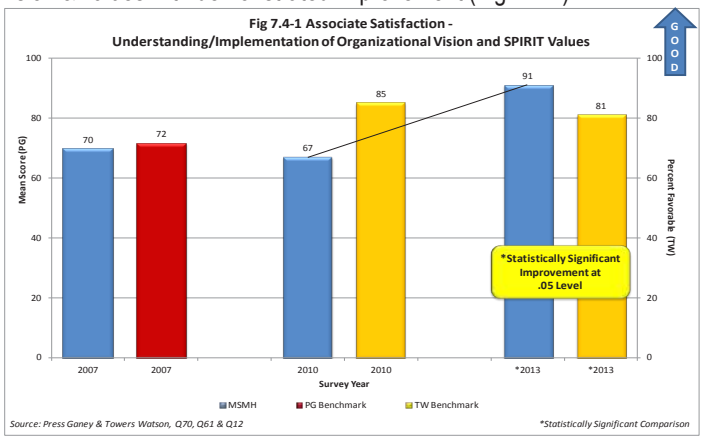
MSMH met but did not exceed benchmarks for associate perception about opportunities for advancement in 2007 and 2010 associate surveys. Thus, SLs added internal promotions to the HR dashboard, added JDs to the associate portal and advertised leadership positions internally. As a result, internal promotions increased and AE scores exceeded the 2010 TW benchmark by 10 points at the 2013 associate survey (Figs 7.3-34 & 7.3-35).



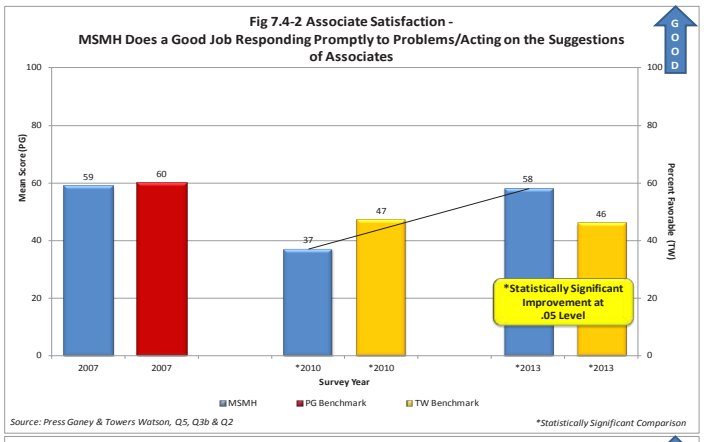


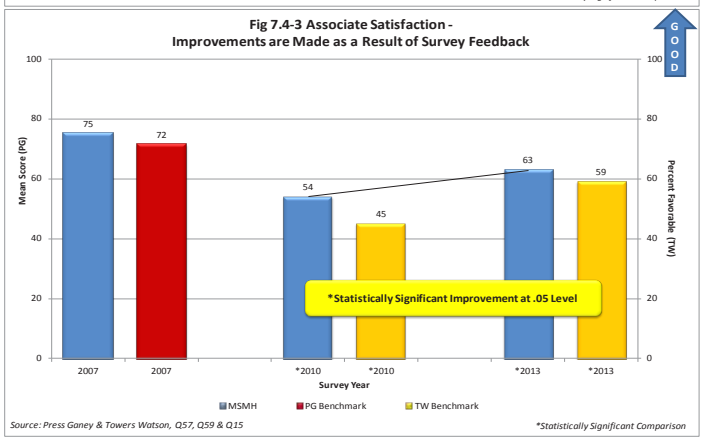
7.4 Leadership and Governance Outcomes 7.4a(1) Leadership

Frequent and varied communications are key elements of MSMH's continuous improvement core competency. SLs have measured communications with associates since 1993 with results reported to the BOD and associates for transparency. Tools have changed over the years. Data presented reflect results for like questions, against benchmarks. APs are developed, with input from WF, and Pulse Checks done mid-cycle to focus attention on actions/implementation accomplished. Recent cycles have included SLs' communication on vision & values with demonstrated improvement (Fig 7.4-1).

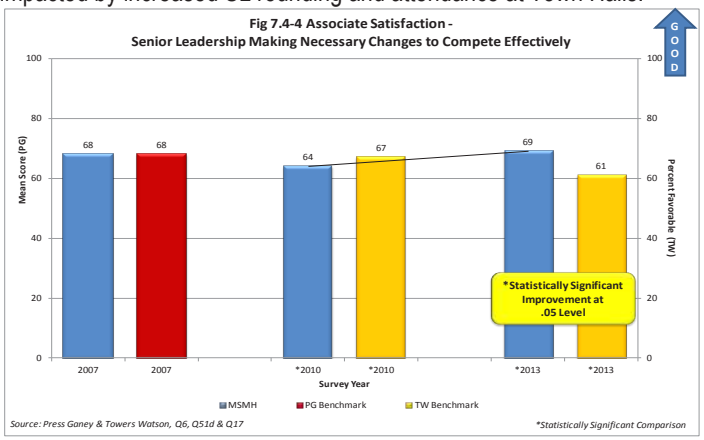


This approach and other listening vehicles led to associates belief that SLs do a good job acting on their suggestions and make improvements as a result of this survey process (Fig 7.4-2 & 7.4-3), demonstrating effective two way communication and a focus on action.

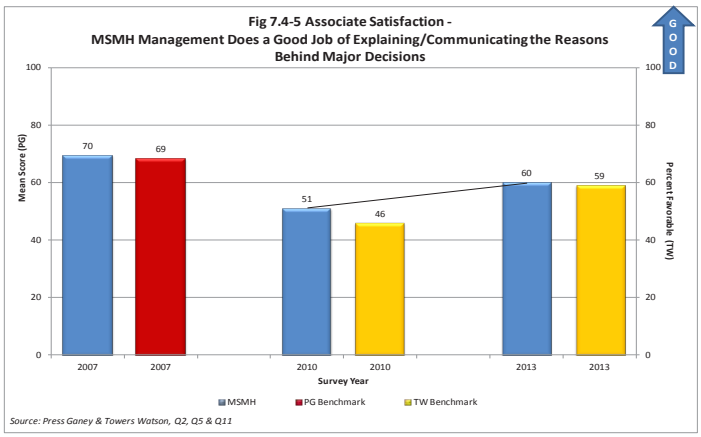




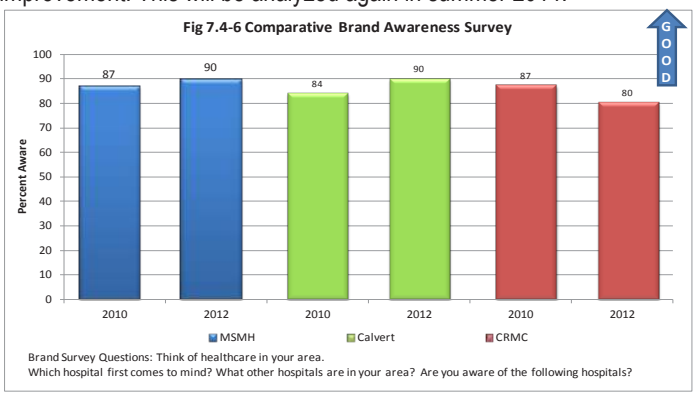
Survey results also confirm associates' recognition that SLs are making necessary changes to compete (Fig 7.4-4) with statistically significant improvement and better than benchmark noted likely impacted by increased SL rounding and attendance at Town Halls.



SLs appreciated the need for enhanced communication about major decisions particularly if significant change is required of the WF (Fig 7.4-5) with better than benchmark results sustained.



As a measure of SLs communication with POCs, SLs assessed the initial success of the merger communications (including a focus on MSH vision & values) in analyzing the community's brand recognition of MSMH & MSH (Fig 7.4-6), which demonstrates significant improvement. This will be analyzed again in summer 2014.



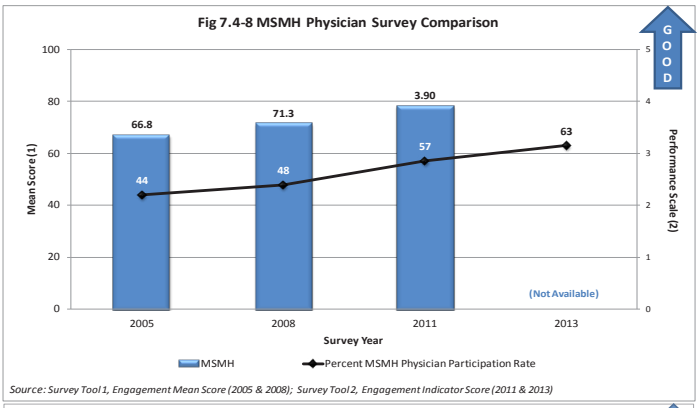
Another measure of SLs communication with POCs is in response to effectively handling patient complaints with a focus on the Patient First & Service Values (Fig 7.4-7). CMS requires resolution within 7 days.

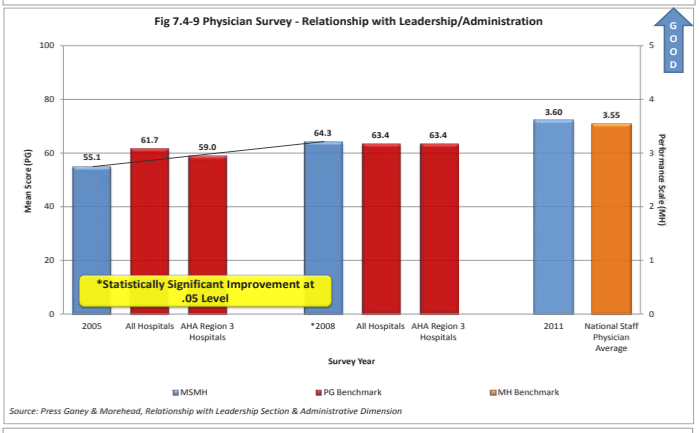
Fig 7.4-7 Percentage of Complaints Resolved Within 24 Hours

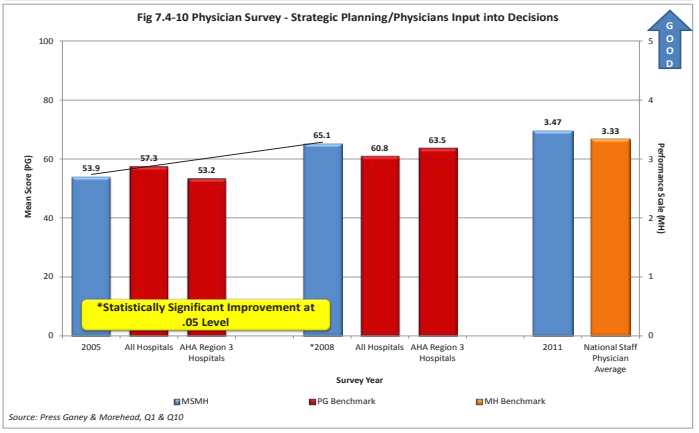
	CY2011	CY2012	CY2013
% resolved within 24 hours	97.2%	95.6%	95.1%

MSMH developed a MedStar Way Dashboard to focus and hardwire behaviors that are key elements proven to positively impact patient satisfaction, including SLs Rounding. Measurement began in CY2012 and was then incorporated into an individual dashboard for each SL and documented within TM. Over CY2013, SLs Rounding performance improved from 54% in quarter 1 to 97.9% in quarter 4.

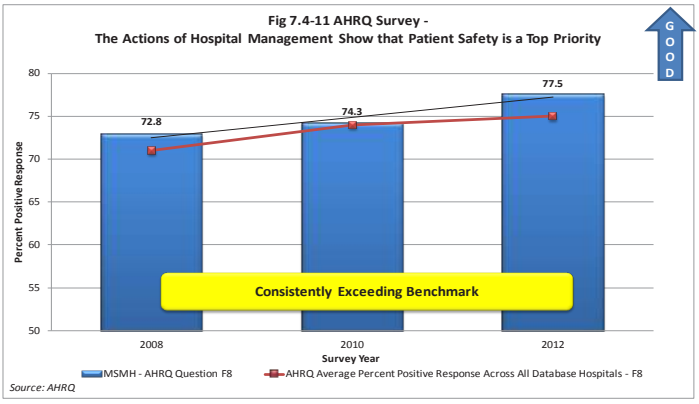
MS satisfaction with SL communications has been measured and results reported to the MS and BOD since 1996, with APs developed from MS input. MS participation rates have increased indicating improved engagement (Fig 7.4-8). Results of the most recent surveys are depicted in Figs 7.4-9 through 7.4-10. While not exact matches, results are depicted side by side to demonstrate improvement in like topics and outperformance of benchmarks. Concerted effort was undertaken in implementing APs following the 2005 survey which resulted in a statistically significantly improved score in Relationship with SLs. One strategy implemented was the inclusion of MS in the evaluation and selection of the EMR. 2013 results demonstrate continued better than benchmark performance. The choice to go-live with a fully integrated EMR with CPOE and full ED notes, followed by the merger led to MS work flow disruption and uncertainty, clearly impacting the 2011 results, though better than benchmark.



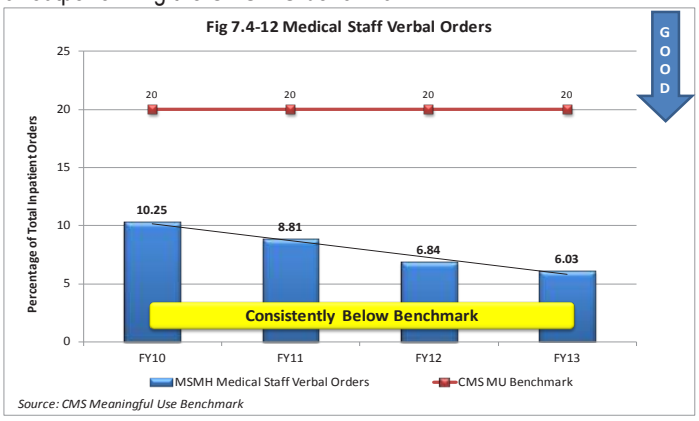




As a key component of the Patient First value, Patient Safety is paramount, and thus SLs instituted measuring the Culture of Safety, utilizing the AHRQ survey. Specific questions from the AHRQ survey provide more insight in to the WF's perception of SLs focus on safety (Fig 7.4-11) and show performance above benchmarks. See Figs 7.3-27 & 7.3-28.



Another key measure of Patient Safety is reducing verbal orders (Fig 7.4-12) using the Hospital's innovative EMR. SLs' decision to collect, analyze and present data across MS departments facilitated deployment of targeted activities, resulting in continuous improvement, far outperforming the CMS MU benchmark.

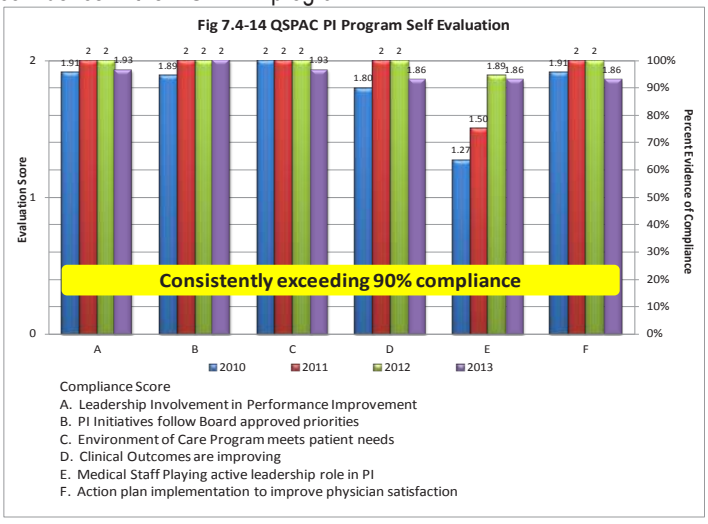


7.4a(2) Governance Key governance processes include the oversight of MS credentialing in accordance with TJC standards & MS Bylaws. Fig 7.4-13 illustrates strong compliance for the MS appointment & reappointment processes.

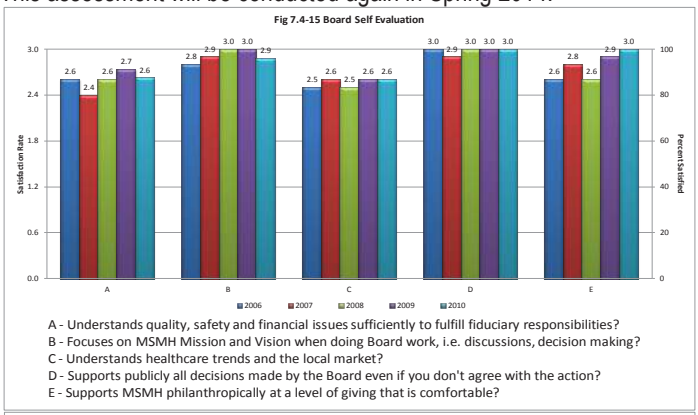
Fig 7.4-13 Governance Process Audit Results

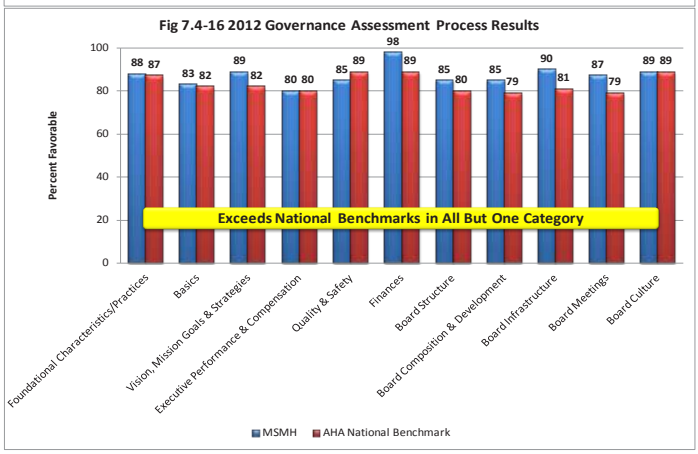
MS Reappointments	CY2011	CY2012	CY2013
# MS members requiring reappointment ≤ 2 years (Percent completed)	132 (100%)	177 (100%)	157 (100%)
# MS reappointed	120	159	140
# MS who chose not to reappoint	12	18	17
# MS denied reappointment	0	0	0
MS Appointments	**CY2011**	**CY2012**	**CY2013**
# new MS members	63	50	60
# new MS members with >120 days temporary privileges (% non-compliant)	0 (0%)	0 (0%)	0 (0%)
# Medicare Fraud Screening (% compliant)	63 (100%)	50 (100%)	60 (100%)
# FPPE done (% compliant)	63 (100%)	50 (100%)	60 (100%)
# FPPE renewed	7	14	14
# FPPE advanced	56	36	46

As evidence of a commitment to continuous improvement, the BOD QSPAC annually conducts a performance evaluation of its Organizational Performance Improvement Program. This internally developed tool is based upon TJC standards and no external benchmarks are available. Fig 7.4-14 demonstrates strong BOD confidence in the MSMH PI program.



The MSMH BOD further measures its own success by conducting a self-assessment. Fig 7.4-15 demonstrates significant strength in 5 areas of BOD responsibilities from 2006 to 2010. This internally developed tool was used and thus no external benchmark was available. MSMH subsequently joined the new MedStar initiative working with the AHA's Governance Assessment Process (GAP) tool to access national benchmarks (Fig 7.4-16). The gamut of indicators outperform benchmarks, nevertheless APs are developed and implemented by the BOD to ensure further continuous improvement. This assessment will be conducted again in Spring 2014.





Mechanisms to ensure internal accountability utilize resources within MSMH & MSH. MSMH audit functions are reported through RCMC and are focused on vulnerable areas such as chemotherapy or rehabilitation billing practices. Expert consultants are sought to conduct operations audits to enable MSMH to improve and implement best practices. Such audits include Mercer for HR, Cardinal Health for pharmacy and Solucient for EVS. Results of these operational audits and subsequent AP implementation are reported to the BOD. In addition to opportunities for improvement, the MSH Internal Audit Program provides extensive review of potential risks and operational control concerns. If identified, APs are developed, implemented & reported to the MSH BOD. External audits provide additional review & confidence in BOD oversight. Excellent results of internal and external fiscal accountability audits are depicted in Figs 7.4-17 & 7.4-18.

Fig 7.4-17 Internal Audit Results

MSH Internal Audits	Report Date	OFI Identified	OFI Resolved
Physician Contracting	06/2010	8	8
Accounts Receivable	11/2011	11	11
External Quality Data Reporting	09/2013	2	2

Fig 7.4-18 Governance Fiscal Accountability Results

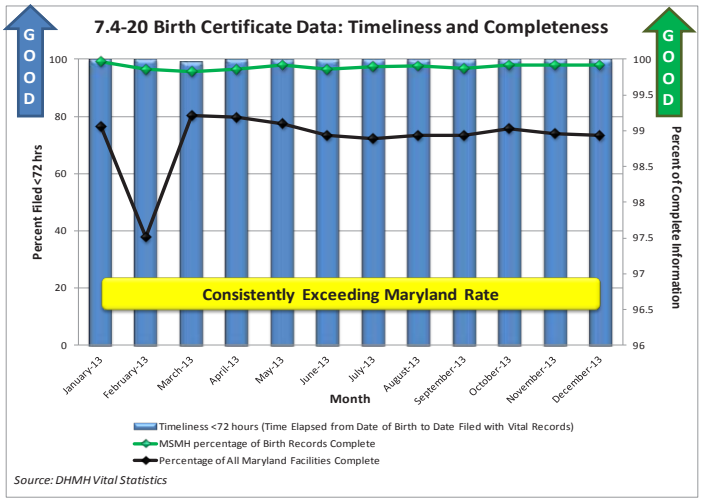
External	2009	2010	2011	2012	2013
Audit adjustments required	No	No	No	No	No
Material control weaknesses identified	No	No	No	No	No
IRS 990 Filed/BOD reviewed	N/A	Yes	Yes	Yes	Due 5/14
HSCRC Community Benefit Report filed	Yes	Yes	Yes	Yes	Yes

7.4(3) Law, Regulation, and Accreditation Legal, regulatory and accreditation requirements results show full compliance in Fig 7.4-19.

Fig 7.4-19 Legal, Regulatory and Accreditation Requirements

Legal & Regulatory Agencies/Requisites		
DHMH	State Oversight, Patient Safety, Professional Licensure	Fully compliant
EEOC	Non-discriminatory practices	Fully compliant
EMTALA	Patient transfers, appropriateness, patient rights	Fully compliant
FLSA	Fair/equitable labor practices	Fully compliant
NIOSH	Infection Control standards	Fully compliant
NRC	Radiation safety	Fully compliant
OCR, ADA	Patient and staff rights	Fully compliant
OIG	Privacy/security of health information	Fully compliant
SMC HD	Food service inspection	Fully compliant
Occupational Health & Safety		
DLLR	Elevators & Boilers/Pressure Vessels	Fully compliant
Fire Marshall	Workplace safety	Fully compliant
NFPA	Fire Suppression	Fully compliant
OSHA	Workplace safety/infections	Fully compliant
Accreditation & Licensure		
AABB	Blood Bank Accreditation	Fully compliant
CAP, CLIA	Laboratory Accrediting, Licensure	Fully compliant
COP	CMS Conditions of Participation	Fully compliant
MQSA	Mammography Standards	Fully compliant
TJC	The Joint Commission	Fully compliant
Financial & Environmental		
DHHS/CMS	Medicare/Medicaid	Fully compliant
EPA	Environmental Impact	Fully compliant
HSCRC	Maryland State hospital rate setting	Fully compliant
IRS	Not-for-profit status	Fully compliant

Two examples of DHMH performance expectations required of the MSMH Obstetrics service are the submission of timely and complete Birth Certificates where results consistently out perform all Maryland facilities (Fig 7.4-20) and Newborn Screening where specimens are to be received by the State within 72 hours. In Fall 2013, when DHMH analyzed results, the State average was 60% but MSMH's was 39.78%. MSMH analyzed its process & redesigned steps and CY2013 4th quarter results are 90.50% for MSMH versus the 85.82% MD average.



From time to time, governmental special audits occur. MHCC conducted an HAI – SSI audit on CDC NHSN reported data for CY11. MSMH was informed it had outstanding results with only 1 of 268 charts found to have the HAI coded incorrectly. A prior HAI audit of antibiotic prevalence & appropriateness revealed zero deficiencies. All such State audits are reported to the BOD with follow-up as appropriate.

By seeking certifications and recognitions that exceed required licensure and regulatory compliance, MSMH strives to assure the community of its high quality and standards. MSMH is proud to be the first in the region and in the top 3 Maryland hospitals to achieve ACR accreditation for all modalities and also to achieve EMR HIMSS Stage 6 certification in 2008 (Fig 7.4-21). MSMH was named one of the 2013 Top 100 Hospitals in the country and the only one in Maryland by *Modern HealthCare* (Truven Health Analytics, formerly Thompson Reuters). This determination was made based upon the highest national scores from 14 separate objective measures of hospital performance affecting patients and the quality of care in the community.

Fig 7.4-21 Certification, Accreditation & Recognition Above Required

Certifications/Accreditations	*Years achieved*
ADA Recognized Self-Management Education Program	2003 to present
AHA – Stroke	2009 to present
American Association of Cardiovascular and Pulmonary Rehabilitation	2012 to present
American College of Radiology – CT	2008 to present
American College of Radiology – Mammography	2001 to present
American College of Radiology - MRI	2009 to present
American College of Radiology – Nuclear Medicine	2010 to present
American College of Radiology – Ultrasound	2008 to present
American College of Surgeons Commission on Cancer	1977 to present
HIMSS Stage 6	2010
International Board Certified Lactation Consultation	1998 to present
MIEMSS Stroke	2007 to present

Fig 7.4-21 Certification, Accreditation & Recognition Above Required, *continued*

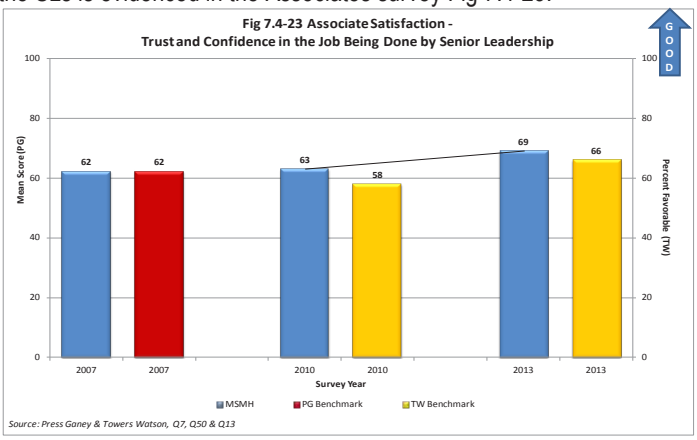
Recognitions	*Years achieved*
Modern Healthcare, Top 100 US Hospitals	2013
Delmarva Quality Excellence	2004, 2008-2013
William Donald Schaefer Helping People Award	2013
Delmarva Medication Reconciliation Excellence	2011
HealthGrades 5 Star Rating – COPD Treatment	2007-2013
HealthGrades Patient Safety Excellence	2012, 2013
Maryland Life Finest Healthcare	2012
Press Ganey Most Improved ED	2004
AWE – EcoLeadership	2009-2013
AWE – Health and Wellness	2009-2013
AWE – Workplace Excellence	2009-2013
AWE – Diversity	2013
Chamber of Commerce Lighthouse Award	2011
CSM CEO of the Year	2010
CSM Leading Edge Partner in Education	2012
Nursing Spectrum Excellence in Nursing Leadership	2009
Aster Awards in Marketing & Public Relations	2004, 2005, 2007, 2008, 2010-2013
Healthcare Advertising Awards	2009, 2010, 2012, 2013

Associate licensure is maintained by HR. MS credentialing is managed by the MSO. Associates and MS are not authorized to work without proper licensure. Regulatory and accreditation requirements for associates/MS' specific licenses and proficiency data (Fig 7.4-22) demonstrate consistently strong performance.

Fig 7.4-22 Associate and MS Licensure and Proficiency

	CY2010	CY2011	CY2012	CY2013
Licensure				
Associates worked with current license	100%	100%	100%	100%
MS worked with current license	100%	100%	100%	100%
Proficiency				
Glucometer Point of Care	100%	100%	100%	100%
Restraint/Seclusion	100%	100%	100%	91%
Knowledge of RACE	99.3%	100%	99.2%	100%
Code Red: Elements Implemented	91.7%	100%	98.7%	100%

7.4(4) Ethics Associates' assessment of Trust and Confidence in the SLs is evidenced in the Associates survey Fig 7.4-23.

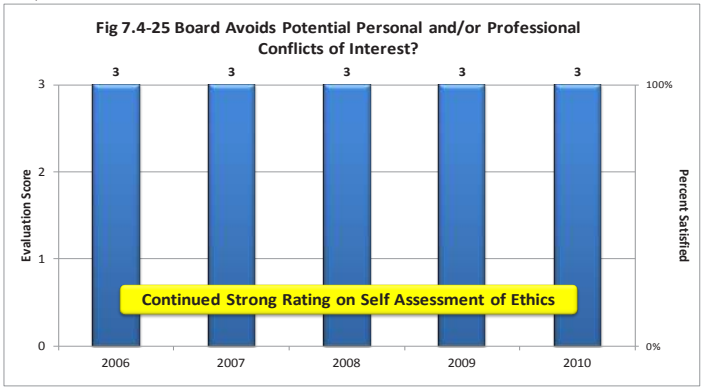


The MSMH BOD assures compliance with non-profit requirements by greater than 50% composition of independent board members as shown in Fig 7.4-24. To ensure MS engagement the BOD also includes physician membership.

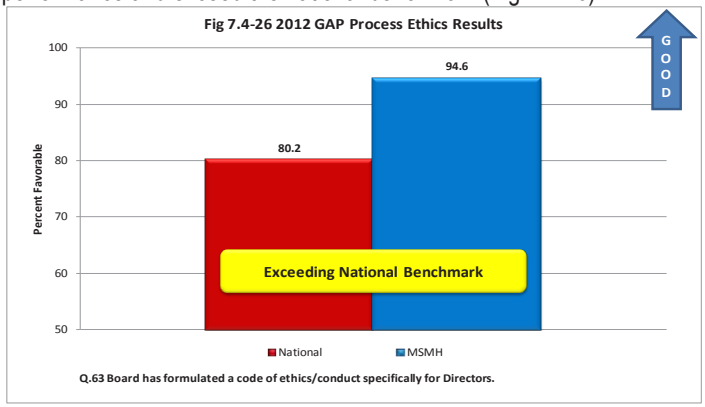
Fig 7.4-24 MSMH BOD Independent & Physician Membership

Year	*>50% independent members*	*# MS Directors*
2011	Yes	2
2012	Yes	2
2013	Yes	4

Within the annual Board Self-Evaluation survey, the BOD considers its own ethical performance (Fig 7.4-25). As an internally developed tool, no external benchmark exists.



Results from the 2012 GAP Survey measure BOD ethical performance and exceed the national benchmark (Fig 7.4-26).



Additionally, there is an online, annual COI Survey for BOD members, SLs, DLs, MEC and paid MS members (Fig 7.4-27). Failure to participate & comply would result in dismissal from their position.

Fig 7.4-27 Leadership Compliance Annual Conflict of Interest Survey

Compliance with COI Survey			
FY	**BOD**	**SLs**	**MEC/Paid MS**
2011	100%	100%	100%
2012	100%	100%	100%
2013	100%	100%	100%

MedStar maintains a System-wide Compliance Hotline to encourage associates to report concerns about breaches in ethical behavior. Fig 7.4-28 illustrates the excellent results of such reporting along with other allegations and conclusions around ethical breaches. All questions identified have been addressed and full compliance assured.

Fig 7.4-28 Compliance Reporting and Resolutions

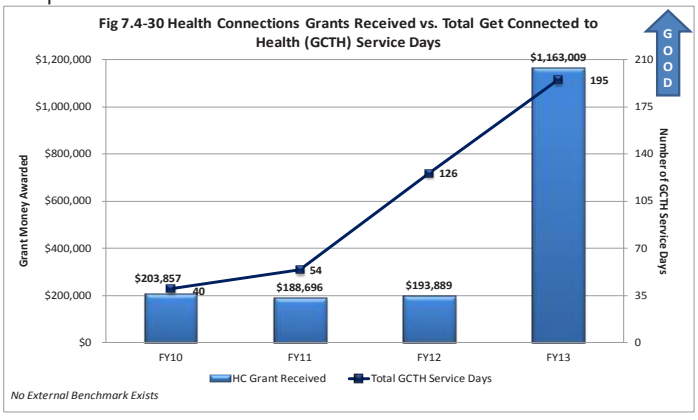
	2009	2010	2011	2012	2013
Ethics Violation	0	0	0	0	0
Fraud Occurrence	0	0	0	0	0
Compliance Violation	0	0	0	0	0
EEOC Claims Validated	0	0	0	0	0
Malpractice Claims Paid	0	1	1	0	0
TJC Complaint Findings	0	0	0	0	0
DHMH Complaint/Deficiency	0	0	2	0	0
HIPAA Breach Terminations	0	0	0	2	0
VIP Privacy Audits	-	-	-	0	1
Exit Interview Concerns	2	0	0	0	0

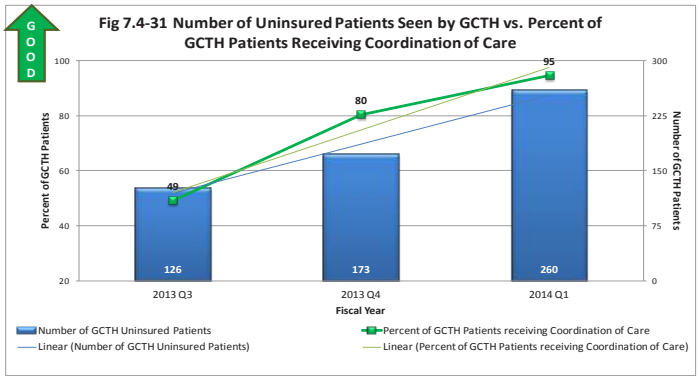
7.4(5) Society MSMH has over a 100 year history of service to its community regardless of a patients' ability to pay. Moreover MSMH is a community leader, advocating that the community's scarce resources be coordinated effectively to better serve and improve the health of its citizens. Fig 7.4-29 illustrates MSMH funds allocated towards community benefit programs further demonstrating the hospital's commitment to its mission – promoting, maintaining and improving health through education and service, assuring high quality, patient safety and fiscal integrity.

Fig 7.4-29 Community Benefit

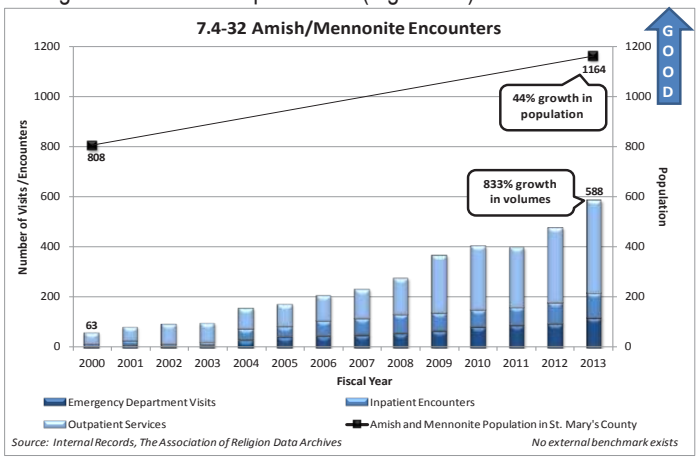
	FY10	FY11	FY12	FY13
Dollars Reported to HSCRC	$8.2M	$9.0M	$11.0M	$12.0M
State Evaluation Score Awarded	100%	100%	100%	Not Available
% of Operating Expenses	7.61%	8.04%	9.02%	9.73%

Many MSMH community benefit programs are provided by HC. Fig 7.4-30 reflects commitment to serving the uninsured patient segment in spite of changing healthcare reimbursement through grant funding. Fig 7.4-31 demonstrates successful improvement in ensuring GCTH patients receive coordinated care even as volumes are growing. Access to care barriers of physician shortage and health disparities in the African American community were identified in the 2012 Community Health Needs Assessment and during the writing of the HEZ grant. MSMH was awarded one of the first 5 HEZ in the State due to our evidence based comprehensive strategy to reduce these and other disparities in the next 4 years with a $3.4M grant in 2013 that includes increased providers, care coordinators, community health workers, and transportation.





Another special patient segment is the Amish/Mennonite community. In 2000, complaints were brought to SLs' attention regarding a lack of cultural understanding. Annual meetings have been held since 2000 to ensure two way communications and improve relationships resulting in utilization that is growing faster than the population. Cultural sensitivity training for the WF was implemented (Fig 7.4-32).

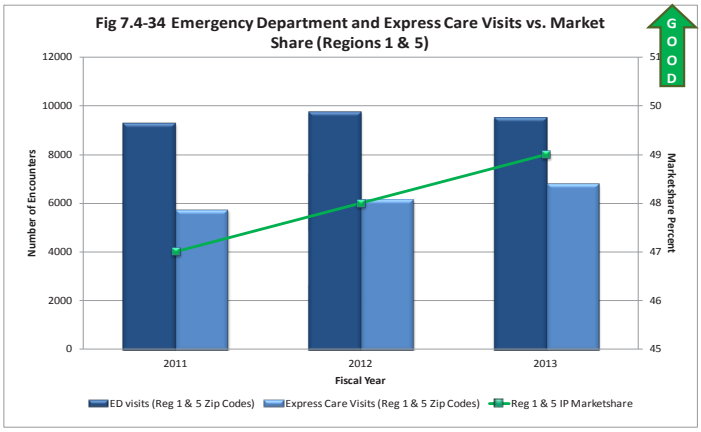


One of the major reasons that the BOD chose to merge with MSH was to ensure sustainability through access to primary & specialty care for the community by improving physician recruitment outcomes. Early after the merger, significant transitions occurred in enhancing hospital based physician services. Fig 7.4-33 demonstrates the success of recruitment efforts, leveraging the reputation, depth & breadth of MSH resources.

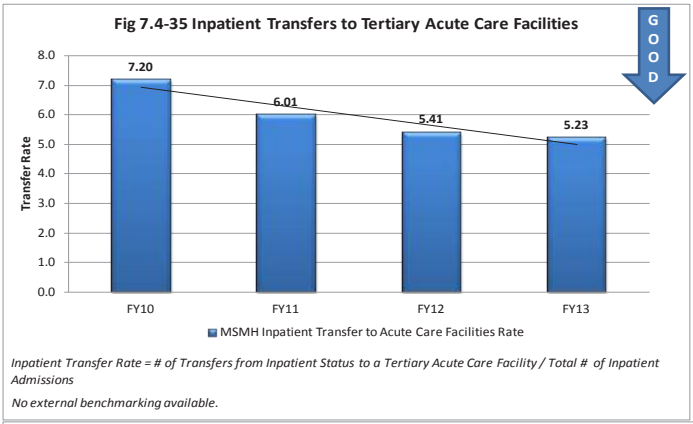
Fig 7.4-33 Physician Recruitment

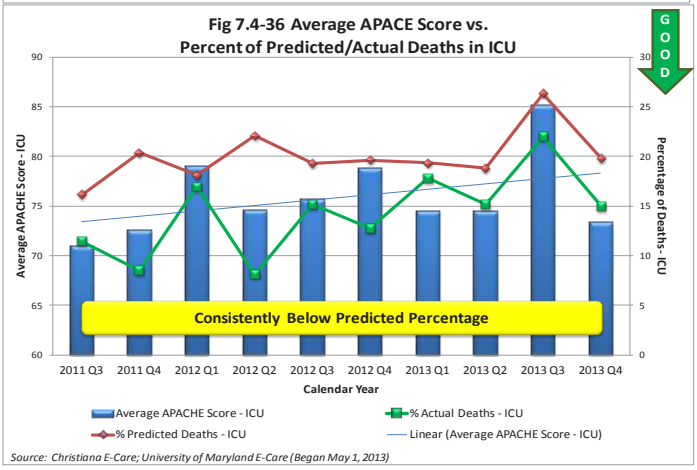
	FY09		FY10		FY11		FY12		FY13	
	Non MSH	MSH	Non MSH	MSH	Non MSH	MSH	Non MSH	MSH	Non MSH	MSH
Primary Care	1	0	2	1	0	0	1	2	2	2
Specialty	0	0	1	0	2	5	3	1	1	3

Fig 7.4-34 illustrates success in expanding primary care access in the underserved northern end of the county, leading to improved market share however not yet reduced ED utilization for the area, though 2013 indicates an early sign of success.

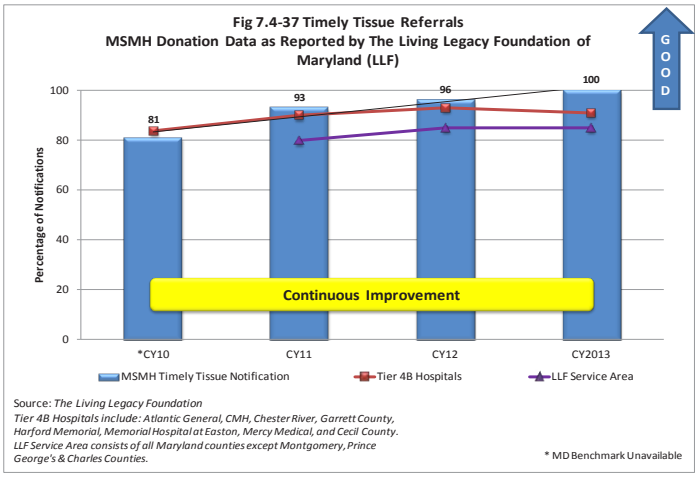


MSMH's approach to implementing 24/7 ICU Intensivist coverage via employed physicians and eCare's remote access has in part lead to successfully reducing inpatient transfer rates (Fig 7.4-35) No external benchmark exists. The success of the eCare program is also evident in Fig 7.4-36 where case mix/severity of illness (APACHE score) is increasing due to keeping sicker patients at MSMH, yet realizing consistently lower actual deaths than would be predicted with these sicker patients. Future AOP implementation, in collaboration with MSH colleagues to expand telemedicine services will continue to improve access close to home.

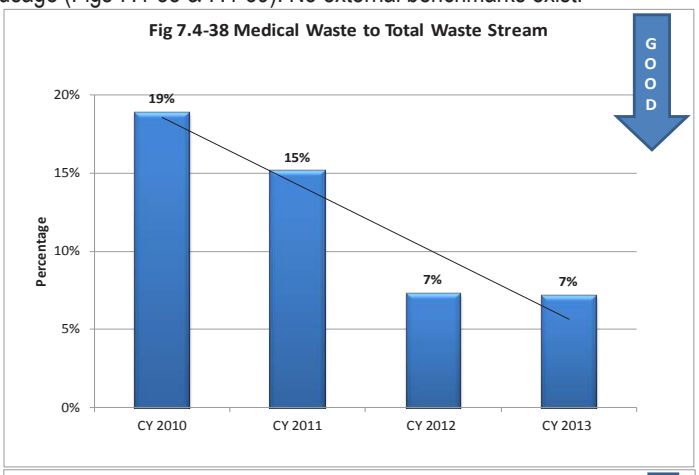


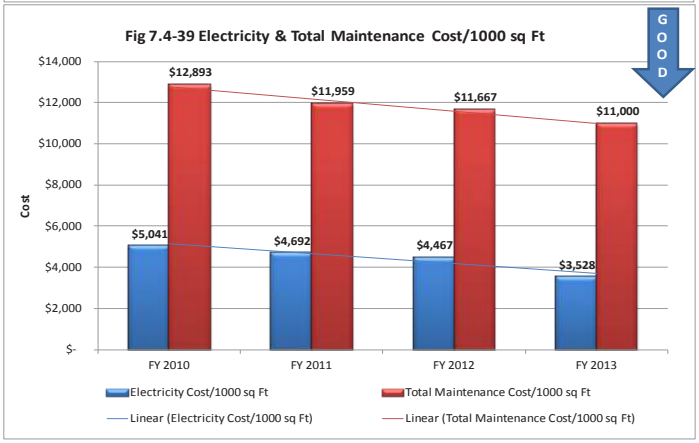


Although a small community hospital far from tertiary care, MSMH is active in securing organ donations (Fig 7.4-37). Also MSMH hosts an MGUH Transplant Clinic for prescreening and post care of kidney transplant patients, another example of improving access via MSH.

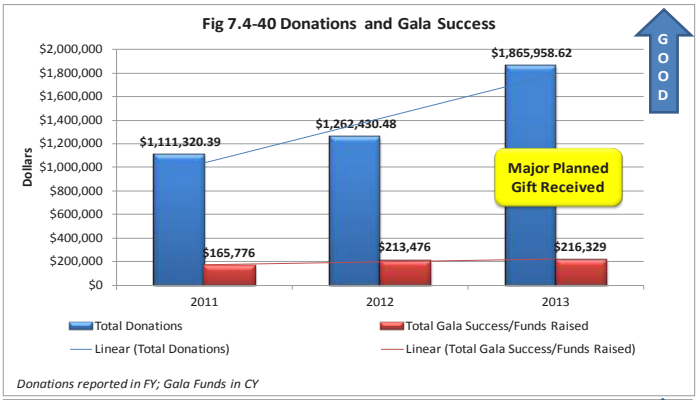


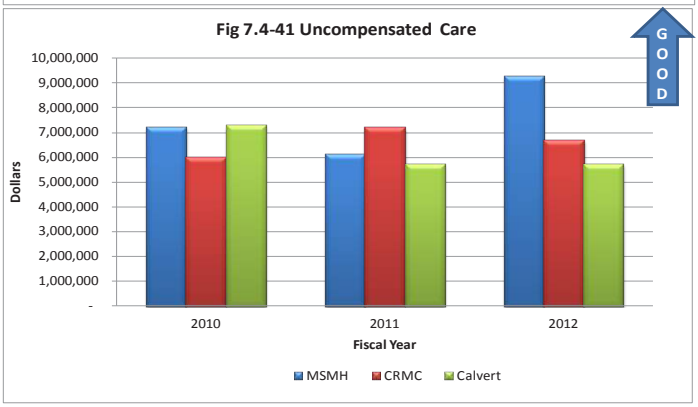
Mindful of the quality of rural life and focused on utilizing scarce resources efficiently, SLs/DLs actively pursue green initiatives: reducing maintenance costs and working with the local utility, reducing electricity usage (Figs 7.4-38 & 7.4-39). No external benchmarks exist.





Finally, evidence of community support and engagement in MSMH is demonstrated by increased donations and support of the hospital Foundation Gala (Fig 7.4-40) and the hospital's continuing commitment to provide uncompensated services (Fig 7.4-41). No external benchmark exists.



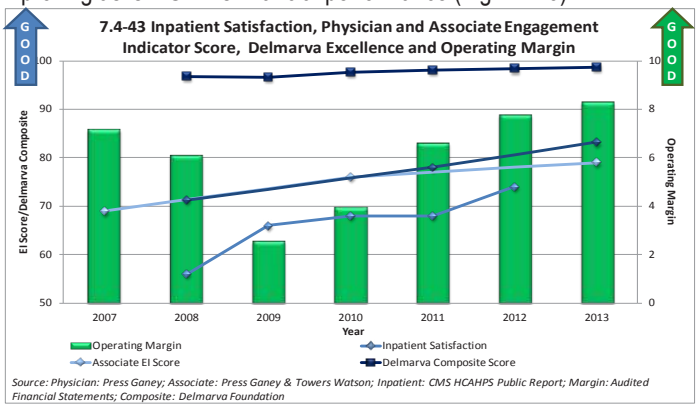


7.4b Strategy Implementation Key measures demonstrating AOP accomplishments are in Fig 7.4-42. SLs strive to achieve the MVV and build core competencies (P.1.a). All measures in the AOP BSC meet or are within 5% of target in FY13 except for SSEs. In FY13, SLs identified latent system failures regarding alarm management and fatigue which accounted for 4 of the 6 SSEs. APs were developed and timely TJC SEA EBPs were incorporated. ED visits are starting to decline as healthcare reform is implemented, as insurers scrutinize ED utilization and primary care access improves. ASC volumes dropped when a competing ASC opened, however, volumes are rebounding.

Fig 7.4-42 MSMH Annual Operating Plan BSC

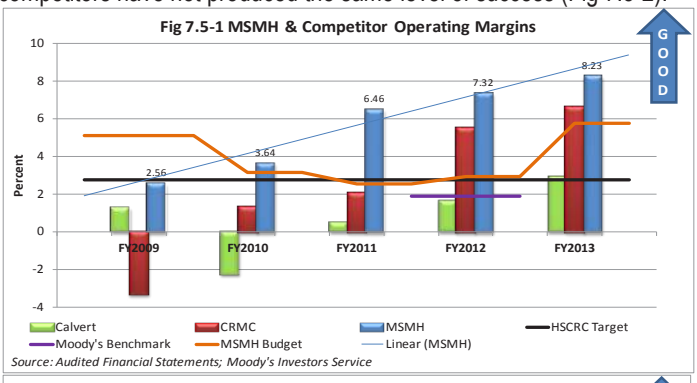
Focus	Key Measures	FY11	FY12	FY13	FY14 Projected
Highest Quality Safety	ICU CLABSI Rate	0	0	0	0
	Delmarva Composite Score	96%	98.44%	98.70%	98.70%
	HSCRC QBR Ranking of MD Hospitals	#1	#2	#2	#2
	SSEs	2	5	6	1
Best Place to Work	Employee Engagement Index	76%		79%	81%
	Associate Survey Participation Rate	>80%		>80%	>80%
	BSN RNs/ Total RNs	36%	42%	46%	50%
Best Patient Experience	Overall Inpatient Experience	69%	75.0%	74.3%	75.0%
	Overall Ambulatory Surgery	79%	81.4%	85.3%	85.5%
	Discharge Information	85%	87.2%	90.6%	91.0%
Market Leadership	Admits/Observations	10,345	10,578	10,713	10,828
	Ambulatory Surgeries	5,340	5,461	4,674	5,151
	ED Visits	54,981	57,028	56,482	52,772
Financial Strength	Operating Margin	6.50%	7.30%	6.80%	8.00%
	Total Expenses/EIPA	$5,928	$6,235	$6,375	$6,268
	Total FTE/1,000 EIPD	15.52	15.45	15.15	14.58

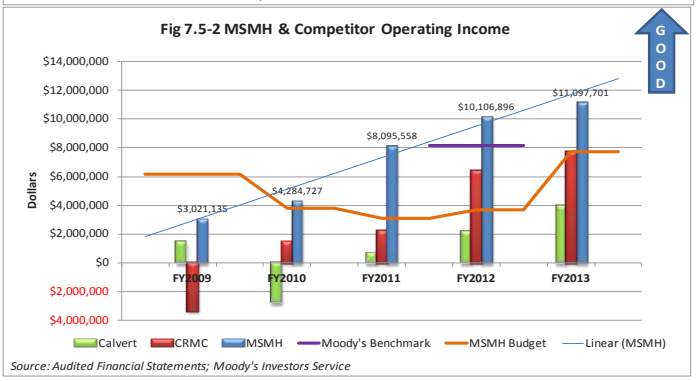
To summarize key AOP results: with sustained outstanding quality, and increasingly engaged associates & MS, inpatient satisfaction is improving as is MSMH's financial performance (Fig 7.4-43).



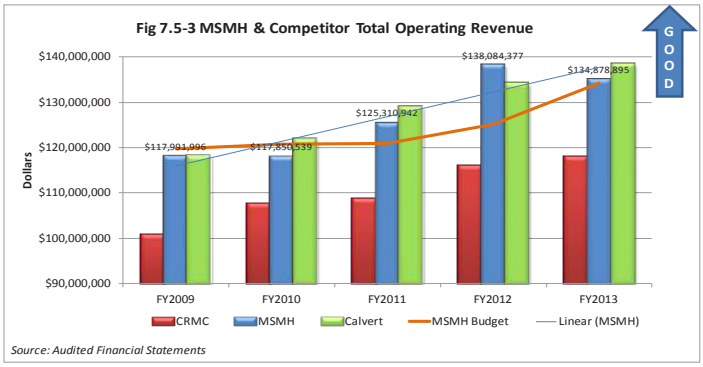
7.5 Financial and Market Outcomes

7.5a.(1) Financial Performance Over the past 20 years, MSMH has averaged an annual operating margin of 6.05%. The HSCRC has a long-term operating margin target of 2.75% for hospitals in the State and the Moody's median in 2012 for A3 rated stand alone hospitals was 1.9%. As shown in Fig 7.5-1, at the height of the recent economic down-turn, MSMH dipped slightly below the HSCRC target, maintained a level of performance above the Moody's median, and quickly recovered, showing 5 consecutive years of improvement. Regional competitors have not produced the same level of success (Fig 7.5-2).

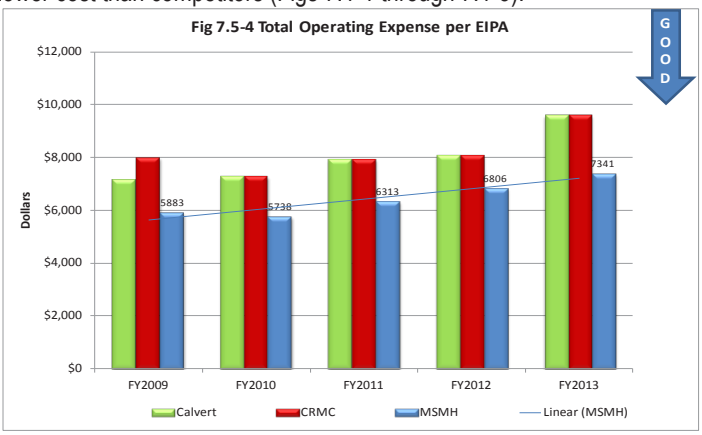




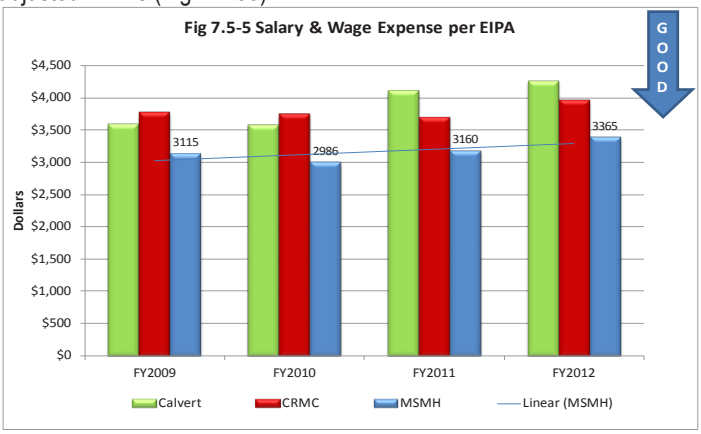
MSMH has the highest operating income (Fig 7.5-2), despite not having the largest revenue base of the 3 hospitals in Southern Maryland market (Fig 7.5-3). FY2012 operating income exceeded the Moody's median for A3 rated stand-alone hospitals.



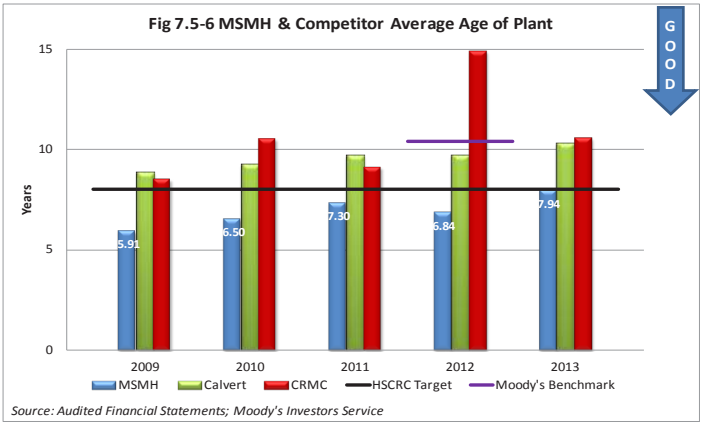
The financial success of MSMH is driven by an ability to operate efficiently and control expenses. MSMH's total expense per EIPA is the lowest in the region (Fig 7.5-4). MSMH provides high quality care at a lower cost than competitors (Figs 7.1-1 through 7.1-3).



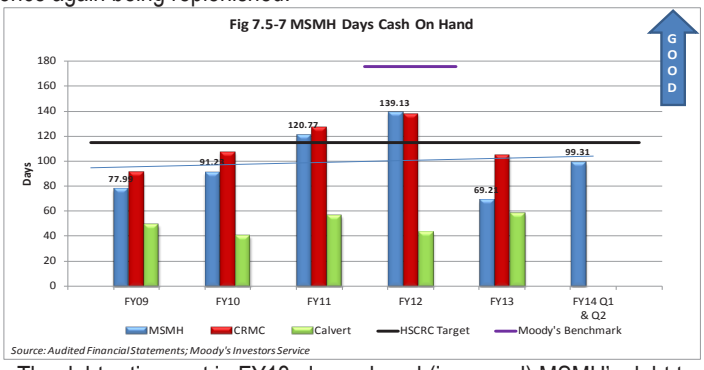
With personnel costs representing upwards of 60% of a typical hospital's total operating costs, a key component of financial success is maximizing associate productivity. MSMH outperforms its competitors in salary and wage expense (Fig 7.5-5) through continuous improvements in productivity as measured by FTE per 1,000 CMI adjusted EIPDs (Fig 7.1-35).



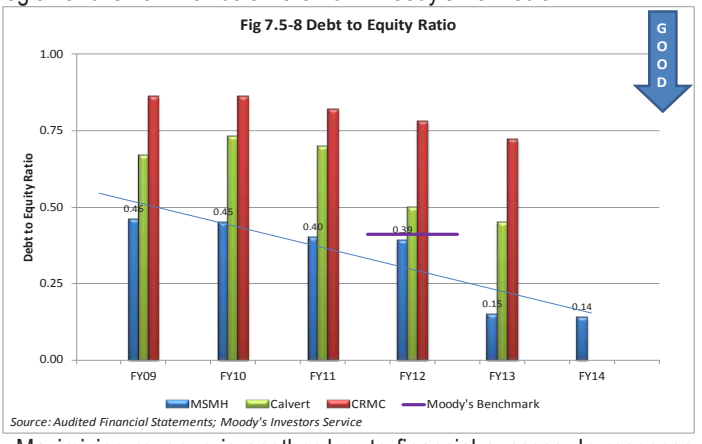
POCs satisfaction has also been enhanced by ongoing investments in the physical plant, equipment, and technology. These investments result in an Average Age of Plant (a measure of the "newness" of fixed assets) lower than competitors, the HSCRC's target, and the Moody's 2012 A3 rating median. MSMH is the only hospital in the region with average age of plant lower than the HSCRC target (Fig 7.5-6). (Note: CRMC's change in FY12 was the result of a change in accounting estimates made in conjunction with its merger with a health system).



A significant capital outlay was made in FY08 in support of implementation of the integrated EMR. This purchase was funded entirely by operating cash because financing an asset with such a short allowable useful life was not practical. The impact on days cash on hand was substantial, but as shown in Fig 7.5-7, strong payables management and solid revenue cycle performance led to a steady replenishment of cash through FY12. In FY13, a transaction was completed to retire approximately $28 million in debt from MSMH's books, once again temporarily reducing cash on hand; however, as shown in Fig 7.5-7, through the first half of FY14, the cash balance is once again being replenished.

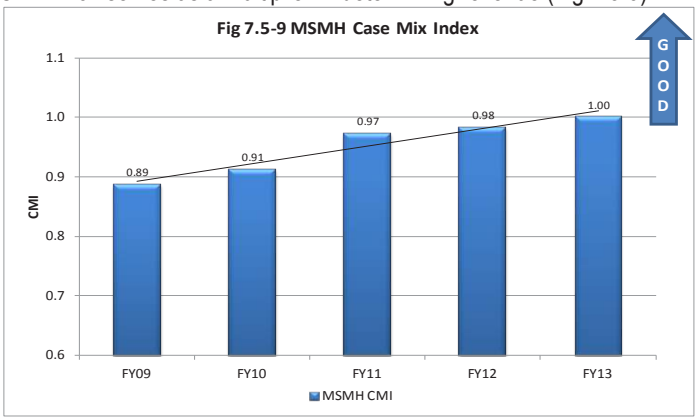


The debt retirement in FY13 also reduced (improved) MSMH's debt to equity ratio – a measure of the extent an organization is leveraged. Higher leverage indicates a higher degree of risk that an entity will not be able to meet its financial obligations. As shown in Fig 7.5-8, MSMH has historically had the lowest debt to equity ratio of hospitals in the region and is now well below the 2012 Moody's A3 median.

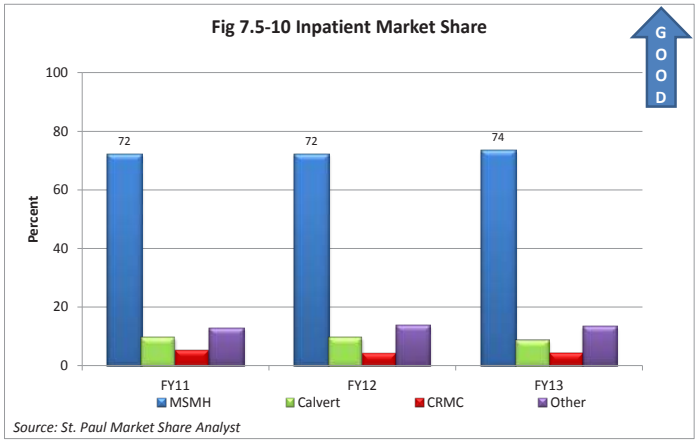


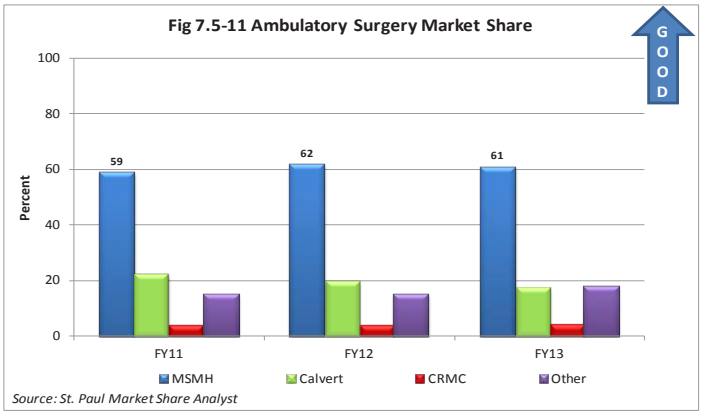
Maximizing revenue is another key to financial success. In response to the workforce shortage challenge, MSMH was able to leverage EMR technology to outsource transcription and coding. These initiatives, along with eCare and the subsequent implementation of a Clinical

Documentation Improvement Program, also enabled by EMR technology, have had the desired results; namely a steady increase in CMI which serves as a multiplier in determining revenue (Fig 7.5-9).

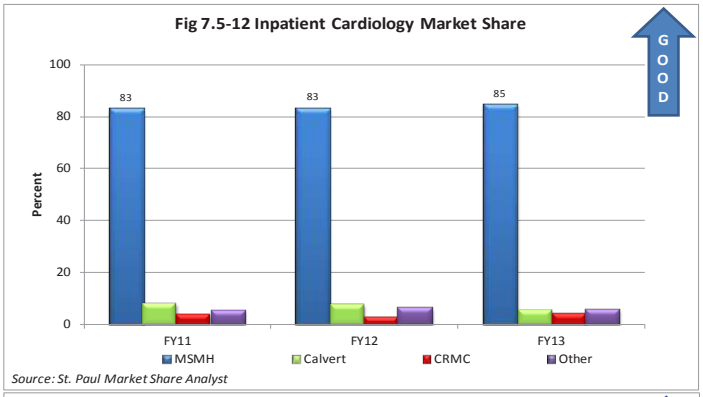


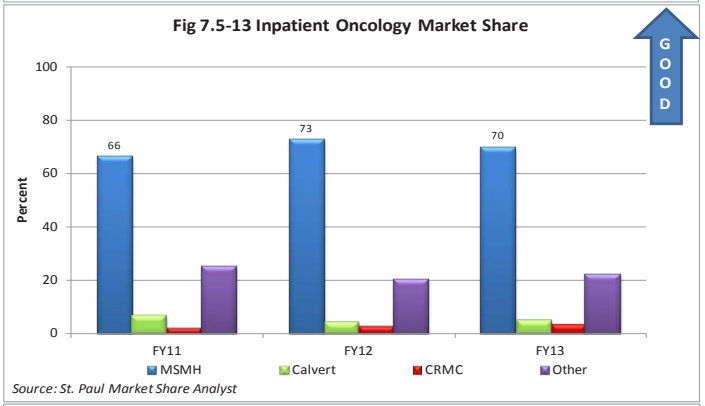
7.5a.(2) Marketplace Performance As shown in Figs 7.5-10 & 7.5-11, MSMH has consistently captured the majority of market share for patients living in MSMH's primary service area.

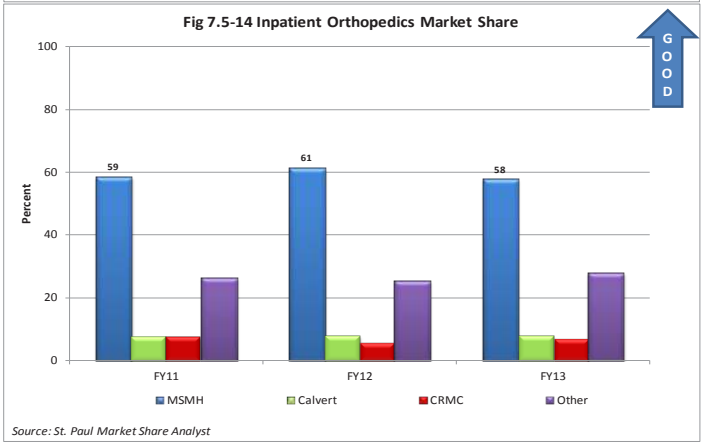




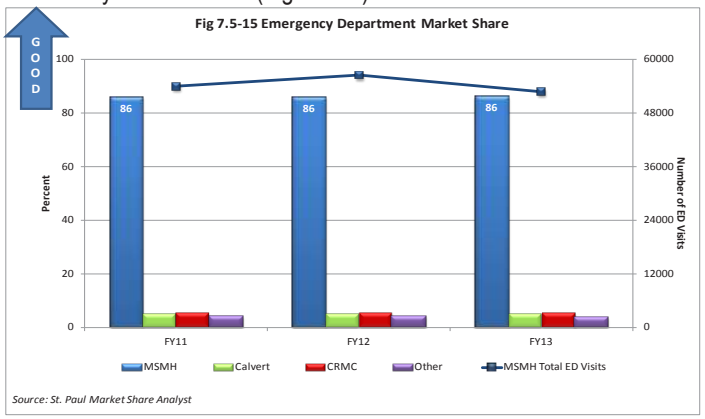
Despite implementation of outpatient observation status in FY11, inpatient market share for Cardiology remains strong (Fig 7.5-12); the AOP focused service lines of Oncology (Fig 7.5-13) and Orthopedics (Fig 7.5-14) have also been consistently strong.

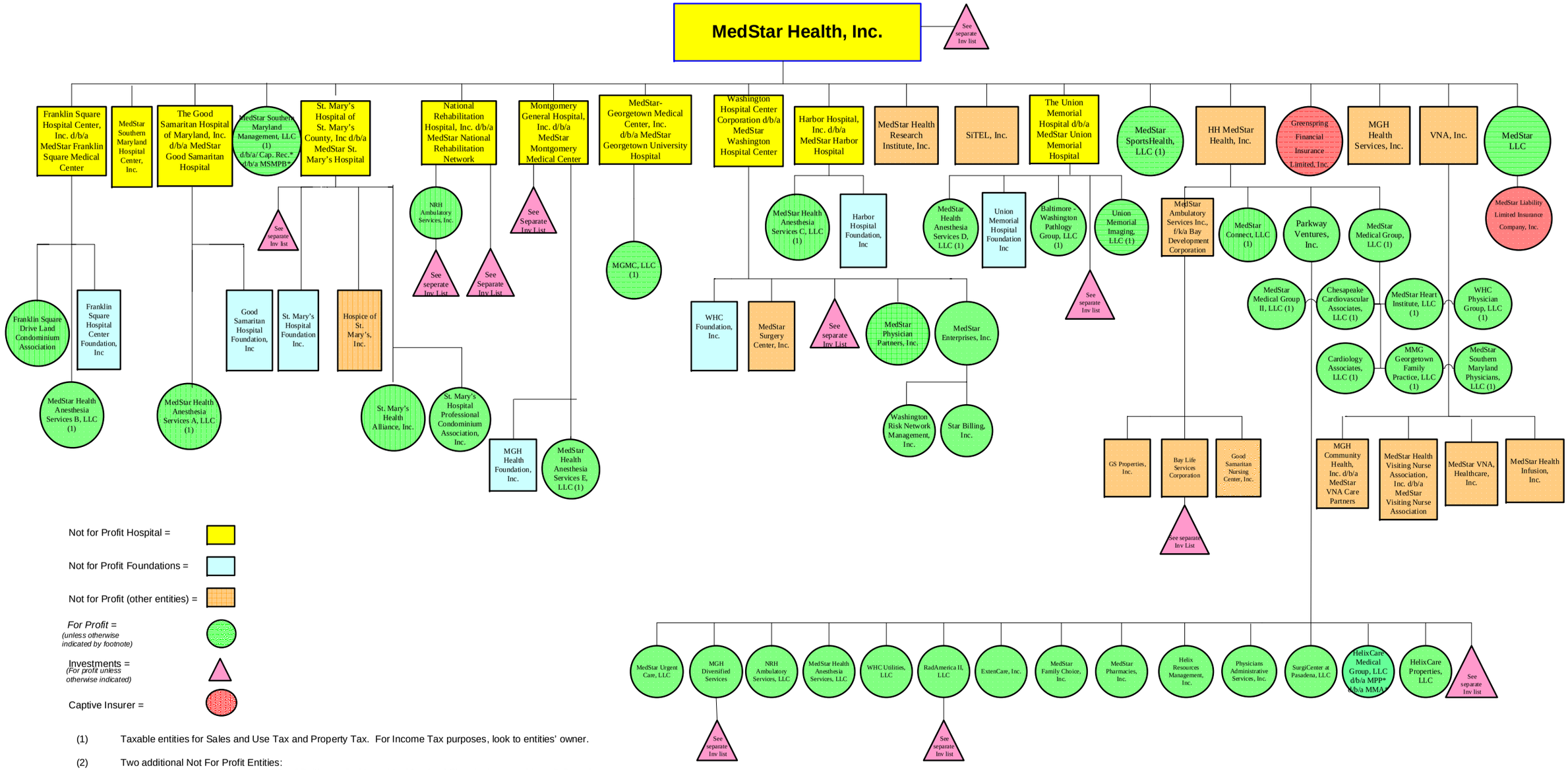






For the remaining patient segment, the ED, MSMH market share is consistently 85% or better (Fig 7.5-15).





(1) Taxable entities for Sales and Use Tax and Property Tax. For Income Tax purposes, look to entities' owner.

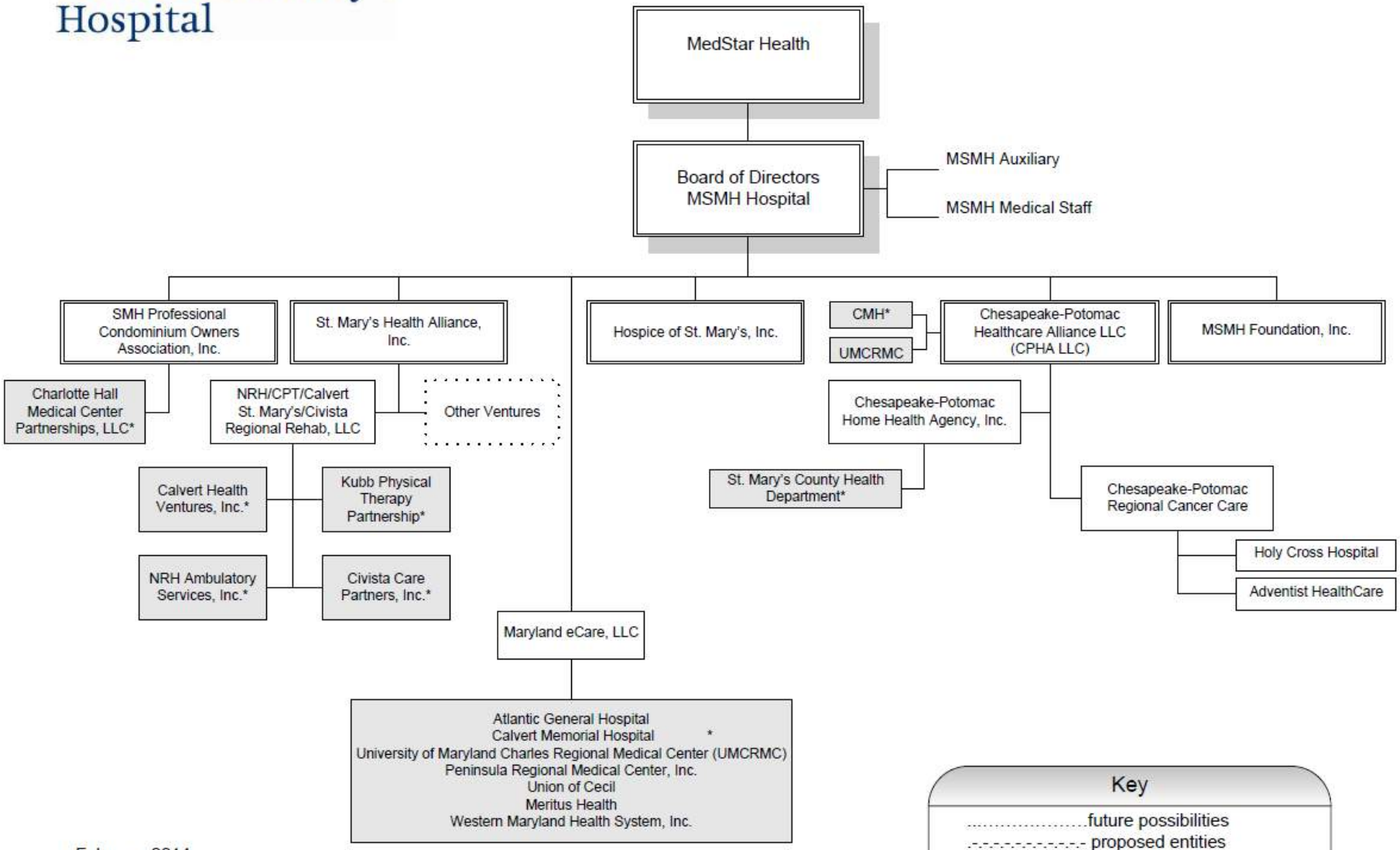
(2) Two additional Not For Profit Entities:
(i) Church Home & Hospital of the City of Baltimore (holds residual funds of Church Home and Hospital); and
(ii) Church Home Corporation (licensed as life care community; 2 remaining residents)

d/b/a full names

*Capitol Receivables Management
*MedStar Southern Maryland Physician Billing
*MedStar Physician Partners
* Metropolitan Medical Associates

MedStar St. Mary's Hospital

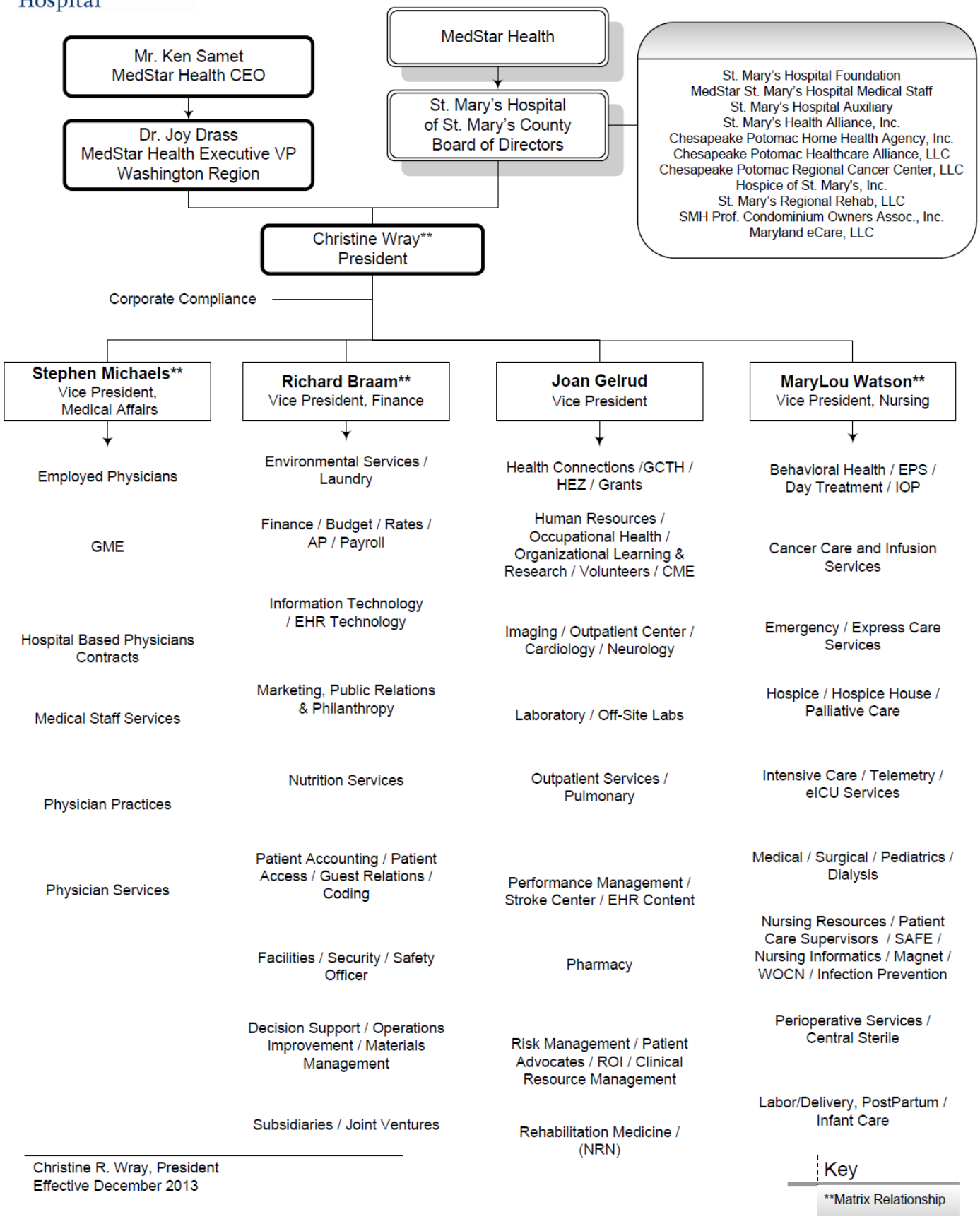
Organizational Relationships



February 2014

MedStar St. Mary's Hospital

Functional Organization Chart - Departments



Christine R. Wray, President
Effective December 2013

Glossary of Abbreviations and Terms

A

AABB	American Association of Blood Banks
AACVPR	American Association of Cardiovascular & Pulmonary Rehabilitation
ACLS	Advanced Cardiovascular Life Support
ACOG	American College of Obstetrics & Gynecology
ACR	American College of Radiologists
ACS	American College of Surgeons
Action OI	Action for Operations Improvement. A comparative database for operations improvement initiatives used to benchmark key performance indicators.
ADA	American Diabetes Association – or – Americans with Disabilities Act
Adaptive Design – A PI data tool	
ADC	Automated Dispensing Cabinets
Admin	Administration or Administrative
ADT	Admissions, Discharges and Transfers
AES	Associate Engagement Survey
AHA	American Hospital Association
AHRQ	Agency for Healthcare Research & Quality
AMI	Acute Myocardial Infarction
ANSI	American National Standards Institute
AOP	Annual Operating Plan
AP(s)	Action Plan(s)
APACHE	Acute Physiology and Chronic Health Evaluation
APR-DRG	All Payer Related Diagnosis Related Groups
ARR	Admissions, Readmissions, and Revenue – HSCRC reimbursement methodology
ASC	Ambulatory Surgery Center
ASERC	Associate Satisfaction, Engagement and Retention Committee
Associate	Employee
AWE	Alliance for Workplace Excellence

B

BLS	Basic Life Support – or – Bureau of Labor & Statistics
BOD	Board of Directors
BSC	Balanced Score Card
BSN	Bachelor of Science in Nursing

C

CAP	College of American Pathologists
Care Mobile – a handheld medication barcode reading device	
CAUTI	Catheter Associated Urinary Tract Infection
CDC	Center for Disease Control
CEO	Chief Executive Officer
CET	Corporate Executive Team
CFO	Chief Financial Officer
Chap	Chapter
CHF	Congestive Heart Failure
CLABSI	Central Line Associated Blood Stream Infection
CLIA	Clinical Laboratory Improvement Amendments
CMC	Civista Medical Center
CME	Continuing Medical Education
CMH	Calvert Memorial Hospital
CMI	Case Mix Index
CMO	Chief Medical Officer
CMS	Centers for Medicare and Medicaid Services
CN	Charge Nurse

CNO	Chief Nursing Officer
CoC	Commission on Cancer
Code Green	– Associate communication for an emergency response to combative people
Code I	Associate communication for activation of our Hospital Information System Emergency Plan
Code Pink	Associate communication for an emergency response for an abduction/potential abduction of an infant/child
Code Red	Associate communication for an emergency response to an internal disaster/fire
Code Tan	Associate communication for an emergency response to an internal hazardous materials spill
COI	Conflict of Interest
COP	Conditions of Participation
COPD	Chronic Obstructive Pulmonary Disease
COS	Chief of Staff
CPHHA	Chesapeake-Potomac Home Health Agency
CPOE	Computerized Physician Order Entry
CQI	Continuous Quality Improvement
CRISP	Chesapeake Regional Information System for our Patients
CRMC	University of Maryland Charles Regional Medical Center (formerly Civista Medical Center)
CSM	College of Southern Maryland
CT	Computed Tomography
CY	Calendar year

D

DBA	Doing Business As
DCDN	Distributed Care Delivery Network
DECD	Department of Economic & Community Development
DHHS	Department of Health & Human Services
DHMH	Department of Health and Mental Hygiene
DISC	Personality Test or Personality Assessment – Drive, Influence, Steadiness, Compliance
DL(s)	Department Leader(s)
DLLR	Department of Labor, Licensing and Regulation (State of Maryland)
DMAIC	Design, Measure, Analyze, Improve and Control
DME	Durable Medical Equipment
DNS	Data not stable
DOL	Department of Labor
DRG	Diagnosis Related Groups

E

EAP	Employee Assistance Program
EBP	Evidence Based Practice or Protocol
eCare	Maryland Hospitals forming the electronic ICU System of remote Intensivist coverage
ECRI	Economic Cycle Research Institute
ED	Emergency Department
EDACS	Enhanced Digital Access Communication System
EEI	Employee Engagement Index
EEOC	Equal Employment Opportunity Commission
eICU	Electronic ICU, remotely monitored
EIPA	Equivalent inpatient admission
EIPD	Equivalent inpatient day
EL(s)	Executive Lead(s) (a VP on a project)
EMR	Electronic Medical Record
EMS	Emergency Medical System
EMTALA	Emergency Medical Treatment & Active Labor Act
EOC	Environment of Care
EOP(s)	Emergency Operations Plan(s)

EPA	Environmental Protection Agency
ERM	Enterprise Risk Management
EVP	Executive Vice President
EVS	Environmental Services (Housekeeping & Linen)

F

FACHE	Fellow of the American College of Healthcare Executives
FADE	Focus, Analyze, Design, Evaluate/Execute
FAQ(s)	Frequently asked question(s)
FDA	Food and Drug Administration
FEMA	Federal Emergency Management Agency
Fig(s)	Figure(s)
FLSA	Fair Labor Standards Act
FMEA	Failure Mode and Effect Analysis
FPPE	Focused Professional Practice Evaluation
FQHC	Federally Qualified Health Center
FTE	Full Time Equivalent
FY	Fiscal Year, July 1 through June 30

G

G2G	Good To Great Leadership Challenge
GAP	Governance Assessment Process
GCTH	Get Connected to Health (mobile van providing primary healthcare in the community)
GME	Graduate Medical Education

Green Team – Hospital team that explores environmental friendly alternatives & initiatives such as recycling programs

H

HAI	Hospital Acquired Infection
HC	Health Connections (hospital department)
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HD	Health Department

HealthGrades - independent healthcare ratings company

HEZ	Health Enterprise Zone
HF	Heart Failure
HHRA	Human Health Risk Assessment
HICS	Hospital Incident Command System
HIE	Health Information Exchange
HIM	Health Information Management
HIMSS	Healthcare Information and Management Systems Society Analytics EMR Adoption Model
HIPAA	Health Insurance Portability and Accountability Act
HIT	Health Information Technology
HOSM	Hospice of St. Mary's
HR	Human Resources
HRO	High Reliability Organization
HSCRC	Health Services Cost Review Commission

I

ICC	Intensive Care Center
ICD-10	International Classification of Diseases, 10th Revision
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
IMSP	Information Management Strategic Plan
IP	Inpatient
IRS	Internal Revenue Service
ISMP	Institute for Safe Medical Practices
IT	Information Technology

J

JD	Job Description

K

KPI	Key Performance Indicators

L

LC — Leadership Council – comprised of Senior Leaders & Department Leaders at MSMH

LDC — Learning & Development Council – an interdisciplinary team of leaders & frontline associates facilitating training, education & development across the organization.

Leadership – Consists of President, VPs, DLs and MEC members

Lean — A management philosophy focused on reducing waste and increasing efficiency while improving overall value

Leapfrog — A group working to initiate breakthrough improvements in the safety, quality and affordability of healthcare for Americans.

LIP — Licensed Independent Practitioner

LLC — Limited Liability Corporation

LMS — Learning Management System (SiTEL)

LOS — Length of Stay

LS — Lifesaver System (occurrence documentation)

LSS — Lean and Six (6)-Sigma

LT — Leadership Team of MedStar

LWBS — Left Without Being Seen

M

MacLeod — A statewide entity specializing in comparing various staffing levels among hospitals

Maryland eCare – The consortium formed of several hospitals in Maryland to better afford electronic ICU coverage with Intensivists.

MBON — Maryland Board of Nursing

MD — Maryland

MDRO — Multi drug resistant organisms

MEC — Medical Executive Committee (comprised of Medical Staff Officers & Department Chairs)

MedChi — Medical and Chirurgical Faculty of the State of Maryland (The Maryland State Medical Society)

Med/Surg/Peds – Medical/Surgical/Pediatrics (a MSMH department, also called MSP)

MFC — MedStar Family Choice

Mgt — Management

MGUH — MedStar Georgetown University Hospital

MH — Morehead

MHA — Maryland Hospital Association

MHAC — Maryland Hospital Acquired Condition

MHCC — Maryland Health Care Commission

MHEI — Maryland Healthcare Education Institute

MHI — MedStar Heart Institute

MHQCC — Maryland Healthcare Quality Cost Council

MHRI — MedStar Health Research Institute

MI2 — MedStar Institute for Innovation

MIEMSS — Maryland Institute of Emergency Medical Services System

Mkt — Market

MMR — Measles, Mumps, Rubella

Moody's — Financial rating agency

Moorehead Associates - Physician satisfaction & engagement survey vendor

MOST — MedStar Obstetrical Safety Training

MPP — MedStar Physician Partners

MPR — Marketing & Public Relations

MPSC — Maryland Patient Safety Center

MQSA — Mammography Quality Standards Act

MR — Medical Record

MRI — Magnetic Resonance Imaging

MS — Medical Staff

MSDS — Material Safety Data Sheets

MSH — MedStar Health

MSMH	MedStar St. Mary's Hospital
MSO	Medical Staff Office
MSP	Medical/Surgical/Pediatrics (a MSMH department, also called Med/Surg/Peds)
MU	Meaningful Use
MVV	Mission, Vision, and Values
MWHC	MedStar Washington Hospital Center

N

NASPR	Naval Air Station, Patuxent River
NFPA	National Fire Protection Association
NDNQI	National Database for Nursing Quality Indicators
NHSN	National Healthcare Safety Network
NIOSH	National Institute for Occupational Safety & Health
NIST	National Institute of Standards & Technology
NQF	National Quality Foundation
NP	Nurse Practitioner
NRC	Nuclear Regulatory Commission

NRC – National Research Corporation/NRC Institute – vendor used by MSMH for patient satisfaction surveying.

O

OB	Obstetrics
OCR	Office for Civil Rights
OFI	Opportunity for Improvement
OH	Occupational Health
OIG	Office of Inspector General
OLR	Organizational Learning and Research (hospital department)
OP	Outpatient
OPPE	Ongoing Professional Practice Evaluation
OR	Operating Room
ORYX	**The Joint Commission**'s performance measurement and improvement initiative
OSHA	Occupational Safety & Health Administration
OTH	Other Maryland hospitals, non-regional

P

PA	Physician's Assistant
PALS	Pediatric Advanced Life Support
PC	Personal Computer
PCM	Performance & Compliance Management
PCP	Primary Care Practitioner
PEC	Patient Experience Council
PET	Positron Emission Tomography
PG	Press Ganey
PHI	Protected Health Information
PI	Performance Improvement
PM	Performance Measurement
PN	Pneumonia
POCs	Patients & Other Customers
PRN	Latin phrase for whenever necessary
PSA	Primary Service Area
PSC	Patient Safety Council
PTO	Paid Time Off

Q

QAPI	Quality Assessment Performance Improvement
QBR	Quality Based Reimbursement
QIO	Quality Improvement Organization
QSPAC	Quality, Safety & Professional Affairs Council (Board Committee)

R

RAC	Recovery Audit Contractors

RACE	MSMH's acronym for Fire Safety - Rescue, Activate Alarm, Contain Fire, Evacuate/ Extinguish
RCA	Root Cause Analysis
RCI	Rapid Cycle Improvement
RCMC	Revenue Cycle Management Committee
Rep(s)	Representatives(s)
RIF	Reduction in Force
RN	Registered Nurse
ROI	Return on Investment
RRB	Ruby Review Board

S

S3	Strategic Surveillance System
SA	Strategic Advantage
St. Paul Group – HSCRC data warehouse contractor	
SBAR	A standardized communication technique – Situation, Background, Assessment, Recommendation
SC	Strategic Challenge
SCIP	Surgical Care Improvement Project
SEA	Sentinel Event Alerts
Sec(s)	Section(s)
Sg2	Name of company for utilization projections
SIPOC	Supply, Input, Process, Output, Customer
SiTEL	Simulation Training & Education Lab (MedStar's Online Learning System)
SL	Senior Leader, Senior Leadership
SMC	St. Mary's County
SNF	Skilled Nursing Facility
SP	Strategic Plan
SPIRIT	Acronym for MSMH's Values – Service, Patient First, Integrity, Respect, Innovation, and Teamwork.
SPP	Strategic Planning Process
SSA	Secondary Service Area
SSE	Serious Safety Event
SSI	Surgical Site Infection
Standard & Poor's – Financial rating agency	
SWOT	Strengths, Weaknesses, Opportunities, and Threats

T

TAT	Turnaround Time
TDaP	Tetanus, Diptheria and Pertussis vaccine
THR	Total Hip Replacement
TJC	The Joint Commission
TKR	Total Knee Replacement
TM	Talent Manager
Total Rewards – associate benefits including but not limited to medical, dental & vision coverage, disability & life insurances	
TW	Towers Watson, associate satisfaction & engagement survey vendor (external group)
Tx	Treatment

U

UHC	University Health System Consortium
US	United States

V

VAP	Ventilator Associated Pneumonia
VAT	Value Analysis Team
VHA	Voluntary Hospitals of America
VOC	Voice of the Customer
VP	Vice President
VP1	VP responsible for PM, OLR, HC, Physiology Services, Imaging
VP2	VP responsible for Pharmacy, Laboratory, Plant, Environment
VPF	Vice President, Finance

VPMA	Vice President, Medical Affairs
VPN	Vice President, Nursing
VTE	Venous Thromboembolism

W

WF	Workforce
WHFBC	Women's Health & Family Birthing Center (a MSMH department)